RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS 4 JULY 2018 (No. 5 OF 2018) IN THE CASE 2017.V9- ACHTERGRACHT

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

K. L.,
the person concerned,
counsellor: R.P. van Campen, LL.M.

1. The course of the proceedings

On 13 November 2017, 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 Achtergracht from M. Schipper, inspector ILT/Shipping in Rotterdam. 13 written appendices and 1 video recording 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 10 January 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.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

On 20 February 2018, R.P. Van Campen, LL.M., submitted a defence on behalf of the party concerned. The inspector has not filed a reply to this.

The presiding judge stipulated that the hearing of the case will be held at 15.00 hours on 22 May 2018 at the courtroom of the Disciplinary Court in Amsterdam. The following persons appeared at that hearing:
M. Schipper, inspector ILT/Shipping and the person concerned accompanied by R.P. van Campen, LL.M. The hearing of the person concerned took place with the assistance of Ms R. Horn, an interpreter in the Estonian language who is not a sworn interpreter but who is listed in the 'List of Alternative Translators and Interpreters' under the Sworn Court Interpreters and Translators Act ('Uitwijklijst Wbtv').

2. The petition

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

On Saturday 14 November 2015, a fatal accident occurred on board the Dutch seagoing vessel Achtergracht; during a Neptune ritual held on the hatch crane deck that day, the Filipino trainee/cadet A.F. S. (hereinafter S.), born on 20 October 1994, lost his life. Together with the cook he underwent that ritual a few days after both had passed the equator for the first time. One part of the ritual involved walking blindfolded over a wooden plank and – as they were told – jumping overboard into the water from there. Before this part started, the plank had been between the hatch and the container rail; however; for the ritual itself it had been laid flat on the hatch crane deck, with the end approximately two metres from the gangway two to three metres below. S. was the first in turn. He walked carefully along the plank and then took a big jump, precisely where there was nobody standing by to catch him. He jumped so far that he fell into the gangway that was two to three metres lower. This fall led to his death.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

As a result of this accident, the person concerned was blamed for not acting as the captain of the ship in a manner befitting a good seaman towards the persons on board. Reference was made to a relevant provision:

- Section 4.4 of the Dutch Seafarers Act, in conjunction with Section 55a of that Act.

3. The position of the person concerned

In summarised form, the person concerned has pleaded as follows in his statement of defence: The fatal accident did not happen during work, but during a voluntary activity outside the workplace, in which the captain did not play a leading role; the initiative lies in the Neptune ritual, which is held among the lower deck personnel. This activity therefore falls outside the responsibility of the captain. Moreover, the accident was unforeseeable; it could reasonably be assumed that S., who was not wearing a life jacket, was not actually intended to jump overboard, all the more so as he was taken by the hand by other crew members when walking onto the plank, which would not have been possible if the plank had still been over the gangway to the container rail. The captain was also ready to catch S. if he lost his balance. It was unforeseeable that S. would make a longer and more sideways jump, as a result of which the captain could not catch S. He and the shipping company are not aware of any previous incident involving the Neptune ritual. Furthermore, it is not the case that the captain is responsible at all times for an absolutely safe environment; the standard of good seamanship is an open standard, in the interpretation of which reasonableness and fairness play a role. In view of this and the unforeseeable nature of the accident, the captain can therefore not be held accountable. Two other ship's officers were also present during the ritual; they were not charged, even though if the captain should have recognised the danger, the same would apply equally to them. Personal circumstances include the captain's impeccable record, the fact that he is also facing criminally prosecution (involuntary manslaughter) and will soon have to face trial; the fact that the fatal accident is a heavy

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

psychological burden for him, which he must carry with him for the rest of his life, and that he has, of course, learned a lesson from the incident.

