MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS
OF 20 December 2017 (NO. 12 OF 2017)
IN THE CASE 2017.V4 – ALMA

As petitioned by:

the Minister of Infrastructure and the Environment, now the Ministry of Infrastructure and Water Management in The Hague,

petitioner,
authorised representative: M. Schipper,
ILT/Shipping inspector,

versus

R.D. v. d. V.,
the person concerned,
counsel: M. Verhagen, LL.M.

1. The course of the proceedings

On 7 July 2017, the Maritime Disciplinary Court received a petition for a disciplinary hearing of the case against the person concerned as the captain of the Dutch seagoing vessel Alma from M. Schipper, inspector ILT/Shipping. The petition included 19 appendices.

The Disciplinary Court has notified the person concerned of the petition by letter (sent both by registered and ordinary mail), enclosing a copy of the petition with appendices, and has informed the person concerned of the right of appeal.

No statement of defence has been received from the person concerned.

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The presiding judge stipulated that the oral hearing of the case would be held at 11.15 hours on 8 November 2017 at the offices of the Disciplinary Court in Amsterdam. The petitioner and the person concerned were summoned – both by ordinary and registered mail – to appear at the hearing of the Disciplinary Court.

The court hearing was held on 8 November 2017. M. Schipper, inspector at the ILT/Shipping appeared at the hearing for the petitioner. The person concerned appeared, represented by his counsellor, M. Verhagen, LL.M.

2. The petition

In summarised form, the following forms the basis for the petition.
An accident took place on board the vessel Alma on 18 May 2016. Whilst loading in the port of Moerdijk, seaman Y.P. M. was crushed between two vertically loaded containers and died of his injuries.

The following charges – rendered in concise form – have been brought against the person concerned:
(a) the person concerned failed to sufficiently supervise compliance with all measures (instructions and regulations) taken by the employer to limit the danger of falling when working with containers and for working safely at heights on board.
(b) the safety management system for working at heights and the work involved in loading and unloading containers as prescribed in the ISM Code were not applied in full.

The person concerned is charged with thus acting contrary to the care expected of a good seaman in respect of the persons on board, the vessel, the cargo, the environment and shipping (Sections 4 and 55a of the Dutch Seafarer's Act), in conjunction with, inter alia, Section 63.1 of the Ships Decree of 2004.

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3. The position of the person concerned

The person concerned has not filed a statement of defence. The person concerned has stated at the hearing that he is not in agreement with the charges or the conclusion that work was systematically carried out unsafely. On the contrary, he was the person who promoted occupational safety. He saw to it that the stevedore worked with a safety cage, he ensured that the correct 'arresters' were on board, and whenever he noticed crew members breaking the rules he spoke to them about it. He urged the crew members not to allow themselves to be rushed by the stevedore and told them to tell the captain if they were asked to do things that they did not believe could be done safely. He impressed on the crew that they must not move within range of the crane and emphasised that they could only move over the containers using a safety cage and a safety harness. It was the chief mate's task to supervise and to speak to the crew members if he noticed any unsafe situations.

4. The assessment of the petition

1. A safety management certificate and a certificate of conformity under the ISM Code was required for the Alma (container feeder, 3,999 BRT). The manager/ship manager and ISM Company Holwerda Shipmanagement B.V. had developed an ISM safety management system. This company was responsible for ensuring that the system was in fact operated.
The person concerned and the crew members were apparently employed by Holwerda Shipcrew.
It was compulsory to have a safety committee on board the Alma, the task of which was to identify unsafe situations and ensure that the compulsory protection equipment was used correctly, such as – for working at heights – wearing a safety harness attached to a safety line. The committee was supposed to report on these matters and advise the captain.

2. The sections of the ISM Manual for the ship (attached to the petition as appendix 9) contain – rendered briefly and concisely – the following information.

