RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS 28 DECEMBER 2018 (No. 12 OF 2018) IN THE CASE 2018.V12-NIEUWE DIEP

As petitioned by:

the Minister of Infrastructure and the Environment, now the Ministry of Infrastructure and Water Management,
in The Hague,
petitioner,
authorised representative: K. van de Wall,
inspector at the Human Environment and Transport Inspectorate (ILT)/Shipping in Zwijndrecht;

versus

P. Z.,
the person concerned,
lawyer: A. J. van Steenderen.

1. The course of the proceedings

On 13 July 2018, the Maritime Disciplinary Court received a written petition for a disciplinary hearing of the case against the person concerned as the captain of the Dutch seagoing vessel Nieuwe Diep from M. Schipper, inspector ILT/Shipping in Rotterdam. Nineteen 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.

On 23 August 2018 a statement of defence was received from the lawyer of the person concerned. Nine appendices were attached to the petition.

The presiding judge stipulated that the oral hearing of the case will be held at 11.00 hours on 16 November 2018 at the offices of the Disciplinary Court in Amsterdam.
The Human Environment and Transport Inspectorate and the person concerned and his lawyer were summoned – the latter both by ordinary and registered mail – to appear at the hearing of the Disciplinary Court. D. W. was called as a witness.

The court hearing was held on 16 November 2018. Ms K. van der Wall, ILT/Shipping inspector, appeared at the hearing for the petitioner, assisted by *Meester* 't Hart of the ILT. The person concerned appeared, represented by his lawyer. The witness also appeared.

2. The petition

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

On Sunday, 4 March 2018, at around 10:45 p.m., an accident occurred in the port of Terschelling on board the State vessel Nieuwe Diep, in which a crew member was struck by a breaking mooring line. The mooring line struck against his helmet and hearing protector/headset, causing him a fright but leaving him otherwise unharmed. To be on the safe side, the crew member was taken to the hospital in Leeuwarden.

The Government Shipping Company (*Rijksrederij*) of the Directorate-General for Public Works and Water Management (*Rijkswaterstaat*) reported the accident to ILT.

At the time of the accident the Nieuwe Diep was in the process of mooring. This was hampered by quantities of ice between ship and shore. After several

unsuccessful attempts to manoeuvre the ice out of the way between ship and shore, the stern was first pulled to shore by a capstan on the stern.
After an unsuccessful attempt to pull the ship from the forecastle on the warping head of the anchor winch to shore with a mooring line, the imminent victim tried the same with the capstan on the work deck and a mooring line from there to shore. At that point the mooring line broke.

3. Objections of the Inspector

According to the Inspector, the person concerned allowed operations to be carried out on deck by personnel on their own initiative. He thus deprived himself of the ability to control the work, which was anything but normal due to the circumstances, and thus have it performed safely. It should be noted that mooring and unmooring have long been recognised as life-threatening work, where accidents often occur and can often lead to serious injury and death. The accident could have been prevented if, in accordance with instructions, safety information and good seamanship in particular, he had required his crew to act solely on his instructions. Not only by controlling the victim's work, but also by ensuring adequate supervision and support during the work.

The person concerned cannot be demonstrably held responsible for other matters, such as the absence of snapback zones, the fact that the emergency stop could not be operated properly, the capstan's excessive speed and having too many turns around the head.

4. The position of the person concerned

In summary, the person concerned argued that the victim of the accident, the boatswain, acted independently when the ship was already moored. His (unnecessary) attempt to pull the starboard foreship even closer could not have been known to the person concerned. In his opinion, it has not been sufficiently established that he did not act as a reasonably competent and

reasonably professional colleague would have done in accordance with the standard of good seamanship. According to his counsel, it should also be noted that he was an acting captain on a ship other than his regular vessel and that the shipping company is jointly responsible.

