MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 12 SEPTEMBER 2018 (No. 10 OF 2018) IN THE CASE 2018.V5 – ARAGONBORG

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

M.L.R. R.,
the person concerned,
who did not appear.

1. The course of the proceedings

On 21 March 2018, the Maritime Disciplinary Court received a written petition for a disciplinary hearing of the case against the person concerned as the chief mate of the Dutch seagoing vessel Aragonborg from M. Schipper, inspector ILT/Shipping in Rotterdam (referred to below as the Inspector). 21 written appendices were attached to the petition.

The Disciplinary Court sent the person concerned a letter in the English language (both by registered and ordinary mail) dated 17 April 2018 informing him of the petition, enclosing a translation of the petition and its appendices in English. The person concerned was informed of his right to file a statement of defence.

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The person concerned submitted a statement of defence by email dated 28 May 2018. The inspector did not respond to this.

The presiding judge stipulated that the hearing of the case will be held at 13.30 hours on 13 July 2018 at the courtroom of the Disciplinary Court in Amsterdam. The person concerned was summoned – in the English language and by both ordinary and registered mail – to appear at the hearing of the Disciplinary Court.
The hearing was held at 11.30 hours on 13 July 2018. The Inspector appeared for the petitioner. The person concerned did not appear. In a letter dated 19 June 2018, he stated that he would not be present and why. Leave was granted to proceed in default of appearance against him.

2. The petition

In summarised form, the following forms the basis for the petition.

On Wednesday 20 September 2017, ILT received a telephone report of an accident earlier that day on board the seagoing vessel Aragonborg. One crew member – the second mate – had been seriously injured. At that moment the ship was unloading in Farnsund, Norway. The accident took place at the top of crane 3 of the ship. The victim was there because the hook of the crane, despite the lifting and lowering of the hoisting cable, would not descend. His intention was to solve the problem by slightly raising the crane jib. After he had given instructions for this to be done, the hook suddenly came loose. The hoisting cable, which had been loose until then, suddenly tightened and struck the second mate, who was seriously injured as a result.
The person concerned is accused of not having recognised the dangers of the presence in the immediate vicinity of a slack hanging steel cable with an unstable heavy weight attached and of not having prevented the second mate from going to solve the problem at the top of the crane. He has thus acted contrary to Article 4(4) of the Seafarers' Act, in conjunction with Article 55a of that Act.

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3. The position of the person concerned

In his statement of defence, the person concerned expressed his disagreement with the accusation made against him. He points out, among other things, that the second mate (i) was himself in charge of the operation in the context of which the problem occurred, (ii) had also been warned by A/B J. C., but had deliberately ignored this warning and (iii) was able to clearly observe/assess the situation on the spot in a different manner from the person concerned. In the opinion of the person concerned, the second mate was the victim of his own imprudent action.

4. The assessment of the petition

A. With regard to the circumstances of the accident, the petition states, among other things:

On 20 September 2017, at around 12.00 hours, the second mate was in charge of lowering the MOB boat. For this purpose he wanted to release the lashing rings from the hook of crane 3. To do this, the hook had to be lowered slightly. The second mate therefore instructed a more experienced cadet to operate the crane. Since there was no view of the hook from the crane cabin because of the open hatches, the second mate himself kept an eye on the hook on the deck. For some reason, the hook could not be lowered, even after lifting and lowering the hoisting cable a couple of times. The second mate then instructed the crane operator to look at the top of the crane. The crane operator reported on this as follows: "the wire on top is slack and the wire on the drum is a bit messy". The second mate then reported the problem to the person concerned and to the captain. He said he was confident that he could solve the problem, but he did ask for assistance. The person concerned promised the captain that he would take stock of the situation. On deck the second mate told him he wanted to solve the problem by slightly raising the crane jib. He wanted to go on top of the crane because he would then have a clear image of the distance between the top of the crane jib and the bottom of the bridge wing. He asked the person concerned

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to keep an eye on the hook from the bridge wing. The person concerned saw that the hoisting cable was hanging very slackly. He therefore proposed to first raise and then lower the cable, but because this pulled the cable tightly on the drum this attempt was stopped. The person concerned instructed A/B J. C. to go with the second mate to the top of the crane and to assist the second mate there. However, A/B J. C. had already warned the second mate that time that it was very dangerous to go on top of the crane because the hoist cable was slack/not tightened. The person concerned suggested to the second mate to first sort out the hoisting cable on the winch, but according to the second mate that was not possible.
A suggestion to turn the crane slightly outward did not present a solution either. The second mate therefore asked the person concerned (repeatedly and emphatically) whether he could continue with his intention to raise the crane slightly. After giving the matter some thought, the person concerned granted this permission, with the instruction to proceed very carefully. According to the person concerned, at that moment he did not know how tightly or loosely the hoisting cable was on the drum and could not assess the danger properly; he did not have a clear view of the situation and no eye contact with the second mate; there was only radio contact. The second mate gave the order by radio to slowly raise the crane. With a lot of noise the hook came loose. As a result, the steel hoisting cable suddenly tightened and struck the second mate, who was seriously injured and lost consciousness as a result. He was taken to the hospital in Kristiansand by helicopter. He had a broken shoulder, cerebral swelling and a neck injury, but eventually recovered. He cannot remember anything about the accident up to now.

