RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 26 November 2021 (NO. 14 OF 2021) IN THE CASE OF 2021.V4-THUN LIFFEY

As petitioned by:

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

versus

P.J. v. H.,
the person concerned,
lawyer: J.M. de Boer.

1. The course of the proceedings

On 25 March 2021, the Disciplinary Court received a written request for disciplinary proceedings from the aforementioned B.A.C van Geest against the person concerned as master of the vessel Thun Liffey, sailing under the Dutch flag. Twenty-one appendices were attached to the petition.

The Disciplinary Court has notified the person concerned of the petition, enclosing a copy of the petition with appendices and informed the person concerned of the right of appeal.
On 16 June 2021, a statement of defence was received from the person concerned.

The presiding judge stipulated that the oral hearing of the case will be held at 11.00 hours on 15 October 2021 at the offices of the Disciplinary Court in Amsterdam.

The court hearing was held on 15 October 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 appeared at the hearing, represented by his lawyer.

2. Grounds

The petition for a disciplinary hearing was filed in response to the accident described below.
On 29 December 2020, the Thun Liffey ran aground after departing from Londonderry. This happened just after the pilot had been disembarked with the pilot boat. The vessel was aground for several hours before being released by the rising water and the help of two tugboats.

The Thun Liffey is a Dutch oil and chemical tanker, belonging to Thun Tankers B.V. in Delfzijl. The vessel was built in 2020, has an overall length of 141.57 metres, a gross tonnage of 11,826 GT and is propelled by a 4480 kW engine. At the time of the accident, the crew consisted of sixteen people in total.

3. The Inspector's objections

According to the Inspector, the person concerned acted as master contrary to the duty of care that he, as a good seaman, should observe with regard to the persons on board, the ship, the cargo, the environment and shipping traffic (Section 55a of the Seafarers Act).
In particular, the person concerned:

1. by heeding to the pilot boat's skipper to give even more leeway to starboard, he effectively surrendered his vessel's safe navigation to the

pilot boat's skipper. That was certainly the case when the person concerned could not monitor his position, course and speed over ground because he was looking out over the starboard side. He did that because it took so long to disembark the pilot.

2. did not switch on the ECDIS screen on the starboard bridge console or have it switched on.
3. did not instruct the chief officer to monitor the vessel's position, course, and speed from the starboard console when he left the centre console to look out to starboard.
4. took insufficient account of the influence of the strong ebb tide and rising NNW wind on the vessel when disembarking the pilot.
5. The vessel was grounded for several hours.

The Inspector cites as the regulations not complied with:
STCW code Part A
Section A-II/1 – Standards regarding the master and deck department – Bridge Resource Management.
Section A-II/2 – Standard of competence – Situation Awareness.
STCW code part A Chapter VIII – section A PART 4 – WATCHKEEPING AT SEA
(4.1 – principles to be observed in keeping a navigational watch)
"Navigation with pilot on board
49 Despite the duties and obligations of pilots, their presence on board does not relieve the master or officer in charge of the navigational watch from their duties and obligations for the safety of the ship. The master and the pilot shall exchange information regarding navigation procedures, local conditions and the ship's characteristics. The master and/or the officer in charge of the navigational watch shall co-operate closely with the pilot and maintain an accurate check on the ship's position and movement."

The demand is to impose a suspension of the navigation licence for four weeks, two weeks of which are conditionally.

4. The position of the person concerned

In summary, the applicant has argued that the accusations against him are based on incorrect facts and assumptions. It follows from the correct facts that the person concerned turned to a safe course too late because the pilot remained on board far too long. The pilot and the pilot boat skipper could and should have stopped the operation when it took too long and warned the person concerned, which they failed to do. The chief officer and third officer should also have provided the person concerned with information, which they failed to do.