5. The assessment of the petition

A. The petition shows the following.

I, Martijn Schipper, have claimed and received the following information from the *Rijksrederij* in the investigation against the ship's captain P. Z. of the seagoing vessel Nieuwe Diep, sailing under the Dutch flag: [..]

- Work instruction 'Mooring and unmooring (bridge)" from the ship's safety management system (SMS), attached as Annex 9 to this petition.
- Work instruction 'Mooring and unmooring (deck)" from the ship's safety management system (SMS), attached as Annex 10 to this petition.
- Working conditions sheet D101 – Mooring and unmooring from the occupational health and safety catalogue, attached to this petition as Annex 11. The work instruction in Annex 10 refers to this document.
- Cover page [...] and chapter 13 of the publication "Dat is juist" (That's right) of Stichting Scheepvaart, attached as Annex 13 to the petition.

B. A work instruction 'Mooring and unmooring (bridge)' from the ship's safety management system (SMS), attached as Annex 9 to the petition, includes – in summarised and concise form – the following information:

"3.1 General

The acting Captain/Navigator/Officer of the Watch makes the preparations for mooring and unmooring the ship.

- [..]
- Discuss mooring and unmooring steps with the crew.
  - which side alongside/mooring;
  - Which and how many mooring lines to use;

- Order of hauling, casting off, securing;
- Any means of communication/channel, testing;

During mooring and unmooring the captain on the bridge is responsible for the safe manoeuvring of the ship. Orders to secure/cast off are communicated verbally, preferably by means of handheld radios/VHF equipment."

4.1 Tasks and responsibilities

[..]

Acting captain/navigator/Officer of the watch:

- Person with primary responsibility for mooring or unmooring of the vessel.
- [..]
- Provides information on mooring or unmooring to crew.
- Provides communication during mooring or unmooring.

C. A copy of Working Conditions Sheet D101 – Mooring and unmooring, from the occupational health and safety catalogue, attached to this petition as annex 11, which includes, in summarised form, the following:

"Stopping and securing mooring lines

Mooring lines and cables should never be handled using a winch by one person only."

D. The publication "Dat is juist" ('That's right') by the Stichting Scheepvaart, attached as annex 13 to the petition, includes – in summary – the following:

"13. Anchoring, mooring and unmooring

13.1 General

13.1. Anchoring and securing or casting off the vessel are common activities. They are often experienced as routine actions, but they are associated with major safety risks. Serious and even fatal accidents occur regularly during mooring and unmooring."

E. A report on the hearing of witnesses (Annex 15 to the petition) which – in summary – mentions, among other things, the following:

On 29 June 2018 we, Martijn Schipper and Zeljko Tomijenovic respectively senior inspector and inspector at ILT, interviewed the victim, H.T. S., about the accident on board the Nieuwe Diep in the port of Terschelling.

"It had been a long day. At about 22.45 hours we were almost alongside. We sailed with as little sheer as possible along the quay. The ice kept accumulating. First we took out the aft mooring line and we managed to pull the stern with the mooring line on the capstan alongside. After that a seaman tried to pull the ship to shore with the capstan on the forecastle. That did not work.
I myself then came up with the idea of using the capstan on the main deck. I don't think we have discussed this with the people on the bridge, but I don't know for sure anymore.
I wore a helmet with earcups and integrated communication. I was in contact with the bridge and the rest of the crew.
The first part of the procedure went well. I think I first had three turns around the capstan, but it didn't catch so I added an extra turn. At one point it slowed down a bit. Then the mooring line pulled a bit to get more grip. I immediately noticed that the mooring line was getting thinner. I tried to press the emergency stop, but that was not easy because a protective cross was placed over it. I therefore had to bend down and kneel down to press the button. At that moment I was hit, exactly on the earcup of my helmet.
In the end I only had a few abrasions and I was very lucky. The reason I went to the hospital also had to do with my use of medicine."