4. The assessment of the petition

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

S., born on 20 October 1994 in the Republic of the Philippines, was a trainee/cadet on board the Achtergracht when this Dutch seagoing ship was on its way from Brazil to Amsterdam with a cargo of cocoa beans on 14 November 2015. He had embarked a little more than a month before the accident; his Seafarer's registration certificate states as the date of issue: 10 June 2015 It was the first time he had crossed the equator.
He and the Filipino the chef cook, to whom the same applied, voluntarily participated in the Neptune ritual. There had been no use or administration of drugs or excessive amounts of alcohol during the ritual. The accident happened during the last part of the ritual, when the 'victim' was to walk a plank and jump off. At the time of the accident, the site of the ritual was the hatch crane deck of the Achtergracht.

B. A report of the hearing (by the examining magistrate at the District Court of Amsterdam) of the expert witness P.J.J. Margry, professor of European Ethnology, submitted by the person concerned with his defence, includes, among other things, the following, which is freely reproduced:

The Neptune ritual is performed when a sailor passes the equator for the first time. Just like any other ritual, this ritual has a fixed course, but parts of it can change, depending on, for example, the culture and the composition of the crew. In such rituals people are often blindfolded. The suggestion is also often made that someone should be thrown overboard. In principle, participation is not compulsory, but there is peer pressure: it is difficult to get out of it, especially in a closed group on the high seas. Masculinity is very

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

important to seafarers. Margry believes that there is a lot of pressure, because nobody wants to be excluded from the group. During the ritual, the lower deck is in charge of the performance of the ritual rather than the captain of the ship.

C. An IMO Crew List of the Achtergracht attached to the application gives the names of 15 crewmembers, including those of S., the person concerned, the cook and the chief engineer. The dates of birth set out in that list show that S., with a date of birth of 20 October 1994, was the youngest member of the crew.

D. A report of the hearing of witness V.V. S. (hereinafter: the cook) drawn up on 23 November 2015 by (the reporting officers of) the National Police, Central Unit, Infrastructure Department, contains as his statement, among other things, the following (appendix 10A to the application), freely reproduced:
V.V. S. was on board the Achtergracht as a ship's cook. This was his third contract with Rederij Spliethoff, but also his first cross of the equator. This was also the case for S., who was on board as a trainee/cadet. The cook voluntarily participated in the Neptune ritual 'because that's all part of it'. First he and S. were picked up from the kitchen and they walked to the fore ship where they had to write a poem for Neptune's wife; then they were taken blindfolded to the middle part of the upper deck. There the blindfold was taken off and they had to drink (a can) of beer that tasted of Tabasco and soy sauce. After reading out the poems and singing both had to take their place in the 'stocks' and had to answer questions (about the ship) for about three minutes. If their answers were incorrect, they were pelted with leftover food. For the next part they had to crawl under a net that was stretched over the hatch, while they were sprayed with the fire hose. After that they went back into the stocks and were blindfolded again. Then they had to walk on a kind of duo-ski over the deck. After these were removed the cook had to wait blindfolded, while S. was taken away. Shortly afterwards he heard everyone shouting 'jump jump', after which everything suddenly went silent. Then,

when his blindfold was taken off, he saw a lot of blood. S. was lying in the gangway. The cook knew that the others had wanted them to think that they were jumping overboard. However, the plank from which he had to jump was on the hatch when his blindfold was taken off. During the ceremony he had already seen the plank (estimated to be about 3 metres long and 40 centimetres wide), but at that time it was resting over the gangway from the hatch on the container rail. After the accident, the captain immediately went to the bridge to make a call. The third mate and the boatswain were with S. Approximately one hour after the accident, it was established at approximately 15:00 hours that S. had died. The body was then attended to and placed in the cold store. The Filipino crew set up a memorial for S. and every evening, according to Philippine customs, they commemorated him. When asked what the atmosphere was like on board before and after the accident, the cook stated: 'It was fine before the accident and everyone was looking forward to the ceremony. After the accident there was a sad atmosphere'.

