MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS
OF 12 April 2017 (NO. 5 OF 2017)
IN THE CASE 2016.V7-AMADEUS AMETHIST

As petitioned by:

the Minister of Infrastructure and the Environment in The Hague,
petitioner,
authorised representative: M. Schipper,
ILT/Shipping inspector,

versus

M.J.C. V.,
the person concerned.
counsel: A. Jumelet, LL.M.

1. The course of the proceedings

On 28 September 2016, the Maritime Disciplinary Court received a written petition for a disciplinary hearing of the case against the person concerned as the first officer of the Dutch seagoing vessel Amadeus Amethist from M. Schipper, inspector ILT/Shipping. Fourteen appendices were attached to the petition.

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 or any other response 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 11.00 hours on 3 March 2017 at the offices of the Disciplinary Court in Amsterdam.
The Human Environment and Transport Inspectorate and the person concerned and his counsellor were summoned – the latter both by ordinary and registered mail – to appear at the hearing of the Disciplinary Court.
The court hearing was held on 3 March 2017. M. Schipper, inspector at the ILT/Shipping appeared at the hearing for the petitioner. The person concerned appeared, represented by his counsellor.

2. The petition

In summarised form, the following forms the basis for the petition.
On 23 February 2016 an accident that resulted in a serious injury took place on board the Dutch seagoing vessel Amadeus Amethist whilst moored in the Port of Antwerp.
During work on the hatch carrier, which was to be lowered fully to the 'river position' for the first time by the crew, the starboard side of the hatch carrier descended unexpectedly. The victim, apprentice A.M., was under the hatch carrier at the time. Two other crew members suffered minor injuries. The person concerned was the first officer and was in charge of the work.

The petitioner takes the view that the accident was caused by the human error of the person concerned, who should have anticipated that the crane frame of the hatch carrier would fall down when a certain securing pin was forcefully removed. The person concerned should have thought more carefully before having this securing pin removed.
Under the principles of good seamanship, ship's officers have a duty of care and responsibility towards the other crew members, especially concerning occupational safety. The inexperience of this apprentice was an additional reason for caution. The person concerned did not sufficiently act with the due care and responsibility expected of him, especially regarding the failure

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to prevent the apprentice and boatswain from being underneath the suspended crane frame. Also, the apprentice was not wearing a helmet.

The petitioner charges the person concerned with acting in breach of the principles of good seamanship within the meaning 55a of the Dutch Seafarer's Act.

3. The position of the person concerned

No reply has been received from the person concerned prior to the hearing.

4. The assessment of the petition

A. The structure of the hatch carrier and the procedure to be followed for lowering it are described in the petition. This information is based on the report of the ILT inspector Van Waesberghe (appendix 5 to the petition, pp. 22-25), with the supplier's operating instructions for the hatch carrier Appendix 7, pp. 43-44), the photos taken after the accident (appendix 6, pp. 26-32) and the new procedure drawn up by the shipping manager after the accident (appendix 12, pp. 59-71).

The structure of the hatch carrier is roughly as follows.
(a) There is a crane frame consisting of two vertical sections on the port and starboard sides and a horizontal section that runs from port to starboard above the hold. At the bottom of the vertical sections on the port and starboard sides there is a horizontal construction beam with wheels on it, which fit the hatch carrier onto the crane rails. The crane rails are on top of the coaming on the port and starboard sides.
(b) there is a hoisting frame under the horizontal section and between the vertical sections of the crane frame.
(c) there are two hydraulically operated cylinders: one on the port side and one on the starboard side, which can be used to raise and lower the hoisting frame in relation to the crane frame. The pistons of these cylinders are

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attached to the lower construction beams of the crane frame; the cylinder housings are attached to the hoisting frame with a securing pin. The connection between the crane frame and the hoisting frame is thus formed by these securing pins.
The entire hydraulic system is controlled from the starboard side.