5. The ruling of the Disciplinary Court

The means of evidence

In assessing the application, the Disciplinary Court takes the following evidence as its starting point:

A. The statement of the person concerned at the hearing, in so far as it states:

"I do not remember a lot about what happened when disembarking the pilot. I could not verify my memory with the VDR data at the time. What I remember most clearly is that the pilot boat did not want to come alongside. To this day, it is not clear to me why not. Normally, this is a very quick operation. The pilot went below, as he confirmed. He was in contact with the pilot boat via VHF and said that he was going below. He was on deck within half a minute. From that moment on I was alert and wanted to get back on course as soon as possible, but that did not happen. There was nothing special about it. Everything went as standard. Because the wind was picking up, the pilot wanted to disembark earlier. The 'Tuns buoy' already had water over it, which is why he wanted to disembark faster. I do not know exactly when he said he wanted to disembark earlier, but according to the VDR data, it was several minutes to 15 minutes before he actually left the bridge. I did not see any problem with allowing the pilot to disembark sooner. Disembarking a pilot is not rocket science. When the pilot indicated a few minutes or a

quarter of an hour before he left the bridge that he wanted to disembark sooner, I thought about how that would affect the navigation. I knew roughly where I was, we were already off the shipping track, and I knew we did not have too much room. The pilot had already sailed a little more south of our original course, but there was still no problem. I was a little north of the centre, I seem to remember.
The bridge composition at that time was as follows. I was on the bridge as master. The pilot gave helm orders to the helmsman. The 3rd officer was officer of the watch and was busy with the navigation. The chief officer was also on the bridge and was keeping a lookout.

I disagree with the objection that I turned over navigation to the skipper of the pilot boat. I could not verify my own recollections against the VDR data at that time, and according to that data, it did not happen. At some point, the pilot disembarked. He first called the pilot boat that he was going below. Then he changed the course from 65 to 70 degrees and asked if I agreed. I agreed. He then went below with the 3rd officer. He was on deck within half a minute. When he had just left the bridge, I got a call from the pilot boat asking me to give a little more leeway. I turned to 75 degrees, which I did by giving the helm order to the helmsman to go to 75 degrees. A few seconds later, I moved a little more to starboard and set the course at 80 degrees. I did that myself. I had a windsock so I could monitor that pretty well. At one point I had the impression that it was taking quite a long time, and to give the pilot some more leeway, so that he could disembark as soon as possible, I gave the helm order starboard 10. The pilot boat told me that he had no leeway, he asked for more leeway and I said that was fine and that I was working on it. I did not give any more helm orders at that time. I received no information or input at all from the pilot or the pilot boat or the third officer on deck about what was going on. The pilot did not disembark. I wondered why it was taking so long, and because I was not given any information, I went to look myself. I went to the third window from starboard to see what was going on. I was under the impression that the pilot was already on the pilot ladder, but he was still on deck, and nothing else was happening, so

that was a bit strange. Then I gave the helm order amidships and then steady and then the pilot disembarked. I then immediately gave port 20 and a little more pitch to make sure I got back on course as quickly as possible. Before I walked over to the starboard bridge wing, I did not think it would be a problem. I did not have much room and thought it would be a bit tight. I would still have had plenty of room if the pilot had disembarked immediately. In retrospect, it was not a good place to be because I was in danger of getting outside the channel where it was shallow. That is why I wanted to see for myself what was going on. I was standing behind the ECDIS centre console and moved to starboard because I was not being kept informed. I did not know what was going on. I had asked the third officer via the walkie-talkie at course 80 if it was all right at that time. The answer was not entirely understandable, but I understood that the leeway was not quite right. I then gave another 80 degrees and ordered starboard 10 and still received no input. I did ask what the status was and then walked over to the window.

All the equipment was on, except the ECDISs on the bridge wings. We never do that: there is no point. When navigating from the centre console, you have two ECDISs. Monitoring with the ECDIS on the bridge wings is only useful when manoeuvring. You do not have a very good view from there. Before departure, I turn on the ECDISs on the wings because that is easy for manoeuvring. It depends on the situation whether I turn them off after that. We do not navigate with the ECDISs on the bridge wings. Sometimes they are left switched off. They were on when we left Londonderry. We were moored on the port side. Only the port side was switched on. Starboard was not switched on because there was no point. That certainly did not affect the course of events. Standing at the third window, I was probably looking forward towards the pilot station[1]. From there, it is too far away to look at the ECDIS. The ECDIS screen on the wing is directed aft. We manoeuvre from the centre. When I was standing on the starboard side of the bridge, I did not