B. The facts of the accident described above under A are reflected in and confirmed by the written statements of the person concerned, A/B J. C., cadet D.K.A. C. and cadet G.A. K., which are attached to the petition.

C. Annex 20 to the petition is the email correspondence between the person concerned and the 'HSEQ fleet manager' of Wagenborg Shipping B.V., which company manages the Aragonborg. The person concerned stated that

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the second mate, who was responsible for lowering the MOB boat on the day in question, told him between 13:30 and 13:45 hours about a problem with crane 3 and asked him to watch the hook of the crane, which was not visible from the crane cabin due to the open hatches. On the spot he saw that the crane was still in the fixed position (in the jib rest), with the hook secured with two straps, one of which was on deck. He was told that the hook could not be lowered. He saw that the hoisting cable was very slack. The second mate told him that he was going to look at top of the crane. Because the person concerned did not want the second mate to go there alone, he instructed A/B J. C. to join the second mate and assist him. The second mate said he wanted to raise the crane jib a little. After first making some other suggestions, the person concerned agreed to this. Shortly after the second mate had ordered the slow raising of the jib, the hook came loose. A little later, the person concerned heard that the second mate had been hit by the hoisting cable and was unconscious. In response to the question of the HSEQ manager of whether the person concerned would do things differently if a similar situation arose, the person concerned writes: 'I shouldn't have allowed anyone to go on top of the crane'.

D. A Report Health and Safety Accident Merchant Shipping, annexed to the petition, states, under the heading 'Measures', inter alia:
'What measures could have been taken, to prevent this accident': 'Not being on top of the crane. Better last risk assessment in unexpected situation'.

E. The 'Shipboard Operation Manual' used by Wagenborg Shipping on its managed vessels is attached as an appendix to the petition. Section 17 of this, entitled 'Risk Management', describes, among other things, how to act in the event of activities that involve safety aspects, including 'unforeseen jobs'. This must include a Last Minute Risk Assessment and a Safety Briefing.

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5. The ruling of the Disciplinary Court

A. The findings based on the content of the documents referred to above are as follows.

On 20 September 2017, the Dutch seagoing vessel Aragonborg B.V., owned by the shipping company Aragonborg B.V. and managed by Wagenborg Shipping B.V., was being unloaded in Farnsund, Norway. For this reason the ship's hatches were open. The crew of the ship included: the person concerned as the chief mate, the second mate, mate J. P. v.d. L., A/B J. C. and the cadets D.K.A. C. and G.A. K. On that day, the second mate was instructed to launch/lower the MOB boat as an exercise. To do this, he first wanted to unhook the hook of ship's crane 3 (partly lashed to the deck). For that purpose the hook had to be lowered slightly first. The second mate instructed the more experienced cadet D.K.A. C. to do this, who had to operate the crane and at the same time explain the operation to G.A. K. Because there was no view of the hook from the crane cabin because of the open hatches, the second mate himself kept an eye on that hook on the deck. For some reason, the hook could not be lowered, even after raising and lowering the hoisting cable a couple of times. The second mate was told by A/B J. C. or D.K.A. C. when asked: "the wire on top is slack and the wire on the drum is a bit messy". The second mate then reported the problem to the person concerned and to the captain. He said he was confident that he could solve the problem, but he asked for assistance. The person concerned then agreed with the captain that he would take stock of the situation. On deck the second mate told him he wanted to solve the problem by slightly raising the crane jib. For this purpose the second mate wanted to go on top of the crane in order to have a clear view of the distance between the upper side of the crane jib and the lower side of the bridge wing. He asked the person concerned to keep an eye on the hook from the bridge wing. The person concerned saw that the hoisting cable was hanging very slackly. The person concerned therefore suggested that the cable be raised and lowered first, but because this meant that the cable would be wound tightly on the drum, this was stopped. The person concerned then instructed A/B J. C. to accompany