E. A report of the examination of witnesses by the examining magistrate of the cook at the District Court of Amsterdam on 17 March 2017 includes as the cook's statement (appendix 10B to the application):
You ask me where the plank that we had to jump from was located. That plank was not over the water but within the ship. That plank was pointed out, I had no blindfold on at that time, and someone said: that's where you will jump from.'

F. A report of the questioning drawn up on 23 November 2015 by (the reporting officers of) the Police National Unit, the Infrastructure Department, of the person concerned, includes the following as his statement (appendix 11 to the application), freely reproduced:
The person concerned has been captain of the Achtergracht since 18 August 2015. He has been in the service of the Spliethoff shipping company as captain since 28 December 2011. S. was a trainee/cadet officer. He had joined the Achtergracht at the beginning of October 2015. It was his first sea

voyage; before that he had not sailed on any other ships. The date on which the Neptune ritual was held was decided by the person concerned: Saturday 14 November 2015. This was a few days after the Achtergracht had passed the equator, but at weekends on Saturday the crew is free after 12:00 hours, except for those on watch. The weather was good: wind force 4, good visibility, partly cloudy, light swell. The person concerned also made the Neptune certificates. As captain he welcomed Neptune; he also observed. The equipment used during the ceremony was present on board: (including) wooden skis, a gangplank net, a wooden sword and rifle and a Neptune trident made of metal and a wooden plank that is only used for the ceremony. According to the person concerned, the ceremony was as follows: S. and the cook were first taken to the fore ship, where they had to write a letter to Neptune; half an hour later they were taken to the hatchway coaming (number 3), where they were given a drink consisting of beer, Tabasco and soup flavouring, one can each; after that they were asked funny questions, without physical punishment, and they had to crawl under a net, while they were sprayed with the fire hose. For the next part they were blindfolded and walked with wooden skis over the hatchway coaming. During the interrogation they were able to see the gangplank from which they were to jump. At that time it was close to the edge of the ship. This was to make them think they would jump into the water. However, as soon as the blindfold is removed, the plank is pulled back so that they do not fall into the water, but step on the hatchway coaming. To this end, the gangplank was approximately 2.5 metres from the edge of the hatch. There were no specific safety measures in place, but there was supervision. The person concerned was observing. When S. was on the plank, the person concerned and the crewmembers took a certain position. That was to prevent an accident. At the end of the gangway S. jumped up slightly, after which he fell forward and stumbled when he landed. After that he fell with his head down into the gangway. The jump that S. had made went sidewards. The person concerned and the boatswain were not prepared for this. The person concerned had not undergone the Neptune ritual himself. In his view, this ceremony was organised by everyone, not by anyone in particular.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

G. A translation, attached as appendix 11 to the application, of a 'Statement by the Captain on an Accident resulting in Fatality', drawn up on 15 November 2015, contains information including the following:
Everything went well until the 'walking the plank' part. [..] As usual, the plank was walked in a safe way. There was always someone ready to prevent injury. This time I myself and the boatswain were ready to catch S. The 3rd mate also stood behind S. to catch him. At 2.07 pm S. jumped as planned (because he was blindfolded, he did not know where to jump). He made a small jump and suddenly another and fell against the deck. After the fall he did not move again. [..] I saw a lot of blood coming from the mouth and nose of S.. The crew acted quickly. The O2-set was quickly brought to the scene, together with a stretcher. A neck brace was also fitted. Chief engineer S. took charge. I myself hurried to the bridge to contact the Dutch Coastguard for the Radio Medical Service. [..] At about 2:50 pm S. heart stopped beating. The resuscitation was resumed, but without success. [..] The stated time of death was 15.00 UTC. [..] The body was washed, dried, dressed and moved to the cold store in a body bag. [..].'