F. At the hearing, rendered in summarised and concise form, the person concerned made the following statement:

There was ice that day and that was different than normal. In principle, however, the mooring procedure remained the same.
According to the person concerned, there was no reason to give any other instructions. In principle, the standard mooring procedure would not be changed. In special cases he does consult with the boatswain but there was no reason to do so here. Furthermore, everyone had a headset on for mutual communication.
The person concerned explains the normal mooring procedure. In this case the only difference was the formation of ice. This meant there was a greater distance between ship and shore. This was no reason for the person concerned to intervene, as he was consulting with the mate when the incident occurred. His intention was to leave the vessel as it was.
The person concerned did not receive the information that the boatswain pulled the ship towards the quay on his own initiative. He did not see what the boatswain had done until he walked to the window.
The boatswain had not reported that he intended to make another attempt to pull the vessel closer to the shore from the working deck. The person concerned felt that the boatswain did not make the right decision when he acted on his own initiative.
The capstan on the work deck is meant to haul in the buoys.
It is true that another seaman had previously used a capstan. However, this was no reason for the person concerned to intervene.
The person on the foredeck, the forecastle, hauled in the vessel. He then secured the mooring line. The person concerned did not see that the capstan on the work deck was used to straighten the ship.
The presiding judge asks whether the capstan is operated by one man only.
The person concerned confirms this.
The presiding judge suggests that according to working conditions sheet D101, there should always be two men on a capstan in every situation.

The person concerned did not give instructions to use the capstan to pull the ship alongside.
The person concerned allowed this to happen and he admits to this. The capstan on the work deck is used differently.
Everyone on deck was using the prescribed personal protective equipment.
The person concerned saw that the later victim was standing along the mooring line, but according to the person concerned there was no other place to stand.
No snapback zone was indicated on deck, which means that no safe place was indicated. At the time he was not familiar with the concept of snapback zone. In fact, in this specific situation there was no safe place to pull the mooring line.
Mr Berghuis asks whether the company safety rules had been followed. The person concerned indicates that the mooring procedure applies to everyone, that everyone knows what their task is and which procedure must be followed. The SMS (Safety Management System) but also the Working Conditions Provisions are important, as is the action plan.
Mr Berghuis asks to what extent the crew is aware of all the safety provisions. The person concerned feels that they are not, and nor is he fully aware of them himself.
Mr Berghuis replies that working conditions sheet D-101 describes very clearly the need for snapback zones.
The person concerned is not familiar with the Risk Assessment (risk assessment manager).
The person concerned indicates that these safety requirements are only now being gone through, but the crew did not know all of this. These requirements are now also discussed in advance on board.
The ice manoeuvres were followed. There was heavy ice. The person concerned could have made the ship turn astern but did not think that this was necessary. There was no need to bring the ship closer to shore, according to the person concerned. However, the boatswain thought otherwise.

If the SMS reported the risks associated with ice, there would have been an increased risk, which would have called for a Last Minute Risk Assessment. However, the person concerned did not see any danger at the time of the incident. The person concerned indicates that the capstan on the work deck was not used more frequently. If this was the case, it was not in the presence of the person concerned.
There was no communication between the person concerned and the boatswain.
The decision to send the boatswain to the hospital was made because of his medical history, not because of the incident. There was a first aid situation. Fortunately, the boatswain was left unscathed.
If the person concerned had known that the boatswain was going to use the work deck capstans he would not have given permission for this.
The inspector wishes to discuss the Working Conditions Decree. This states that accidents can happen due to inattention among crew members. Mutual control is of great importance, especially in routine operations. There must be good communication between the bridge and the crew during manoeuvres. The safety regulations state that the captain bears ultimate responsibility. She asks about what was discussed in advance, because of the ice conditions that made the situation different.
The person concerned indicates that he did not discuss anything because nothing unusual was being done.
The mooring had not yet ended when the person concerned sought contact with the crew. The person concerned had not yet indicated to the crew that the mooring was complete. He had already decided this and communicated it to the mate on the bridge.
The above remark – that the mooring was completed – was therefore also usual; after mooring the situation is reviewed for a few minutes before the captain gives the order that the ship is in place and that the engine can be stopped.
The usual procedure is to wait until the vessel is alongside before the person concerned gives those orders.