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(1) Procedure cargo operations [4.1.3] (appendix 9C, p. 61/66).
Safety regulations for loading/unloading. During loading and discharging, the officer of the watch takes care that crew, stevedores and other cargo interests observe the safety regulations conscientiously.
Various other tasks are specified for the chief mate and the officer of the watch, such as supervising the correct performance of the loading and lashing work, checking the correct implementation of the stowage plan and checking for dangerous goods.
(2) work instruction Safety regulations Loading operations [4.1.3.1] (appendix 9D, p. 67).
-Everybody must avoid unsafe situations.
-The officer of the watch must immediately respond correctively if anybody is in a dangerous situation or acts dangerously.
-The officer of the watch takes care that everyone uses personal safety equipment.
-Walking under a hoist is strictly forbidden.
-It is not allowed for the crew to work on deck in an area where loading operations are performed.
(3) work instruction Lashing and unlashing containers [4.1.3.7] (appendix 9E, p. 68).
Ratings and officers engaged in cargo securing operations have to be trained in the lashing and unlashing of containers as to carry out their duties in a safe manner. (..) Safe systems of work such as working at heights (4.5.1.3) have to be implemented and the crew involved in lashing operations have to be familiar with them.
It is strictly prohibited to climb on containers without the use of stairs or a gearbox.
(4) work instruction Working at height [4.5.1.3] (appendix 9I, p. 77).
This procedure shall apply if the job site is at a height ≥ 2 meter.
[precautions:] Always inspect safety harness and life line. [standing orders:] Always secure yourself.

3. A document entitled 'Familiarization with the ship' dated 9 May 2016 (appendix 9H to the petition, pp. 75/76) shows that on that date Y.P. M. was

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familiarised, as a new crew member of the Alma, with the working conditions on board, with the safety procedures and with the lashing equipment.

4. An official report of findings of V.P.J. Kin, health and safety inspector at the SZW Inspectorate (appendix 4 to the petition, pp 18/19) contains, rendered briefly and concisely, information including the following.
At about 22.45 hours on 18 May 2016 I was at a dockyard in Moerdijk. I saw the container ship Alma there, loaded with containers. I saw to shore cranes. A container was suspended from one of the cranes at a slanting angle on a spreader. This container was hanging at a slanting angle above the victim, Y.P. M., who was laying on his front on another container, at the end of its short side. The slanting suspended container was resting on its short side opposite the place where the victim was lying on the other, lower container. These containers were connected together with two twist locks.
On the bridge of the ship, together with the captain of the Alma, I viewed the camera images made at the time of the accident from the bridge using the Alma's fixed camera system. I made a film of these images. I saw the following. The ship was being loaded with containers. There were three containers in a row roughly in the middle of the ship. The container farthest to the left of the three was hoisted again with the crane. On one side of this container there was a gap under it, estimated at 0.5 to 1 metre high. A person came into view, who reached out with his hand for the top side of the lower container. The person climbed onto the lower container and laid down in the gap between the containers. A few seconds later the uppermost container lowered onto the person. The upper container then rose briefly and lowered again. The camera time log showed the time as 20.45 hours. The work with loading the containers continued after this.

5. An official report of findings drawn up by M. Schipper (appendix 8 to the petition, pp 39/53) contains, rendered briefly and concisely, information including the following.

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I have viewed the film images that were recorded by the camera on the bridge of the Alma on 18 May 2016 from 19.48 hours onwards. The duration of the recording was 1:08 hours.
I saw the following. After the hatches had been closed, containers were placed on the hatches using two shore cranes. Five athwartships rows (bays) of containers were loaded. I saw several unsafe situations, which I categorised and placed in a table. I gave the time and the location of each observation of an unsafe situation.
Briefly summarised:
A. People located in the direct vicinity of the containers that were being placed on board at the time. Seven observations.
B. A person working under a partially hoisted container. One observation.
C. People located under or virtually under hoisted containers. Four observations.
D. A person located under or virtually under the hoisted man cage. One observation.
E. A person located in the hoisted man cage, without this person using a safety harness, without being connected to the safety line (which was present) and with the doors of the man cage open. Two observations.
F. Various people located at heights and working without being connected to safety lines. Thirteen observations.
G. A person jumped, without being connected to a safety line, at a height from one row of containers to another row of containers, while there was a gap between the two rows. One observation.
H. A person, who was not attached to a safety line, climbed from a container at a height without making use of a ladder or other sound climbing equipment. One observation.

This official report also contains, rendered in concise form, a description of the images of the accident.
The foremost crane turned to the container placed farthest to the port side in the top level of the second from foremost bay. A CCT inspector was standing on the quay; the chief mate was located at the tank containers in the rearmost bay.

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The side of the container pointing towards the stern was lifted slightly by the foremost crane so that the container was suspended at a slanting angle; the front of the container was attached to the container placed under it.
Shortly after this a person – who was to become the victim – was working at least with his hand between the partially hoisted container and the container under it.
Just after this the victim climbed completely between the containers and carried out work there. The inspector, who was first briefly out of sight, looked towards the containers (the reporting officer does not consider it plausible that the inspector had a view of the gap between the two containers, since the other containers in the same bay are at the same height between them]. The victim was already situated in the space between the two containers. The hoisted container was then lowered onto the container underneath it, while the victim was still between the two containers. The container was then lifted again by the rear side and put back down again. The victim was still in between the containers. The work then continued.