[1] 'Pilot station' in this text refers to the position on the deck of the vessel where the pilot ladder is located

turn on the ECDIS because if you are standing on the starboard side and behind the screen you cannot see outside. You would not have a view of the pilot station. You also have a piece of wood in front of your eyes.
The investigation report states that the third officer acknowledged the ECDIS alarm. I do not know what alarm it was. A guard zone is mentioned in the voyage plan. You ask what is meant by that. This means the 'look ahead' of the ECDIS. If I'm moored in shallow water, the alarm will go off within the set time of the guard zone. The settings of the ECDIS are configured on departure. We look at where the shallows are. There were no buoys in the shallows.

I confirm that I took over the 'plotting, positions, in charge of navigation' tasks when the third officer left the bridge. You point out in objection 3, that I did not instruct the chief officer to monitor our position, course and speed when I walked away from the centre console. I confirm that I was engaged with the navigation, not the chief officer. The chief officer showed little initiative. Normally I would assume that a chief officer knows what to do. I would have preferred that he provided me with information and walked over to the centre console. I should be able to assume that a chief officer knows what he's doing.
You refer to page 8 of the investigation report under point 5.6: "Captain moved to SB window on bridge to have a better look on deck/pilot boat, thereby losing his orientation". I confirm that the latter is a finding of the chief engineer. The three of us (TC: the investigation team) discussed this. I felt I knew exactly where I was, of course. The claim that I lost my bearings does not look good in the report. It was the impression of the three people at the time. Again, I was able to interpret this point better in retrospect based on the VDR data.
You point to conclusion number 6 on page 14 of the report (Conclusion of onboard investigation). You say that you read there a confirmation of objection number 3. I state that this was not my conclusion but rather that of the office.

The pilot ladder was ready at 7:30. The officer did not check this, which is why the third officer went below as well. There was no pre-check. It is not clear why the pilot boat did not come alongside. The pilot boat was able to come alongside later when the vessel stopped. The fact that it took so long for the pilot to transfer must have had something to do with the manropes. I do not remember who mentioned the manropes. Using the manropes was not the usual procedure, but that is what the pilot wanted. The average crew member was familiar with the manropes. It was not a lack of knowledge that it took so long. The third officer did not explain this later either. It remains unclear. Nobody knows what caused it.

Visibility during the incident was good. I could see the land to starboard and port sides quite clearly. We have an anemometer and I could see the status of the sea. The wind was picking up and there was a strong ebb tide. I was not worried at the time because the pilot would normally disembark immediately, after which I could directly give port rudder and start the turn without any problems. If it takes that long, there is going to be a problem. I started the turn too late. If I had received better input, this would not have happened to me. I was in the process of disembarking a pilot and it seems that something was going on that I had not been informed of. I did not think we should abort the manoeuvre, because the pilot normally goes below directly to the pilot boat. If I give more leeway, I assume the pilot boat is already alongside. I did not see a problem with that at the time. If I had known that earlier, I could have decided to abort earlier. I received no input. I assumed that the pilot had immediately disembarked. Taking the ebb tide and wind into account was one factor, but not the only one. If I had been able to make the port turn earlier, it would not have been a problem. I often have to manoeuvre in strong winds and I take this into account. In my written response to the questions of the Inspector I stated that I was insufficiently aware of the influence of low tide and increasing winds. You say this reads like an admission. I confirm that this is how I felt at the time. I had to send information to the office, was busy with all sorts of things, and caught myself off guard. Even with the interrogation not being live but in writing, I still did

not have a clear impression of the truth. I only had my recollection which turned out not to be entirely in keeping with objective data. I tend to admit it when I've made a mistake. That guided me in my statement.

I have received an official warning from the shipping company. If it happens again, other measures would follow. The shipping company did not specify these other measures. Since the incident, I have done a BRM course in my leave period. The skill I learned on that course that I apply the most in current practice on board is communication."

