RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 9 JULY 2021 (NO. 10 OF 2021) IN THE CASE 2021.V2-TORSTEN

As petitioned by:

the Minister of Infrastructure and Water Management
in The Hague,
petitioner,
represented by: B.A.C. van Geest,
inspector at the Human Environment and Transport Inspectorate (ILT)/Shipping in Zwijndrecht;

versus

A. M.,
the person concerned.

1. The course of the proceedings

On 3 February 2021, the Disciplinary Court received a written request for disciplinary proceedings from inspector B.A.C. van Geest against the person concerned as master of the Dutch vessel Torsten. Twenty-three 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. The person concerned did not avail himself of this opportunity.

The presiding judge stipulated that the oral hearing of the case will be held at 11.00 hours on 28 May 2021 at the offices of the Disciplinary Court in Amsterdam.

The Human Environment and Transport Inspectorate and the person concerned 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 28 May 2021. Inspector B.A.C. van Geest appeared at the hearing on behalf of the petitioner, accompanied by his colleague, ing. K. van der Wall. The person concerned also appeared at the hearing.

At the end of the hearing, in consultation with the person concerned and the inspector, the date of the decision was determined as today's date.

2. The petition

Rendered concisely, the basis of the petition is as follows.

On 28 May 2020, an accident occurred on the multicat Torsten. The vessel was working on the river Elbe (Germany) for a dredging project (Neufelder sand). A floating pipeline had to be detached from its anchor to be connected to a sand dredger. The wire of the main winch was connected to the coupling wire of the floating pipe. The buoy attached to the anchor wire was pulled on deck with the auxiliary winch. When the buoy was pulled on deck with the bow roller, the buoy, still under tension attached to the wire of the auxiliary winch, moved unexpectedly to starboard. A seaman (referred to below as "the victim") sustained an injury to his lower right leg when he was hit by the wire of the auxiliary winch.

This accident was reported by the shipowner to ILT on 4 June 2020.

3. Objections of the Inspector

According to the Inspector:

1. the person concerned created a dangerous task by having the victim guide the taut wire of the auxiliary winch with a short boat hook;
2. no separate risk analysis was carried out for this task, and it was not discussed during a toolbox meeting, partly as a result of which the victim was 'not fully' aware of the risks involved in this task;
3. the communication between the person concerned and the crane operator from the wheelhouse with the victim was not properly set up; it took place with hand signals and there was also a 'blind spot'.

At the hearing, the Inspector demanded the fully conditional suspension of the navigation licence for a period of two weeks.

4. The position of the person concerned

The person concerned acknowledges the facts stated in the petition. He refers to his statement of 1 June 2020 (Annex 7 to the petition) for his statement.
The person concerned considers the demand to be reasonable. He regrets what happened and wants to do better next time.

5. The assessment of the petition

A. The petition shows the following.
The seagoing vessel Torsten (a multicat with IMO number 9623142 and call sign PCLE) of Sleepdienst H. Schramm B.V., sailing under the Dutch flag, has a length of 31.50 metres and a gross tonnage of 364 (Annexes 12 and 13 to the petition).

B. The person concerned made the following written statement on 1 June 2020 (Annex 7 to the petition):

"The work instructions were to release the floating pipe from the anchor, to start coupling it for the sand dredgers Pedro Alvares Cabral and Tristao da Cunha. We started by attaching the yellow can buoy to our auxiliary winch on the starboard side and to haul it on deck. The wire from the main winch was connected to the coupling wire of the floating pipe, so we could not use it. The yellow can buoy came on deck over the bow roller and the victim was located starboard amidships to guide the wire of the auxiliary winch with a boat hook. He was wearing the necessary protective equipment, such as a helmet, safety shoes, gloves and a life jacket. Suddenly there was too much tension on the wire, causing the wire and the yellow can buoy to slide rapidly to starboard. As a result, the wire from the auxiliary winch struck the victim's lower right leg. At that moment, we had a countercurrent of 2 knots, and unfortunately, I could not avoid the wire getting too tight; it took just a split second. The other two seamen were on the right side, portside fore, behind the crane. The victim should have been in a different position instead of starboard amidships. For example, more to starboard aft; in that case, even if the winch wire had shifted, it could not have reached the starboard aft position. I was manoeuvring at this time, and the crane operator was the winch operator on the bridge."
In response to questions from the Inspector, the person concerned replied in writing as follows (Annex 10 to the petition):
The project in question has seven crew members on board.
A toolbox meeting with the customer was held before and during the project. According to the person concerned, internal/oral toolbox meetings took place regularly to optimize the procedure on deck/on the bridge. According to the person concerned, it is not usual to guide the (22mm) wire of a winch with a boat hook, but it is necessary to prevent the hook of the wire from getting caught in the container twistlock fastenings on deck. According to the person concerned a risk analysis had been made for this work (heavy object on deck, such as anchors, can buoys), but not specifically for the use of the boathook. The person concerned refers to Risk Assessment Anchor Handling.