6. An official report on the statement of witness K.W. P., chief mate of the Alma, drawn up by M. Schipper and V.P.J. Kin (appendix 6 to the petition, pp 26/31), contains, rendered briefly and concisely, information including the following.
I was on watch at the time of the accident. I was in charge of the loading and unloading on deck. At the time of the accident I was located in the space between the rearmost hatch and the accommodation. I was checking whether the containers containing hazardous substances had been placed correctly. I am responsible for the loading of the ship. I draw up the loading plan and discuss it with the captain. When I'm on watch I manage the ship's crew. During the loading and unloading operations the chief or second mate coordinates the work on deck. I hand over the loading plan to the inspector of the stevedore, CCT. The communication between the crew and the personnel of CCT takes place verbally.
M. was preparing the twist locks and lashing down the containers. M. was there on his own during the accident. The other seaman on watch was located in a forward bay. I was on the stern in the space between the

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rearmost hatch and the accommodation. The cadet was walking around. I believe that the inspector should have been supervising M. The inspector was given a signal to raise the container and, apparently, the signal to lower it. The inspector was in contact with the crane operator.
I usually supervise on deck. The crew members have been given instructions on what to do and what not to do.
The procedure for fitting twist locks is that the seamen on duty fit and remove them. They close the twist locks on deck.
The procedure for correcting incorrectly placed twist locks or those that have fallen out is that we give the inspector a signal. He is in contact with the crane operator. The container is then hoisted up or completely turned away. We are then able to position the twist locks. The inspector determines whether the container is hoisted or turned away. The inspector stands in a place where eye contact and verbal contact are possible. It is generally the case that they shout to each other about whether the container is correctly positioned. We do not operate this procedure on board; this should be in the inspector's job description.
Crew members are allowed to be on deck during loading, but not in the danger zone. They must stay out of the bays where loading or unloading is taking place. Crew members are not permitted to stand under a hoisted load. We tell the crew members about these rules. We give them instructions before we start work, especially when there are new people. Unlike with other charters, in this situation we work with cranes that together often cover the whole deck, which means that you have to pay closer attention to what the cranes are doing.
If crew members are none the less on deck during loading and unloading or are situated under a load, they are spoken to severely by me or the second mate. They are given a reprimand.
Crew members who are not secured with a safety line when working at heights are also reprimanded.
I see here a number of screenshots of the camera images [of what the reporting officers regard as unsafe situations]. I have not seen all of the situations shown here. That wouldn't be possible. But I did see some things.

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Working safely went well at the beginning of this charter, but gradually, as a result of pressure from the shore organisation, the boundaries were pushed and we found ourselves in a grey area in which we allowed more and more leeway. There comes a time when you gradually find yourselves doing more without properly considering whether everything is going well. After the accident we were in agreement that we had allowed too much and since then we have all got back into line. Safety must always come first, the rest is secondary, even if the people ashore get annoyed or keep chasing us up. People will always push the boundaries, and we have those moments too. It gradually creeps in. You feel that you are under pressure, everything has to be done quickly. There must be no delays.
The crew members are not allowed to ignore any instructions from the "Safety regulations Loading operations" but this still happens. They are told which safety instructions they have to follow.
Crew members are not allowed to crawl between two containers if these are suspended above each other. They are told this verbally. Doing so was therefore not normal and was not something we ever did. Just fiddling about with the twist lock with a stick or a handle, that usually results in the twist lock falling into place on its own. If it did not prove possible to correct the position of a twist lock on the outside of the bay with a stick, then the whole container has to be taken off and you have to go there in the man cage to correct it.
I was in verbal contact with the victim. I regularly do an inspection round and speak to the seamen.
The victim had been given verbal instructions about how things go here in the charter. The second mate did the familiarisation with the victim.

7. An official report on the questioning of the person concerned drawn up by M. Schipper and V.P.J. Kin (appendix 7 to the petition, pp 32/38), contains, rendered briefly and concisely, information including the following.
At the time of the accident I was captain of the ship and I was resting in my cabin. I have to rest when the ship is in the port and before departing for the sea voyage.