H. A report of the hearing of witness O. S. (hereinafter: the chief engineer) drawn up on 23 November 2015 by (the reporting officers of) the National Police, Central Unit, Infrastructure Department, includes the following as his statement (appendix to the defence):
'The plank was part of the scenario. They had laid the plank behind the gangway and made it look as though you have to jump off the plank into the water. After that you are blindfolded and the plank is pushed backwards, away from the water. You think you're jumping from the gangway into the water, but that's not the case. [..] People are standing by to catch them [...]. According to plan, S. walked over the plank, thinking it was hanging over the side, and at the end of the plank he stopped. Normally everyone calls Gooo, Jump. Normally they act as if they are going to jump, but then take a small step. They pretend to jump. [..] I saw that S. walked to the edge of the plank, bent his knees a little and made a jump, a kind of long jump. The captain

stood in front of him to catch him, but S. jumped to the left past the captain. [..] The captain could not reach him. To the left of S. was the 3rd mate, who tried to grab him by his T-shirt, but he didn't succeed, S. jumped just between the two.

I. The report of the Netherlands Forensic Institute on the 'Pathology investigation into a possible non-natural death', drawn up on the instructions of the Amsterdam Public Prosecutor, which is attached as appendix 12 to the petition, states, among other things: 'The cause of death [of S.] was clearly complications of the skull-brain injuries caused by loss of brain function and lack of oxygen owing to the inhalation of mainly blood in the airways, causing closure of the airways.' And in conclusion: 'A. S., aged 21, died as a result of complications caused by an external, violent blow to the head.'

5. The ruling of the Disciplinary Court

A. The findings based on the content of the documents referred to above, the attached video recording and the hearing are as follows.

On Saturday, 14 November 2015, at around 3 p.m., the then 21-year-old Filipino trainee/cadet S. died as a result of an accident. The accident took place on the high seas on board the Dutch seagoing vessel Achtergracht, which was on its way from Brazil to Amsterdam with a cargo of cocoa beans. A few days earlier the Achtergracht had passed the equator. This was the first time for S., who was doing his internship on the Achtergracht, was the youngest of the 15 crewmembers and had not made any previous sea trips. Together with the chef, to whom the latter also applied, he therefore underwent the Neptune ritual. In the final part of the ritual – which took place on hatchway coaming number 3, while there was a slight swell – he had to walk blindfolded over a wooden plank and make a jump at the end of it. Before the blindfold was put on, the wooden plank had been placed over the gangway from the hatchway coaming on the container rail, possibly with the end slightly outboard. This creates the suggestion that a jump should be

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

made overboard from the gangway. After the blindfolds had been put on, however, the gangplank was pulled back to the hatch, up to about 2.5 metres from the edge, so that the jump inboard would end on the hatch. Before S. crossed over the gangway blindfolded and guided by a few crewmembers, he was first turned around several times. At the end of the plank he was encouraged by the bystanders to jump. The person concerned and the boatswain were ready to catch him between the end of the gangway and the edge of the hatch, but because S. – whether or not as a result of turning – jumped sideways, he slipped between the two, after which he fell forward with his head on the gangway approximately 2.5 metres below. S. died an hour later as a result of the resulting skull and brain damage.

B. It is certain that none of those present at the Neptune ritual wanted this fatal accident or was prepared for it to happen. At the same time, however, it must be borne in mind that such an accident must and can be prevented. For example, when choosing to carry out the ritual on the hatch crane deck, adequate fall protection must be provided. This was not the case here: the screen to the lower side of the gangway was only formed by the person concerned and another crew member, who – wrongly – did not take into account that the blindfolded and possibly out of balance (by turning) S. could make a sideways movement instead of jumping straight ahead. It was by no means unforeseeable that a fall of a blindfolded person from the hatchway deck to the lower deck/gangway, approx. 2.5 metres, could have a fatal outcome.