B. The Statement of Facts, drawn up on 29 December 2020 and signed by the person concerned and the pilot (Appendix 5 to the Petition), in so far as it states:

"29/12 0640 lt Pilot on board (Londonderry LSS Oil berth)
Draft: fwd 4.90 mtr aft 6.40 mtr
29/12 0655 lt left berth; 1 tugboat Shrove stand-by
Tide 2.25 m above C.D.
Wind NNW 4
29/12 0706 lt Start SB swing at Culmore Bay, tugboat Shrove stand-by
29/12 0718 lt Completed SB swing
29/12 0720 lt Chief Officer took over engine and steering controls to amidship console.
29/12 0722 lt Helmsman took over steering on hand.
Outbound at low speed, slowly increasing to pitch 40%, then later increase to pitch 50%
29/12 0810 lt exiting dredged channel at Redcastle.
Speed 12.5 knots over ground.
Tide 2.01 m above C.D.
29/12 0835 lt Passing Moville Light
Speed 13+ knots over ground
Course 065
Wind NNW 7

29/12 0840 lt Start reducing speed down to approx. 6 knots for disembarkation pilot.
Course 060
29/12 0840 lt Pilot ladder was prepared at SB side, 1 mtr above water level with 2 man ropes stand-by for pilot ladder.
29/12 0843 lt Pilot left bridge and made his way towards disembarkation station on SB deck. Crew had to adjust the 2 man ropes to correct length.
29/12 0845 lt Pilot boat requested more lee towards SB. Captain steered to 070. Pilot boat requested more lee, captain gave orders to helmsman 20 to SB. Speed was about 6 knots.
29/12 0846 lt Pilot off, Captain gave immediate order 20 PS and gave pitch 50% ahead to make a port swing.
Wind NNW 7 to 8 (approx. 30 knots) Ship turned too slow, ship drifted towards sand bank and ran aground at 0850 lt.
29/12 0850 lt Reduced pitch to 20%.
Tide 1.5 m above C.D. locally. (Position: 55 11.9N 006 56.7 W)
HW River Foyle 29/12 0703 lt / LW 29/12 1329 lt. (about 1 hr difference between tidal times and grounding position)
Wind NNW 7/8 (approx. 30 kn)
(…)
29/12 1359 lt Ship came off and was afloat again. Ship discharged approx. 1465 m3 of ballast from WB
6W, 5W, 4W and 3W (to reduce the pressure on the underwater SB hull plating) at the time ship came
back afloat again.
29/12 1400 lt tugboats maneuvered the ship back toward deeper water. With assistance of 2 tugboats,
ship made his way towards Moville Bay."

C. The investigation report provided by the shipping company to ILT (Appendix 6 to the Petition), in so far as it states:

Final Investigation Report: grounding Incident Thun Liffey Foyle River 29-12-2020

(...)
*"**Investigation team members on board vessel***
Master, chief officer, leader chief engineer".
Incident details:
- Pilot ladder was prepared at SB side, 1 mtr above water level with 2 man ropes stand-by for pilot ladder.
- The pilot made his way down towards the pilot disembarking station on SB deck, accompanied by3 rd officer. Master took over navigation. Bosun and AB had prepared pilot ladder in combination with manropes as requested by pilot. Meanwhile the pilot was waiting on deck for disembarkation.
- Pilot boat requested to give more leeway, while not alongside ship. Captain gave orders to steer more to SB. Wind NNW 7/8, swell more N-ly.
- Captain went SB window, in order to see what was going on at the deck.
- Pilot boat requested to give more leeway again, captain ordered SB 20 to steer more to SB.
- The pilot disembarked. Captain gave immediately Port 20 steering order to helmsman and increased pitch in order to make the PS swing.
- Due to NNW wind force 7/8 and strong ebb-tide, ship drifted towards the "Tuns" bank.
- Ship turned too slow and ship ran aground in position 55 11.9N 006 56.7W. Ship was buoyed approx. from SB-fwd accommodation to SB-before forecastle.
- Captain had bow thruster full to port with rudder hard to SB with pitch 40% ahead, with no visible effect.
- Captain called pilots again and informed pilot that ship was aground. Captain requested pilot to board again and have 2 tugboats stand-by.
- Pilot boarded again and Main Engine was stopped.
(...)
Conclusion on board investigation:
1. Disembarkation position was too close to shallow water and should have been reconsidered by pilot and captain. Original passage plan was not followed. Cross track alarms and look ahead alarm were acknowledged but