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The chief mate is responsible for loading the ship and for how this is done. He manages the crew during loading.
The communication between crew and the personnel of CCT takes place verbally and with gestures.
The agreement with the shore personnel is that we work with a man cage in which my personnel are moved. If a container is not properly secured in the twist locks, it has to be completely removed from the site so that the crew can safely correct and replace it. It is stated in the charter party that a man cage must be available. My people are attached to safety lines in the cage. These are the procedures on board. I instruct the crew to work that way. When they arrive on board they are familiarised in accordance with the ISM procedure. M. had also been informed of these arrangements. He was told verbally by colleagues about specific matters concerning this charter, such as the fact that, unlike at other terminals, the twist locks are laid out by the crew itself, both in England and the Netherlands. Specifically for Moerdijk, this involves rough work and you have to watch out. People do not always work safely on the shore side in Moerdijk. The work is done quickly. The rougher and faster work means that a container is sometimes not placed properly on the twist locks and has to be adjusted later.
M.'s task was to assist with loading. The chief mate was supervising the loading work, but he has also got a lot of other things to do.
The procedure for placing the twist locks is that the crew on the containers, using the man cage and crane, lay out the twist locks, that they lay out the twist locks attached to the man cage with a fall arrester. This is done without a safety line on deck.
The procedure for adjusting incorrectly placed or fallen out twist locks is that a container has to be hoisted up and completely turned away from the place. If this is at a height, someone then has to go in the man cage to the place and adjust what is not correctly positioned.
These procedures are not specifically described. People are not allowed to be under a load, the container therefore has to be turned away.
The crew have been told about these procedures in the familiarisation. M. was familiarised and specifically informed by his colleagues about how to lay

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out the twist locks. Once every two weeks I tell the crew that they have to pay close attention and must not allow themselves to be rushed by the speed of the loading operations.
Crew members are allowed to be on deck during loading, provided that they are not within the reach of the crane or in the bay being loaded. Crew members are not permitted to stand under a hoisted load.
This is all laid down in the ISM instruction 'safety cargo operations'.
If crew members act contrary to these instructions they must be confronted about this by the office, a colleague or the terminal inspector. This also applies if they work at heights without a safety line.
I see here a number of screenshots of the camera images [of what the reporting officers regard as unsafe situations]. These situations arose at first. I insisted on making sure that a man cage and safety line were arranged. I'm shocked by what has happened. This is not what had been arranged.
Crew members are absolutely not allowed to crawl between two containers if these are suspended above each other. That was in no way usual.

8. At the hearing of 8 November 2017, rendered in summarised and concise form, the person concerned made the following statement.

I am still on board the Alma (container feeder of 3,999 BRT, length 101.11m, breadth 18.45 m, 508 TEU) as its captain; the ship is now called A2B Comfort.
The videos were made by the charterer A2B-online in order to record any damage. This is not something that the crew normally checks. I have seen the video images of the day of the accident.
It is unusual in European ports for the crew to have to lay out the twist locks rather than this being done by the shore personnel, but this does happen more in the Netherlands.
Two shore cranes are used, one fore and one aft. For each shore crane there is one seaman who lays out the twist locks and one CCT inspector, who maintains contact with the crane operator with a radio telephone.

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The seamen only had the task of laying out the twist locks in the recess in the deck, the hatch or the lower row of containers for that purpose and closing the twist locks with a metal rod once a container was placed in it.

The chief mate was in charge of the loading work. The chief mate was at the aft bay at the containers containing hazardous substances and therefore did not have a view of what was happening in a container bay forward of that position. It was however the chief mate's task to maintain supervision. That is also laid down in the safety management system.
I was resting during the loading work. I did not arrive at the scene until after the accident.

New seamen such as M. are familiarised by the second mate. I was not there myself. I always made sure that crew members were informed about the way of working. We had a very experienced seaman who instructed his new colleague verbally about the working method and rules. I had asked that experienced seaman to do this. I do not know whether M. was specifically instructed about the working method at CCT. M. was an experienced seaman. I knew him from a previous period.

The two shore cranes were turning rather than gantry cranes; you have to take care to stay out of the crane with the container. People have to stay out of the crane's reach and wait until the whole bay has been filled with containers, and only then lay out the twist locks for the next row of containers.
According to the safety instructions the twist locks have to be laid out at a height from a man cage with fall protection (a fall arrester).
The seaman is taken to the row of containers with the man cage. The seaman lays out the twist locks from the man cage. He walks to do this.
There is a steel cable in the man cage, the fall arrester is hooked onto it. The other end is hooked onto the safety harness worn by the seaman. The cable of the fall arrester rolls with the person, like a car seatbelt. The cable allows sufficient freedom of movement to get the job done.