The procedure for lowering the hatch carrier, in summarised form, comprises the following steps.
(1) The hatch carrier is moved until the wheels rest on a short, lowering section of the crane rails on the port and starboard sides, whereby the holes in the construction beams at the bottom of the crane frame are placed straight above holes in these rail sections.
(2) The crane frame of the hatch carrier is attached to these rail sections by putting bolts through the holes and securing them with nuts.
(3) The hoisting frame is lowered with the hydraulic system until it rests on the hatches.
(4) The handles of the hydraulic system are placed in the vertical position for "lifting crane" or "high pressure".
(5) The crane frame on both the port and starboard sides, is slightly hydraulically raised with the rail sections, resting on the hoisting frame.
(6) The support pins located under the outer ends of the rail sections are now relieved of pressure and are pushed away.
(7) The crane frame on both the port and starboard sides is lowered with the rail sections by setting the hydraulic system to the "hoisting" position, until the rail sections come to rest on a support beam situated half-way across the coaming on the port and starboard sides.
(8) The securing pins, as the connection between the cylinder housings and the hoisting frame, are now relieved of pressure and are taken away.
(9) The cylinder housings are lowered and the hoisting frame stays resting on the hatches.

B. The following information, rendered in concise form, has been drawn from the report of ILT inspector Van Waesberghe (appendix 5, pp. 22-25),

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the statements of the person concerned, the captain and the boatswain (appendices 8-10, pp. 45-57).

The Amadeus Amethist (referred to below as "the ship"), a coastal trading vessel of 1898 BRT, length 88 m, became the property of Amaq B.V. at the beginning of January 2016. The shipping manager is De Bock Maritiem B.V., which is also the employer of the person concerned. After that the ship was moored at a shipyard. This crew had been sailing with the ship for four weeks prior to the accident.

On the afternoon of 23 February 2016 the ship was moored in the Port of Antwerp. The ship was being prepared for the voyage through Albertkanaal. The hatch carrier was to be lowered to river height because of the low clearance height of the bridges in the canal. The crew had not performed this task before. The boatswain had told the captain that he wanted the first officer, the person concerned, to take charge of the work.

Two days prior to arrival in Antwerp, the person concerned, the boatswain, the seamen and the apprentice discussed how to do this work with the aid of the hatch carrier operating instructions of the supplier, which were present on board.

The work was carried out that afternoon under the supervision of the person concerned and by the boatswain, AB R. and apprentice A. M. The person concerned operated the hatch carrier. The first part of the procedure given in the operating instructions was carried out without any difficulties. During step seven – when the crane frame was lowered – some doubts arose: the operating instructions were not entirely clear on this point. This step – step seven – was not fully completed before carrying out step eight, which involved removing the securing pin between the hoisting frame and the crane frame. Attempts were made to remove the securing pin on the starboard side. However, because it was jammed, the securing pin was knocked out using a hammer and chisel. The chisel first of all remained in the hole where

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the pin had been. When AB R. succeeded in removing the chisel, the hatch carrier came down on the starboard side. The apprentice A. M. was standing in the gangway under the hatch carrier and was struck on the head. The boatswain received a glancing blow on his back. AB R. fell down and was slightly injured.
The apprentice A. M. was seriously injured and was taken to hospital.

C. At the hearing of 3 March 2017, rendered in summarised and concise form, the person concerned made the following statement:

On the boatswain's request, prior consultations were held on the procedure for lowering the hatch carrier, based on the supplier's operating instructions. This is a step-by-step plan. All phases of the step-by-step plan were followed. There was no lack of clarity about the precise order at the time. Apart from the person concerned, the boatswain, AB R. and apprentice A.M. were present during the discussion.

The person concerned was in charge of the work. This was on the boatswain's request. The person concerned operated the hydraulic system of the hatch carrier. He had gained some experience of controlling this system during the usual task of raising and lowering the hatches. Other that the boatswain, the other crew members did not have any experience of doing this. The person concerned was therefore the obvious person to operate the hatch carrier. There was no other specific division of tasks for the work.
The steps of the procedure were gone through up to and including step six. After attaching the crane frame to the lowering sections of the crane rails, the hoisting frame was lowered onto the hatches. Once the crane frame had been slightly raised, so that the hoisting frame was suspended, it was possible to push away the supports under the crane sections. The crane frame then had to be lowered onto a support beam on the side of the coaming. This is where it went wrong.
The person concerned first lowered the crane frame slightly, but not completely because he started having doubts about whether this was the

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right step. He felt that it might be necessary to remove the securing pins first. He went to have another look at the operating instructions on the bridge. He had lowered the crane frame back down. After that, AB R. knocked the securing pin out on the starboard side.
The person concerned also consulted with the other crew members. Communication was in English owing to the different nationalities. This is the usual main language on board. The person concerned was in charge of the operation.
The person concerned did not consider asking anybody for help. He thought that he knew the right order and wanted to solve the problem himself. He did not contact anybody else, either the captain or the shipping company.