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the second mate to the top of the crane and to assist the second mate there. However, A/B J. C. had warned the second mate beforehand that it was very dangerous to go to the top of the crane because of the hoisting cable that was hanging loose. The person concerned first suggested to the second mate to sort out the hoisting cable on the winch, but according to the second mate this was not possible. A suggestion to turn the crane slightly outward did not present a solution either. The second mate therefore asked the person concerned (repeatedly and emphatically) whether he could continue with his intention to raise the crane slightly. After first having considered the matter, the person concerned eventually granted this permission, with the instruction to proceed very carefully. According to the person concerned, at that moment he did not know how tightly or loosely the hoisting cable was on the drum and could not assess the danger visually; he did not have a clear view of the situation and there was no visual/eye contact with the chief mate; only radio contact. The second mate gave the order by radio to slowly raise the crane. With a lot of noise the hook came loose. As a result, the steel hoisting cable suddenly tightened and struck the upper body of the second mate, who was seriously injured and lost consciousness as a result. He was taken to the hospital in Kristiansand by helicopter. It turned out that he had suffered a broken shoulder, cerebral swelling and a neck injury. He eventually recovered. He cannot remember the accident.
The cause of the hoisting cable jamming or the crane hook not loosening has not been definitively determined. Partly on the basis of the photographs submitted, the question does arise as to whether the moving parts of the crane were well/sufficiently maintained/greased.

B. The cause thus established shows in the first place that the second mate acted irresponsibly by going (on his own initiative) to the top of the crane, in the vicinity of a slack hoisting cable, and then ordered manoeuvres aimed at freeing the jammed cable/crane hook. In accordance with the instructions in the 'Shipboard Operation Manual', in the context of this – also for him – unforeseen circumstance of a jammed cable/crane hook, he should first have held a 'safety briefing', together with at least the chief mate (the

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person concerned) and A/B J. C., all the more so since A/B J. C. had warned him of the danger of a slack hoisting cable. On the occasion of such a safety briefing, more structured consideration could have been given to the dangers that could have come about if the crane hook were to come loose in combination with the slack hanging steel hoisting cable. It has neither been claimed nor demonstrated that the situation was so urgent that there was no time for reflection.

C. The Disciplinary Court shares the opinion of the Inspector that the person concerned, in his capacity as a chief mate, also acted imputably wrongly in this matter. After becoming involved in solving this problem through the second mate's justified report of the crane hook being jammed, he (the person concerned) should also have considered the associated risks in consultation with the other people present/involved, in particular the not inconceivable danger of a loosening or suddenly tightening hoisting cable. The fact that the problem of the jammed crane hook occurred in the context of an activity assigned to the second mate (the launch of the MOB) and that the person concerned, who had only been 'called in to help', did not have a clear overview of the situation, unlike the second mate, does not constitute an adequate excuse for the person concerned failing to actively monitor the correct observance of the safety regulations. The same applies to his statement that the second mate more or less drew up his own plan and insisted on approval of his intended action (to have a manoeuvre carried out on top of the crane to release the crane hook). It is precisely in situations such as this that use must be made of the existing authority structure on board, in which the person concerned was able to exercise authority over the second mate and could have ordered him to properly identity the safety risks first and in consultation.

D. The person concerned can therefore be held accountable for not properly recognising the accident risk associated with the intended actions of the second mate.
This and failing to prevent the unsafe actions of the second mate constitute

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a violation of the regulation of Article 55a of the Dutch Seafarers Act in conjunction with Section 4.4 of that Act: acting or failing to act on board as ship's officer contrary to the duty of care expected of a good seaman in relation to the other persons on board.

6. The disciplinary measure

The Disciplinary Court judges that the person concerned failed in his responsibilities as a ship's officer, which resulted in a serious accident. The person concerned did not act as befits a responsible officer. More specifically, he failed to ensure the safety of another seafarer. In view of the seriousness of this negligence a suspension of the navigation licence for the duration mentioned below is appropriate. Account has been taken in the favour of the person concerned that his share in the occurrence of the incident was relatively small. Also taking into account that the person concerned was very shocked by what happened and has demonstrated that he is aware that he must never again allow a person to go on top of a crane in the vicinity of the steel hoisting cable under the described circumstances the Disciplinary Court sees good reason to stipulate that the suspension of the navigation licence should be imposed on a fully conditional basis. This penalty is in accordance with the Inspector's demand, which was communicated beforehand.

7. The decision

The Disciplinary Court:

- declares the objection against the person concerned as stated under point 5 to be well-founded;
- suspends the navigation licence of the person concerned for a period of 6 (six) weeks;

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- stipulates that this suspension 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 J.M. van der Klooster, deputy presiding judge, D. Willet and T.W. Kanders, members, in the presence of E.H.G. Kleingeld, LL.M., as secretary and pronounced by A.N. van Zelm van Eldik, LL.M., in public session on 12 September 2018.

J.M. van der Klooster
presiding judge

E.H.G. Kleingeld
secretary

A.N. van Zelm van Eldik
presiding judge

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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