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The arrangement was that the seamen had to be attached to the safety line. It can indeed be seen in the video that the seamen working at heights are not wearing a safety harness or using fall protection when laying out the twist locks.

The charter with A2B-online ran from July 2014. At the beginning of that charter I began to make arrangements for the man cage to be provided. The culture at CCT was along the lines of: why are you being so difficult? They did not regard it as being normal to use a man cage, there was a lot of opposition to this. Later I personally arranged for a good safety harness and fall arresters to be provided. There was opposition to this as well. The man cage was arranged by CCT on my insistence. There had been talks with the management of CCT at the end of 2014. I always stressed the point that people had to be able to work safely.
There was one man cage, owned by CCT, for loading the Alma, and it had to be moved by one of the cranes.

Regarding the adjustment of incorrectly positioned containers or twist locks that had fallen out under a container, we had agreed with CCT that the container in question had to be completely turned away from the position and, if necessary, placed back on the quay, so that they area was free for the seaman to make the adjustment. Adjusting by raising one short side of the container is not in keeping with that agreement. People should never work under a load.
There was no specific procedure for the communication between the seaman and the inspector; no working method had been agreed. It seems that there was no clear communication between the seaman and the inspector before the accident either. The seaman climbed up himself, which he should not have done, and which the inspector should have prevented. The seaman's actions were not in keeping with what had been agreed. The seaman should of course have moved away before the container was put back in its place.
I cannot say with certainty that the seaman was aware of all of this and had been given sufficient instruction. The method for correction of incorrectly

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placed containers had not been laid down in writing at the time, and therefore should have been explained to the seaman.

I regularly spoke to the seamen and told them that if in doubt and if they did not trust the situation they should not continue working, even if they were being rushed. I believe that M.'s English was sufficient to understand this. We regularly and repeatedly raise the point that people have to work with a man cage and a safety harness. If I saw things like this myself, such as people working at heights without a safety line, I responded.
I have read the chief mate's statement. I do not agree with his statement about the boundaries gradually being extended under the pressure of time from the shore and because everything has to be done quickly. I have not experienced that standards were allowed to slide when it came keeping to the agreements. The way I see it, I was constantly correcting. I always raise these matters, I insisted on people working safely and that the crew should not allow themselves to be rushed. The agreement was that people had to use a safety line and work in the man cage, but it's true that the film images show that people were not using the harness and safety line.

Changes have been made since the accident:
- a new instruction has been added to the ISM safety management system explaining the method for correcting the placement of containers
- we now have a fifth seaman
- use is now made of semi-automatic twist locks, which are fitted ashore, on front of the load on the four corners under a container being loaded, after which the container is placed on board; it is no longer necessary to use a man cage with a safety line to lay out the twist locks.

I consult with the mate in the port on the loading and the method. My relations with officer P. were good. Perhaps I gave him too much freedom. He did once say to me that we had to do too much work in this charter, but that was not specifically about safety. We drew up the stowage plan ourselves; at

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other shipping companies this is often done at the office and the mate only checks the stowage plan with the computer.
There was a scheduled time of departure. We had a sailing schedule of 3 times a week unloading/loading in Moerdijk and Immingham.

It is true that I myself stated that work is not always done safely at CCT and that the crew members had to watch out, that rough and fast work resulted in a container not being placed properly on the twist locks, which then had to be corrected. Instruction was so important because of the unsafe work at CCT. Safety at work is also a responsibility of the crew itself.
It could be that there was a 'can-do mentality' among the seamen and officers. There are also examples of people on board being rushed by the terminal personnel, such as the crane operators communicating with others using a loudspeaker. In my opinion, the terminal should not shift responsibility onto the seamen. Their task was to lay out the twist locks, nothing else. In fact, they have to work without any other contact with the shore team. I wanted that kept separate wherever possible.
The order of work was determined by the shore team. Working with a man cage and turning away a container for correction was also managed by the shore team.

I have sent emails about safety at work to the management of CCT and also to the shipping company and the charterer. The shipping company picked this up, but the terminal management was not very responsive.
There was a safety committee on board that advised me. I believe that talks were held with it about working safely when loading and unloading. I cannot give an example of this. No notes have been kept.

5. The ruling of the Disciplinary Court

1. Based on the statements of the person concerned, the content of the official reports and the documents and film images, the following case has been made in this regard.