not sufficient assessed. Planned track was not followed therefore cross track alarm not any more useful.
2. Pilot boat requested 2 times to give more leeway, Pilot boat remained at a distance of approx. 35 meter of the ship and was not alongside and "stand-by" Only when the ship had created enough leeway, the pilot boat made his approach, thereby losing precious time.
3. Captain should have declined to give more leeway, in order to sail more north to a better position, away from shallow waters.
4. Captain lacked information regarding position of ship at the time pilot was disembarking because he was not in the vicinity of RADAR and ECDIS anymore, but was focused on the pilot boat and pilot on deck at SB-side of bridge windows.
5. Look ahead alarm went off but was acknowledge by 3rd officer reported to master
6. Bridge composition changed when the third officer of the watch is left the bridge, The remaining bridge team did not receive new instructions from the Master to compensate for leaving the 3rd officer.
Master failed to give specific instructions to members of remaining bridge team. One option in this case, would have been that Master ordered the Chief Officer to take over duties OOW instead of himself and advised boson to act as the solely look out
7. Pilot and captain should have considered disembarkation of pilot either via PS or further North, passing "Tuns" buoy, where there is more space to manoeuvre.
8. Crew prepared pilot ladder correct in combination with man ropes. The pilot requested the use of man ropes, due to the swell, rough sea-state and a freeboard of approx. 7 meters.
9. It took the pilot boat to long to come alongside the vessel. The pilot boat was warned in advance pilot was underway to pilot ladder. Due to this, valuable time was lost, while the pilot was waiting on deck for the pilot boat to come alongside. Meanwhile, due to NNW 7/8 wind and strong ebb-tide, the ship was pushed towards the shallow waters."

D. The written answers of the person concerned to the following questions posed by the Inspector (Appendix 15 to the Petition):

12. Were you aware in advance of the influence that the strong ebb tide could have on the vessel during the disembarkation of the pilot?

13. Were you aware in advance of the influence that the (increasing) NNW wind could have on the vessel during the disembarkation of the pilot?

Answers:

12. I was not sufficiently aware of the influence of the strong ebb tide on the vessel during the disembarkation of the pilot, as has been shown.

13. I was not sufficiently aware of the influence of the increasing NNW wind on the vessel during the disembarkation of the pilot, as has been shown.

Findings:

The Disciplinary Court states first and foremost that the person concerned, as master, is ultimately responsible for the safe navigation of his ship. This means that – even if he receives insufficient information from his crew or the pilot – he must make active enquiries to find out what is going on if the vessel is in danger. Against this background, the content of the means of evidence referred to above led to the following conclusions being drawn in this case with an adequate measure of certainty.

The third objection is well-founded, in the sense that the person concerned should have instructed the chief officer to keep an eye on the vessel's position, course and speed. The objection states that the person concerned should have done this when he walked away from the centre console to look out to the starboard, but that would have been too late. The person concerned should have made it clear to the chief officer at an earlier stage what his task on the bridge was, namely when it was decided that the pilot would disembark earlier and it became clear that the pilot would leave the bridge with the third officer, a member of the BRM (Bridge Resource

Management) team. The third officer's task should have been taken over. This applies all the more since the chief officer showed no initiative to carry out tasks, according to the person concerned.
If the person concerned had instructed the chief officer to keep an eye on the vessel's position, course, and speed, the person concerned could have concentrated on the communication with the third officer and the pilot station about the disembarkation of the pilot. This disembarkation of the pilot took a total of five minutes from the time the pilot left the bridge to the time the pilot left the vessel. There may have been something wrong with the manropes, but this did not become clear at the hearing. The chief officer could then have warned the person concerned about the shallow waters and (in consultation with the person concerned) intervened. Or the person concerned could have instructed the chief officer to take care of the communication with the pilot, and the person concerned could then have monitored the vessel's position, course, and speed.
The objection also states that the chief officer should have monitored the vessel's position, course, and speed from the starboard console, but as found below on the second objection, this would not have helped prevent the accident due to the limited visibility of that position.