Immediately after mooring, the person concerned was about to report that the procedure was complete. At that moment the person concerned paced up and down and thought about what he was going to do, after which he would communicate with the crew.
But then he saw through the window that the boatswain was in difficulty. The mooring line broke and the rest of the crew walked towards it. The mate was the first person to go outside and then the person concerned also went outside.
The person concerned then gave instructions to call the emergency services. The ambulance crew arrived very quickly. Fortunately, the boatswain was still conscious. However, the ambulance crew were told that he had had a brain haemorrhage in the past. This caused them concern.
The counsel asks which capstan was used by the seaman. The seaman on the forecastle worked with the capstan on the foredeck. Therefore, it was not the capstan on the work deck that the seaman had used.

6. The ruling of the Disciplinary Court

A. The content of the documents referred to above and the statement of the person concerned have led to the following conclusions being drawn in this case (with an adequate measure of certainty).

On Sunday, 4 March 2018, at around 10:45 p.m., an accident occurred in the port of Terschelling on board the State vessel Nieuwe Diep, in which the boatswain was struck by a breaking mooring line. The mooring line struck against his helmet and hearing protector/headset, causing him a fright but leaving him otherwise unharmed. To be on the safe side, the crew member was taken to hospital in Leeuwarden.
At the time of the accident the Nieuwe Diep was in the process of mooring. This was hampered by quantities of ice between ship and shore. First the stern was pulled to shore by a capstan on the stern.
After an unsuccessful attempt to pull the vessel alongside with a mooring line from the forecastle, the imminent victim tried the same, without being

instructed to do so, with the capstan on the work deck and a mooring line from there to shore. At that point the mooring line snapped. The person concerned had not yet at that time indicated to the crew that the mooring was complete. There was no communication between the person concerned and the boatswain, not even when it was not possible to get the starboard ship closer to the shore and he decided to consult with the mate.

B. This shows that the person concerned, who was responsible for mooring as captain, although there were special circumstances due to the great ice conditions, did not organise a toolbox in advance and did not give any instructions to the deck crew at all, not even when the mooring gradually proved to be difficult.
It can be assumed that if the person concerned had done so, the boatswain would not have used the (stronger) capstan on the work deck pull the vessel closer to the shore. Also, not only the boatswain would have been charged with using mooring equipment.

C. The conduct of the person concerned constitutes a violation of the regulation of Section 55a of the Dutch Seafarers Act in conjunction with Section 4.4 of that Act: acting or failing to act on board as captain/ship's officer contrary to the duty of care expected of a good seaman in relation to the persons on board, the ship, its cargo, the environment and shipping.

7. The disciplinary measure

The Maritime Disciplinary Court judges that the person concerned failed in his responsibilities as an acting captain, which resulted in the accident. The person concerned did not act in a manner befitting a responsible captain, as a result of which the safety of the people on board was jeopardised.
Given the circumstances in which the person concerned was working on a vessel other than his own as acting captain, that no serious injury occurred, that the victim was probably only transported to the hospital because of his medical history (and that no report would probably have been made

otherwise), that the shipping company is primarily responsible for the safety culture on board (and that seems to have failed here) and that the person concerned himself has learned lessons from this incident, the Disciplinary Board considers it sufficient to impose a reprimand.

8. The decision

The Disciplinary Court:

- declares the objections against the person concerned as stated under point 5 to be well-founded;
- imposes the measure of reprimand on the person concerned.

Duly delivered by P.C. Santema, presiding judge, H. van der Laan, member, and J. Berghuis, deputy member,
in the presence of E.H.G. Kleingeld, LL.M., as secretary and pronounced by Mr P.C. Santema, LL.M., in public session on 28 December 2018.

P.C. Santema
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.