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On 18 May 2016 the Dutch seagoing vessel Alma was at the CCT terminal in the port of Moerdijk, where the ship was unloaded and then loaded again with containers. The loading was carried out with two rotating CCT shore cranes.
The containers were secured on board with twist locks, with the bottom row on deck or on a hatch and stacked on each other. The twist locks were placed and locked by the Alma's seamen. CCT inspectors were in contact with the crane operators by radio telephone. One man cage, owned by CCT, was present. This made it possible to transport the seamen using the shore crane. If properly positioned, the man cage could also be used by the seamen to work safely at heights, for which purpose a fall arrester was hooked between the steel cable in the man cage and a safety harness that they wore.

During a period of approximately one hour (from 19:48 hours), various unsafe work situations arose, including crew members working at heights without any fall protection or safety harness or in which a seaman was located under or in the vicinity of a container that was being placed on board with a crane, or under the man cage.

An accident took place at approximately 20:45 hours. A container had not been correctly placed on the twist locks. To correct this, a shore crane lifted one short side of the container with a spreader, to make a space under that container and above the container under it. Seaman M. started working in the gap in between. At a given point in time he laid down on the lower container. The crane operator then lowered the top container, crushing seaman M. and causing his death.

2. In the judgment of the Disciplinary Court, the person concerned, who was the captain of the ship and was resting in his cabin during the loading of the ship, cannot be held responsible for the tragic accident and the death of seaman M. The action taken by M. – lying in the opening between a positioned container and a container lifted slightly on the one side, apparently to adjust a twist lock – was extremely dangerous, all the more so

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since it was not clear whether he could be seen there by the inspector or the crane operator.
There is nothing to show that this had happened before; neither has a plausible case been made that anybody, the inspector in particular, asked him to do this. It can be ruled out that the inspector and the crane operator were aware that the seaman was where he was when the uppermost container was lowered onto the seaman. There is nothing to show that there was any communication between the seaman and the inspector shortly before that point in time.
The dangerous actions of the experienced seaman could not reasonably have been foreseen by the chief mate, who was situated further aft and did not have a view of the scene of the accident, or the person concerned.

3. According to the petition, the charge made by the petitioner against the person concerned relates not so much to the accident, but more to the way in which the crew worked when loading the ship with containers. More generally, the charge is that the instructions of the safety management system regarding working at heights and limiting the danger of falling and working on the loading and unloading of containers were not fully complied with and that the person concerned did not adequately supervise compliance with those instructions.

4. Section 63.1 of the Ships Decree 2004 stipulates: The captain of a vessel for which a safety management certificate is required, shall ensure that the safety management system prescribed in the ISM-Code is operated on board the vessel.
Therefore, the question to be answered is what the person concerned can be held specifically responsible for in this regard.

5. The Disciplinary Court first wishes to note the following points.
(a) In accordance with what the petitioner has put forward, responsibility for working safely on board is held primarily by the shipping company/maritime employer of the crew. This should be expressed not only by drawing up procedures and work instructions in the context of an ISM safety

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management system, but also by ensuring that there are sufficient qualified crew members and that the necessary safety equipment is provided in order to make it possible to actually work in accordance with those procedures and instructions and for this to be effectively supervised.
Consideration could also be given to concluding operational agreements with charterers, containing stipulations that have implications for the tasks and activities of the crew and the associated working conditions; it must also be possible to carry out these tasks and activities safely.
The charter concluded with A2B-online involved very frequent loading and unloading, both in Moerdijk and in Immingham, three times a week, with a relatively short sea route in between. This was a demanding schedule for the person concerned as captain and for the whole crew. According to the charter, the twist locks had to be positioned by the crew.
It is the responsibility of the shipping company/ISM Company/maritime employer to ensure that work on board is carried out in accordance with the safety management system and to supervise this. The reports of the safety committee and the audit reports of the Classification Society may play a role in this.
(b) The person concerned has shown that working safely during unloading and loading was very important to him. Following the start of the charter with A2B-online in 2014 he made efforts to ensure that a man cage would be used for loading and unloading – provided by the terminal – and that the man cage (with a steel cable in it) contained the correct safety harnesses and fall arresters. He also saw to it that new crew members were familiarised and instructed, also on the loading and unloading work. He seems to have regularly spoken to the seamen about this.
(c) During the work on board the chief mate – and in some cases the second mate – bears initial responsibility for maintaining supervision during the loading work and for correcting seamen who fail to work in conformity with the safety regulations and instructions. In view of the ship's schedule, the captain has to rest during that period. The mate also has various other tasks during the loading work.