The fourth objection is well-founded. In response to written questions from the Inspector, the person concerned acknowledged that he failed to take sufficient account of the influence of the strong ebb tide and the increasing NNW wind on the vessel during the disembarkation of the pilot. Had he taken these circumstances sufficiently into account, he would not have agreed to the pilot's wish to disembark earlier, in accordance with good seamanship. However, the person concerned could have agreed to the pilot's wish and, in accordance with good seamanship and taking into account the ebb current and the wind, should have cleared more space on the starboard side by positioning the vessel more on the port side of the fairway before starting the manoeuvres in connection with disembarking the pilot. Another possibility if he had realised the influence of the strong ebb tide and

increasing wind is that he could have aborted the operation when he felt that the disembarkation of the pilot was taking too long.

The fifth objection is well-founded. It is an established fact that the vessel was grounded for several hours.

The first objection is unfounded. The person concerned did not transfer the safe navigation of his vessel to the skipper of the pilot boat. He himself took over navigation from the pilot when the pilot left the bridge with the third officer. The person concerned was *in control* and fully engaged in his task of navigating. He gave orders, including the helm order 80 to give even more leeway to starboard. The person concerned did this on his own initiative and not only when the pilot boat captain asked for it. Then he gave the helm order amidships and then *steady*.

The second objection is unfounded. It is true that the ECDIS on the starboard bridge console was not switched on. However, it is understandable that this ECDIS was not switched on, because it was of no use when disembarking the pilot. The screen was not turned halfway so that it was not possible also to look at the pilot station. From the third window where the person concerned was located, this ECDIS was too far from the person concerned to provide any useful information.

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 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.

<u>The disciplinary measure</u>

The Disciplinary Court judges that the person concerned has seriously

neglected his responsibilities as master, which resulted in the vessel's grounding.
An unconditional suspension of the navigation licence for the duration to be indicated is appropriate, in which respect the Disciplinary Court has taken the following into account:

- two of the five objections are unfounded;
- the conduct proven in respect of the three remaining objections is sufficiently serious to warrant a suspension;
- the person concerned received an official warning from the office and was told that if it happened again, other measures would follow;
- there was no damage to the vessel or the environment;
- the person concerned has learned from the incident (cameras have been installed and he applies the communication skills learned on the BRM course).

6. Practical recommendations

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

1. The pilot ladder should be made ready and checked by a competent officer well before the pilot disembarks. This preparation is even more important when using manropes.
   "2.2. The rigging of the pilot transfer arrangements and the embarkation of a pilot shall be supervised by a responsible officer having means of communication with the navigation bridge and who shall also arrange for the escort of the pilot by a safe route to and from the navigation bridge. Personnel engaged in rigging and operating any mechanical equipment shall be instructed in the safe procedures to be adopted and the equipment shall be tested prior to use." – SOLAS CH V, Reg 23
2. A BRM team has a verifying task and should identify and correct individual errors made by team members. All members of the BRM Team must therefore be aware of their responsibilities and job descriptions within the team. This means that if one or more members of the BRM team leave the bridge for a short or long period of time, the master (or another team member) will ensure that their tasks are fulfilled or taken over.

7. The decision

The Disciplinary Court,

- dismisses the objections under 1 and 2 as unfounded;
- declares that objections 3, 4 and 5 are well-founded;
- imposes the measure of suspension of the navigation licence for a period of two weeks.

Duly delivered by P.C. Santema, LL.M., presiding judge, C.R. Tromp and C. Kuiken, members, in the presence of V. Bouchla, LL.M., as secretary, and pronounced by P.C. Santema, LL.M., in public session on 26 November 2021.

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.