According to the person concerned, he gave instructions for the wire to be guided with a boat hook because of the danger that the hook would get stuck in the twistlock opening and that there would be too much tension on the wire, and it could break as a result. The hook has since been replaced by a closed hook with a safety clip, according to the person concerned. The hook can therefore no longer get caught anywhere on the deck. It is possible to seal the container twistlock fasteners, but this is no longer necessary now that a closed hook is used.
According to the person concerned, before the accident he had not seen that the victim was standing in this (wrong) spot. The victim was standing diagonally in front of the starboard winch in our sight when he gave the signal to hoist, then the victim changed position and was standing to the right of the winch, which is a bit of a blind spot for us, according to the person concerned. The person concerned stated that the victim was basically in a good position when we started to haul diagonally right before the winch on the starboard side. But shortly afterwards, he suddenly changed position and stood in our blind spot amidships to the right of the winch, according to the person concerned.
The person concerned stated that the communication was actually automatic; when the crane operator operated the winch, the (later) victim was ready with the boat hook to guide it. The person concerned states that the crane operator gave hand signals to him from the bridge to the deck.
The activity with the boathook was the victim's daily work. Other deck crew members also carried out these activities.
The method of anchoring as used before and during the accident is no longer used. A different and safer anchor configuration (no delta flipper anchors but one concrete box anchor) is now being used, according to the person concerned.

C. The crane operator's statement (Annex 8 to the petition) shows that he could not see the victim while he was operating the winch on the bridge. The AB's statement of 28 May 2020 shows that he could not see the victim from his position on deck in front of the crane (Annex 8 to the petition).

D. The victim's statement (Annex 9 to the petition) shows that on 28 May 2020 he had an accident on the Torsten in which his leg was broken just below the knee. The accident occurred during Anchorhandling (routine work), according to the victim. He states that they had sailed out with the Torsten to pick up the buoy to place it on a *tucker* (should probably read: a *tugger*). According to the victim, the victim then gave a signal to retrieve the buoy and the crane operator did so. The buoy was aboard Torsten, and then the buoy began to slide with the *tuckerwing* (should probably read: *tugger winch)*. The steel wire of the *tucker* (should read *tugger)* then hit his leg, at which point his leg was broken, according to the victim.
The victim's answers to the Inspector's questions (Annex 11 to the petition) show the following:
The victim was standing on the foredeck when he gave the signal to the crane operator to haul. When the victim was hit by the wire, he was, according to his statement, standing starboard with his back against the railing, facing the foredeck and the crane operator. In the meantime, he had not been anywhere else. According to the victim, he had guided the wire of the *tugger winch* with the boathook more than once. The victim stated that he was not fully aware of the risk of the wire sliding across the bow roller. He communicated with the crane operator using hand signals, the victim said.
The victim was readmitted to hospital around September 2020 because there were complications concerning the recovery of his leg, according to an email exchange between the shipping company and the Inspector dated 10 September 2020 (Annex 11 to the petition).

E. The request further contains the following relevant annexes:
- photographs showing where the victim was on the vessel at the time of the accident (Annex 14 to the petition);
- drawings of the old and new anchor configurations (Annexes 15 and 16 to the petition);
- Torsten's Risk Assessment Manual Anchor Handling/PLGR (Annex 17 to the petition). This lists risk-mitigating measures for the activity "heavy object on deck, e.g. anchors, can buoys": "*Use of proper PPE and lifting technique,*

good communication, lashing if necessary" and for the activity "anchor handling": "*use of certified equipment, toolbox meeting, training of personnel*";
- General Anchor Handling Manual (Navconsult) by Schramm (Annex 18 to the petition). This mentions the importance of good communication. It also requires toolbox meetings to be held before certain activities and prior to new activities and at every change of the watch or when new personnel enter the work area. During these toolbox meetings, the foreseeable risks and risk-mitigating measures should be discussed. A written report must be made of the toolbox meetings;
- Instruction Manual Torsten (index and Chapter 4) by JW van Stee (Annex 19 to the petition). This prescribes various types of risk assessment. In addition, a toolbox meeting is prescribed for unforeseen jobs and a last-minute risk assessment (LMRA) for working on deck, including anchor handling;
- JW van Stee Worksheet No.01: Unforeseen Jobs and No. 03: working on deck at sea, including anchor handling (Annex 20 to the petition). With regard to anchor handling, it is emphasised that the master is in charge;
- Victim's Familiarisation record (Annex 21 to the petition) where it is ticked off that the victim is familiar with the on board risk assessment instruction from the Instruction Manual and the JW van Stee worksheets on personal safety;
- May 2020 Work and Rest Hours Registration Form (Annex 22 to the petition.