It was not easy to remove the securing pin on the starboard side. This was done with a hammer and chisel, because the pin was jammed. AB R. managed to get the pin out. It was replaced by the chisel. AB R. then succeeded in getting the chisel out. At that moment the crane frame on the starboard side suddenly fell down. This came as a surprise to the person concerned, otherwise this would not have happened.
When the hatch carrier fell down, it fell on apprentice A. M.'s head. AB R. was working on the pin at the side. It suddenly dropped to a lower position and he banged his knee.
The apprentice was quickly taken to hospital. His condition was critical at the time, but he eventually made a full recovery.

The person concerned acted in accordance with the operating instructions. During the preliminary consultations no problems were established with the consecutive steps of lowering the hatch carrier. However, a problem arose during execution.
It did not occur to the person concerned that the weight of the crane frame and the rail under it were in fact being held by that securing pin.
The person concerned did not anticipate that this accident would occur. Otherwise it would not have happened. He should have generally paid more attention to ensuring that everybody was in a safe place. He was in charge,

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but was also operating the hydraulics. The person concerned thought he could do both things at once.
The boatswain and the apprentice were standing under the hatch carrier and the person concerned knew that and also that the pin was being worked on. The crew members were not wearing helmets. There are occupational safety regulations on board. A helmet was to be worn only when loading and unloading in the port. There were no other regulations in this regard.
After the accident the shipping manager draw up a new procedure for operating and lowering the hatch carrier, which also contained a warning about certain situations, such as if certain pins are jammed. More careful consideration must be given of what to do. It is now compulsory to wear a helmet when working on deck at all times.

The person concerned has served as a first officer since 2007. He had both technical and nautical knowledge and experience based on his training as a maritime officer.
Modifications were made to the hatch carrier at the shipyard. No tests were carried out to establish how to lower and raise the hatch carrier.

5. The ruling of the Disciplinary Court

A. The findings based on the content of the documents referred to above and the statement of the person concerned at the hearing in this case can be taken as follows as established facts.

On the afternoon of 23 February 2016 the Dutch seagoing ship Amadeus Amethist was moored at the Port of Antwerp. The ship's hatch carrier was to be lowered to the river position under the supervision of the person concerned. The other people involved in the work were the boatswain, AB R. and apprentice A. M. None of them had done this work before. The supplier's operating instructions were studied well in advance. The hydraulic system of the hatch carrier was operated by the person concerned. Everybody was situated on the starboard side.

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The first six steps of the lowering procedure were followed. After starting step seven, lowering the crane frame with the crane sections attached to it, the step was broken off and the eighth step was taken first. The crane frame was raised back to the top position. AB R. attempted to remove the securing pin on the starboard side. He knocked out the pin with a hammer and chisel because it was jammed. The securing pin was knocked out of the hole and was replaced by the chisel. AB R. then succeeded in also removing the chisel. At that moment the crane frame on the starboard side fell down. Apprentice A. M. was struck on the head. The boatswain was also struck. AB R. fell down and also sustained an injury.

B. This demonstrates that the procedure for lowering the hatch carrier was not followed correctly. The cause of the starboard side of the crane frame falling down was the removal of the securing pin, which was in fact holding the crane frame.

C. An important cause of the accident was lack of knowledge of the person concerned regarding precisely what to do, and what to do about that lack of knowledge.
It emerged while the work was being carried out that the person concerned was not clear about the correct order of the various steps to be taken to lower the hatch carrier.
In a situation such as this, when a person is no longer sure how to proceed, the person in charge should bring the work to a halt and make enquiries about how to continue with it.
The person concerned did not ask anybody for help. In this case, the captain was the right person to ask – that is the golden rule on board a ship. Furthermore, this happened in the middle of the day and the ship was moored in the port of Antwerp. It is fair to assume that it was possible to contact the office of the shipping manager in the Netherlands, after which the hatch carrier supplier could also have been consulted.