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(d) In keeping with the agreements made with it, CCT should have used a shore crane to place the man cage in such a way that the seamen could work from it with the fall arrester in accordance with the instructions. If it proved necessary to adjust the positioning of a container, the container in question should have been lifted and turned away in its entirety using a shore crane. To that extent, the cooperation of CCT was needed to work in accordance with the agreements.

6. The captain's task as outlined above and in accordance with Section 63 of the Ships Decree 2004 entails verifying that the instructions and work instructions of the safety management system are complied with as required. This means that he must also maintain supervision himself. To the extent that supervision with compliance is partly maintained by ship's officers, the captain must ensure that they keep him properly informed. He must also ensure that the safety committee regularly reports to him on compliance aspects.

7. With regard to the actual compliance with the work instructions for loading and loading and for working at heights there was even more reason for this since - as argued by the person concerned himself - CCT in Moerdijk worked roughly and quickly and not always safely. This approach to work resulted in a container not being positioned properly on the twist locks, and this had to be corrected.
It seems that CCT was not convinced of the need to work with a man cage. An additional reason to continuously check compliance with the work instructions was that the ship was loaded and unloaded at CCT three times a week. It is a generally acknowledged fact that with the course of time people who are frequently involved with working in dangerous situations become accustomed to this and less aware of the dangers and the need to continue to take appropriate safety measures.

8. The video images made on 18 May 2016 during a period of approximately one hour prior to the accident (see paragraph 4.5) show that

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the safety instructions for working during loading and working at heights were not complied with on a very large number of occasions: the seamen were placing the twist locks – also at heights on the containers already loaded on board – without making use of fall arresters. They were not wearing a safety harness on which to connect the fall arrester. There were various times at which the seamen were close to containers that were being loaded with a shore crane; in some cases they were under or virtually under a hoisted container or man cage. There were times when personnel jumped from bay to bay and climbed down a container without any safety equipment. The method used to adjust the positioning of the container involved in the accident was unsafe: the container was not completely lifted up and turned away so that the location was free to carry out the adjustment safely; on the contrary, the approach taken led to an immediately dangerous situation.

On being confronted with these images, chief mate P. stated that he had seen some but not all of this. He had other tasks to perform and in many cases could not see the work being done by the seamen. It seems that he did not intervene or confront the seamen on their behaviour either during or after that period.
Chief mate P., the person primarily responsible for supervising the work of the seamen during the loading of the ship, also stated that: Working safely went well at the beginning of this charter but gradually, as a result of pressure from the shore organisation, the boundaries were pushed and we found ourselves in a grey area in which we allowed more and more leeway. There comes a time when you gradually find yourselves doing more without properly considering whether everything is going well. After the accident we were in agreement that we had allowed too much and since then we have all got back into line. Safety must always come first, the rest is secondary, even if the people ashore get annoyed or keep chasing us up. People will always push their boundaries, and we have those moments too. That sneaks in a bit; you feel a certain pressure; everything has to be done quickly. There must be no delays. Crew members are not allowed to ignore even one safety instruction, but it still happens.

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9. In view of the video images and the statement of chief mate P., the Disciplinary Court considers that a plausible case has been made that the approach to work caught on video was not exceptional but, on the contrary, had become the normal course of events. It must therefore be concluded that the safety management system was structurally and frequently not being applied in full.

10. The person concerned has stated that he does not agree with the statement of the chief mate cited above, but the Disciplinary Court is not convinced by this argument. The chief mate's statement is confirmed by the video images.
The chief mate is the person who was on deck at the time of loading and who could see how things were going. The person concerned has not said that he regularly checked how the work was being carried out and has stated that he had never looked at the video images of the loading work, which makes it unclear what his position is based on. The person concerned has only said that if he saw any unsafe situations – apparently incidentally – he responded to them and impressed on the crew that they had to work according to the rules. It does not follow from this that the statement of the chief mate is incorrect.

11. The Disciplinary Court has come to the conclusion that the person concerned should have included it among its tasks to regularly check the loading and unloading work in order to gain a clear impression of how it was being done. This is not necessarily precluded by the need to take sufficient rest. It seems that the chief mate did not tell the person concerned that the safety regulations were being structurally ignored. There is nothing to show that the person concerned specifically and emphatically asked the chief mate whether the seamen had kept to the rules. To the extent that the second mate had a supervisory task for the loading and unloading work, the same applies to him.
Nothing has been stated or demonstrated regarding the reports of the safety committee to the person concerned. There is nothing to show that the

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person concerned thus kept himself informed of the course of events during loading and unloading.
It can be inferred from the above that the person concerned did not sufficiently inform himself about how the work was actually being done, despite the fact that this was one of his tasks.
It is possible that the person concerned was too quick to assume that the officers and seamen were carrying out their work correctly and taking their own responsibility.