C. Taken together, this means that the Disciplinary Board shares the opinion of the petitioner that the person concerned can be held accountable for the accident and its fatal outcome. By failing to take measures that were reasonably required with a view to the safe performance of the ritual at this location (the hatch crane deck), the person concerned, as captain of the Achtergracht, did not behave as befits a good seaman towards the still young S. In so doing, he has acted in breach of the provisions of Article 4(4) of the Seafarers' Act. It is also added that if an adequate fall prevention system was

not possible at the chosen location, the person concerned should have designated a different location for the performance of the ritual or should have changed how it was carried out. In so far as the person concerned argues that he did not have the authority to do so as captain, this is a sign of a misconception regarding his position as captain of the ship. His authority is not limited to the working hours and the assigned activities, but also extends beyond them and also applies to the performance of a ritual such as the one at issue here, even if it is initiated and carried out by lower-deck crewmembers.

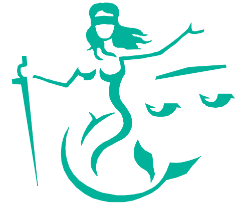
D. Nor was it the case that the captain was unable to attend or was absent during the Neptune ritual; indeed, he was actively involved in it in the sense that he decided on its time, welcomed 'Neptune', signed the 'certificates' and, as he himself says it, played an observing role, which role at the time of the accident was that he was ready to catch S., in which he unfortunately did not succeed.

E. The argument of the person concerned that he was not the only person (at the ritual) present with an officer rank and that it is therefore not fair/reasonable that only he is accused of a disciplinary accusation does not hold either. Here, too, he misconceives his position as captain and ignores the fact that safety on board the ship is primarily the responsibility of the captain. Moreover, the measures/provisions necessary to adequately cover the hazards associated with the ritual (a safety plan) should reasonably have been taken at an earlier stage than during its implementation. Those who undergo the ritual must be able to rely on their safety having been considered. All the more so since this applies to young people without much experience on board a ship. Here, too, it is primarily the person concerned who is accountable.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL

6. The disciplinary measure

The Disciplinary Board is of the opinion that the person concerned has seriously failed in his obligation as captain to ensure the safety of the still young trainee/cadet officer S. S. should not have been exposed unnecessarily to hazards that he might not be able to recognise. The reason for this is that the person concerned – from the point of view of safety – did not provide him with the care that a good seaman should provide. S. has had to pay with his life for this neglect of safety aspects. The fact that this took place in the context of a ritual of initiation that is unnecessary for his training makes it all the more distressing. In view of the seriousness of the negligence, a suspension of the navigation licence for the duration set out below is appropriate in all respects. The fact that this will be departed from in the favour of the person concerned is due to the fact that the person concerned has shown remorse at the hearing and has shown that he is well aware that care for the safety of the crew in general and for vulnerable cadets in particular must henceforth be given the highest priority. A severe measure does not appear necessary to press this home, even less so since the person concerned is suffering from something that is the last thing he wanted to happen. Another factor is that the person concerned has a good record of service and has not previously been punished for neglect in the area of safety. Finally, the fact that he will shortly have to appear before a criminal court has been taken into account in favour of the person concerned. If a criminal conviction is subsequently reached, the seriousness of the offence committed against the victim (involuntary manslaughter) will also be reflected, unlike in this disciplinary case. Taking all of the above into account, the Disciplinary Court sees good cause to impose a partially conditional suspension of the navigation licence for the duration set out below.

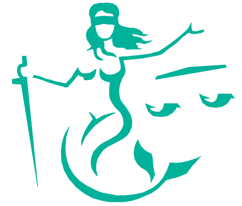


7. The decision

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) months;
- stipulates that of this suspension, a period of 3 (three) months 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.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL



Duly delivered by J.M. van der Klooster, LL.M., deputy presiding judge, E.R. Ballieux,
H. van der Laan, O.F.C. Magel, C.J.M. Schot, in the presence of D.P.M. Bos, LL.M., as secretary, and pronounced by A.N. van Zelm van Eldik, LL.M., in public session on 4 July 2018.

J.M. van der Klooster presiding judge	D.P.M. Bos 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.

DAMRAK 387 1012 ZJ AMSTERDAM, THE NETHERLANDS PHONE: +31 20 6220477
WEBSITE: WWW.MDCN.NL