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D. It seems that the person concerned did not stop to consider the situation of the hatch carrier when he was unsure how to proceed, or what would happen if the securing pin was knocked out.
He evidently failed to understand how the hatch carrier was built and how the various parts, such as the hoisting frame, the crane frame and cylinders were connected to each other.
After inspecting the hatch carrier, whether or not together and in consultation with others, the person concerned should have realised (a) that the securing pins formed the connection between the hoisting frame and the crane frame, (b) that after carrying out step five the entire, considerable weight of the crane frame was resting on those securing pins (which is in principle only for a short amount of time, until the crane frame has been lowered onto the support beam along the coaming) and (c) that if the securing pins had been removed first the crane frame would have suddenly fallen down all at once downwards onto the support beam. The length of crane rail with the wheels on it and the construction beam on the underside of the crane frame are first at the level of the top of the coaming. This fell down all at once to the support beam half-way down the height of the coaming.
Since the person concerned had not realised this, he was not aware of the potentially dangerous situation in which the crane frame was suspended on the securing pins and that this danger would manifest itself as soon as the pins, or one them, were removed.

The idea raised by the person concerned that the securing pins were not movable and that he thought that that was why they were jammed, is not convincing.

That idea is not supported by the photos, particularly photo numbers 4 (p. 29) and 7 (p. 32).

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E. The Disciplinary Court finds that the person concerned should have provided more and clearer leadership and that he should have paid much more attention to the safety of the crew members whilst carrying out the work.
The person concerned was aware that the other crew members had not done this work before and that they knew no more than he did about precisely how to go about it. It was precisely for that reason that the boatswain had specifically asked for the person concerned to be there as the officer in charge.
The decision of the person concerned to operate the hatch carrier himself was unwise because this meant that he was unable to maintain an overview of what was happening, what the others were doing and where they were standing.
The fact that – as argued by the person concerned – this involved teamwork is not an excuse since this does not absolve him of his responsibility as the ship's officer in charge.
It was his duty to ensure that the inexperienced apprentice and the boatswain were not located in the gangway under the crane frame on the starboard side, especially when the crane frame was mounted on the securing pins and people were working on knocking out the securing pins on the starboard side.
It is not clear whether the fact that the crew were not wearing helmets during the work made any difference to the injury sustained by apprentice A. M.

The essence of the charge against the person concerned is that he has failed to understand what was expected of him as the ship's officer in charge and with responsibility and to act accordingly. This first concerns continuing the work without consultation or making enquiries and without sufficiently considering and studying the given situation, as a result of which he failed to appreciate the potentially dangerous situation that had arisen and that the danger would manifest itself if the securing pin on the starboard side was removed. The second concerns his failure to ensure that the other crew members were not standing in a dangerous place, which does not absolve

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them of their own responsibility in this regard. The person concerned had a special duty of care towards the inexperienced apprentice.
During the hearing the Disciplinary Court was not entirely convinced that the person concerned was sufficiently aware of this responsibility.

The person has thus acted contrary to his duty of care in observing the principles of good seamanship as the first officer in relation to the people on board and the ship as provided for in Sections 4.4 and 55a of the Seafarer's Act.

6. The disciplinary measure

A suspension of the navigation licence is an appropriate disciplinary measure for this conduct.
Account can be taken of the circumstances of the accident, that the accident and the serious injury it caused has made a deep impression on the person concerned, that he says he has learned from this and has not acted in a similar way since that time.
However the Disciplinary Court finds that the failure of the person concerned is so serious that it is not sufficient to suspend the navigation licence full conditionally and that the disciplinary measure stated below is to be imposed.

Finally, the Disciplinary Court concurs with the wish of the inspector that as a result of this accident and this ruling, the importance of the responsibility and duty of care of ship's officers towards the other crew in the context of occupational safety and the prevention of accidents and injuries should once again be brought to the attention of the professional grouping as a whole.

7. The decision

The Disciplinary Court:

- declares the objections against the person concerned as stated under point 5 to be well-founded;

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- suspends the navigation licence of the person concerned for a period of twelve weeks;
- stipulates that of this suspension, a period of ten weeks 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, presiding judge, H. van der Laan, P.J. Lensen, C.R. Tromp and A.J. de Heer, members,
in the presence of E.H.G. Kleingeld as secretary and pronounced by
the presiding judge in public session on 12 April 2017.

A.N. van Zelm van Eldik
presiding judge

E.G.H. Kleingeld, LL.M
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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