12. The use of the man cage with a fall arrester was essential to be able to work safely at heights. A requirement for making use of this was that the man cage had to be moved at the right times by a shore crane and put down in the area where the seamen were working, especially for positioning and turning the twist locks and for correcting the incorrect positioning of a container.
If it was necessary to move the man cage in accordance with the crew's work instructions, this was to be done by the shore personnel. There is nothing to show that agreements on this were made with CCT and kept in practice. The same applies to an agreement with CCT on how to correct an incorrectly positioned container in such a way that the container in question was to be completed lifted up and turned away from the location. The communication during the loading and unloading work between the crew, especially the seamen, and the CCT personnel, especially the inspectors, evident left something to be desired. It seems that no clear agreements were made in this regard.
It seems that the direction of the use of the man cage and the method used to correct an incorrectly positioned container was not under the ship's control but was in fact determined entirely by the CCT personnel.
The Disciplinary Court further notes that only one man cage was available for the loading activities, despite the fact that the containers were being loaded at the same time fore and aft of the ship. One seaman was positioning the twist locks on each section. When this had to be done at heights (on the

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lower or the second row of containers), it was not possible for them both to do this from the man cage.

13. It can be concluded from the above that the person concerned was fully aware of the importance of working safely, that he certainly made efforts to ensure that work was done safely, especially by providing safety equipment and instructing the crew, but that he did not do enough to ensure that the work was indeed carried out in accordance with the safety regulations and – when this was not the case – to ensure that this was done at all times.
A good safety culture on board is of the greatest importance: creating and maintaining this is the direct responsibility of the captain.
It seems that this safety culture was not in place in practice, and had not been for a longer period of time. The work was being carried out structurally unsafely. The person concerned could and should have noticed this and put it right. The person concerned thus failed to sufficiently take a lead in bringing about and maintaining the desired safety culture in order to fulfil his statutory tasks pursuant to Section 63 of the Ships Decree 2004 and also his obligations according to the principles of good seamanship.

6. The disciplinary measure

The Disciplinary Court judges that the person concerned has seriously failed in his responsibilities as captain for a longer period of time. This justifies a suspension of his navigation licence.

The Disciplinary Court has taken the following into account. The safety awareness and intentions of the person concerned were good in themselves. He certainly made efforts to ensure that the work was carried out safely. The person concerned has been greatly affected by the accident. Further measures have been taken in response to it: a fifth seaman, and working with semi-automatic twist locks. Note has also been taken of the points made under paragraph 5.5. It has not been demonstrated to the Disciplinary Court

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that the shipping company/maritime employer or the chief mate have also been called to account for this.
The Disciplinary Court regards the facts and circumstances of this case to impose a fully conditional suspension of the navigation licence for the duration set out below.

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7 The decision

The Disciplinary Court:

- declares the objections against the person concerned as stated under paragraph 5, and in particular, 9, 11 and 13 to be well-founded;
- suspends the navigation licence of the person concerned for a period of three months;
- stipulates that this suspension of the navigation licence will not be imposed unless the Disciplinary Court stipulates otherwise in a subsequent ruling based on the fact that the person concerned has once again behaved contrary to his duty of care as a good seaman in respect of the people on board, the vessel, its cargo, the environment or shipping prior to the end of a probationary period, which the Disciplinary Court hereby sets at two years;
- stipulates that the probationary period of the suspension shall commence on the date six weeks following the date of this ruling being forwarded.

Duly delivered by A.N. van Zelm van Eldik, LL.M., presiding judge, R.J. Gutteling, E.R. Ballieux, H. van der Laan and D. Willet, members, in the presence of E.H.G. Kleingeld, LL.M., as secretary and pronounced by the presiding judge in public session on 20 December 2017.

A.N. van Zelm van Eldik
president

E.H.G. Kleingeld
secretary

An appeal against this ruling can be lodged within six weeks of the date of forwarding with the Dutch Trade and Industry Appeals Tribunal ('College van Beroep voor het Bedrijfsleven'), Prins Clauslaan 60, 2595 AJ The Hague, P.O. Box 20021, 2500 EA The Hague, the Netherlands.

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