F. At the hearing, rendered in summarised and concise form, the person concerned made the following statement:
The person concerned stands by its previous statements.
The short boat hook was used to keep the hook clear of the opening of the twistlocks. The use of a boat hook to guide a taut wire from the auxiliary winch was an experiment of the client, the dredging company Jan de Nul. Never before had the floating pipeline been connected between two sand dredgers, nor was it clear to the client himself. The anchor system was not right, and afterwards, it was completely changed. Afterwards, the hook was

changed into a hook with a clip on it, and a plate was welded on the twistlocks on deck. The person concerned fully agrees that he should have realized earlier that the hook without the safety pads in it would get stuck behind it because that was why the victim was standing there. The person concerned feels in hindsight that it would have been better to put the wire between the pins. The person concerned also believes that it would have been better to wait for slack water before hauling the buoy aboard. However, the client would not have accepted this because the client considers production more important.
The person concerned also stated at the hearing that he no longer knows to what extent he took the prescribed risk-mitigating measures for the activities 'heavy object on deck' ('use of proper PPE and lifting technique, good communication, lashing if necessary') and 'anchor handling' ('use of certified equipment, toolbox meeting, training of personnel') from the Torsten *Risk Assessment Manual*. The person concerned also no longer remembers whether a toolbox meeting was held with the crew on the day of the accident. Furthermore, the person concerned stated during the hearing that the circumstances in which Schramm's manual states that *pendant handling* is placed in the second highest category of *initial risk* and *buoy handling* in the lower category and that there was a current of two knots, were not sufficient to perform a *Last Minute Risk Analysis* and to hold a toolbox meeting before the start of the activity. The person concerned does not know what is in the *pocketsize* and has no comment on the question raised at the hearing as to how it is possible that the stack of theory on board does not correspond to hard practice, resulting in accidents which are warned about in all the papers.
Concerning communication, the person concerned stated at the hearing that he was signalling the crane operator using hand signals. The crane operator could see the people for three-quarters of the way, but the victim moved back a bit, and then he was standing diagonally behind the winch and the crane operator lost sight of him.
The person concerned states that this is the first time he has experienced such an incident. He feels sorry for the victim that it happened. According to

the person concerned, the person concerned was shocked and what had happened haunted him for a while, but he is doing much better now.
The person concerned stated that no criminal proceedings were instituted.
According to the person concerned, the consequences of a suspension of his navigation licence would be a loss of income during the period concerned.

6. The ruling of the Disciplinary Court

A. The content of the documents referred to above and the statements of the person concerned at the hearing have led to the following conclusions being drawn in this case (with an adequate measure of certainty).
On 28 May 2020, a work accident occurred, in which a seaman on board the multicat Torsten was injured. The accident occurred during the release of a floating pipe from anchor to be connected to a sand dredger. The wire of the main winch was connected to the coupling wire of the floating pipe. The buoy attached to the anchor wire was pulled on deck with the auxiliary winch. When the buoy had been hauled on deck by the bow roller, the buoy, still attached under tension to the wire of the auxiliary winch, moved unexpectedly to starboard, and the wire of the auxiliary winch hit the victim, causing the victim to be injured.

The person concerned created a dangerous task by having the victim guide the taut wire of the auxiliary winch with a short boat hook. The use of a boat hook to guide a taut wire from the auxiliary winch was an experiment of the client. Never before had the floating pipeline been linked between two sand dredgers. No separate risk analysis was carried out for this task, and it was not discussed during a toolbox meeting. Given the high-risk nature of the work and the fact that it was an experiment, this should have been done. Partly because of this, the victim was "not fully" aware of the risks involved in this task.
The communication between the victim and the crane operator from the wheelhouse was not well established. Communication took place using hand

signals while the victim was standing in the wrong place and was out of sight of the crane operator at one point.
By acting this way, the person concerned endangered the victim, and the victim was injured as a result.

B. The conclusion must be that the objections of the Inspector be declared proven. The proven 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 master 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 Disciplinary Court judges that the person concerned failed in his responsibilities as master, which resulted in the accident. When freeing a floating line from the anchor to be coupled to a sand dredger, the person concerned did not act as befits a responsible master, as a result of which the safety of those on board was endangered. Because the victim was injured in the process, the Disciplinary Court considers an unconditional suspension of the sailing licence for a period of two weeks to be appropriate.

8. Practical recommendations

Following on from, but also separately from, the decision in this case, the Disciplinary Court sees cause to make the following recommendations:

- If measures, procedures and equipment are available on board for a particular activity, they should be used;

- High-risk activities, such as disconnecting a floating pipe from an anchor to be coupled to a sand dredger, are always subject to a Job Safety Analysis, followed by a Risk Assessment, a possible Last Minute

Risk Assessment and a toolbox meeting. The topics covered are the management (overall and at the specific location), division of tasks, communication, visual contact, no-go areas (snap-back zones) and agreements on when an operation will be stopped;

- If the client and the contractor have different safety cases, the most serious safety case applies to performance of the contract;

- Familiarization is not just a formality but must have real substance.

9. The decision

The Disciplinary Court:

- declares the objections against the person concerned as stated under point 6 to be well-founded;
- suspends the navigation licence of the person concerned for a period of two (2) weeks.

Duly delivered by W. van der Velde, presiding judge, T.W. Kanders and J. Berghuis, members, in the presence of V. Bouchla, LL.M., as secretary, and pronounced by P.C. Santema, LL.M., in public session on 9 July 2021.

W. van der Velde
presiding judge

V. Bouchla
secretary

P.C. Santema
presiding judge

V. Bouchla
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.