RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 3 MARCH 2021 (NO. 3 OF 2021) IN THE CASE 2020.V7- ZEALAND ROTTERDAM

As petitioned by:

the Minister of Infrastructure and Water Management
in The Hague,
petitioner,
authorised representative: K. van der Wall,
senior inspector at the Human Environment and Transport Inspectorate (ILT),

versus

A. P.,
the person concerned.

1. The course of the proceedings

On 5 August 2020, the Disciplinary Court received a petition for disciplinary action from the petitioner: referred to below as the Inspector. The petition is directed against the person concerned as master of the seagoing vessel 'Zealand Rotterdam'. Fifty-one annexes were attached to the petition.

The Disciplinary Court notified the person concerned of the petition by letter in the English language (both by registered and ordinary mail), enclosing a copy of the petition, including the appendices, in the English language. The letter informs the person concerned that he is entitled to enter a defence. The petitioner did not make use of this option.

The presiding judge of the Disciplinary Court has ruled that the oral hearing of the case will take place on 20 January 2021 at 11:00 hours.

The inspector and the person concerned were summoned to appear at the hearing of the Disciplinary Court. The summons of the person concerned was sent both by registered letter and by ordinary mail.

The hearing took place on 20 January 2021, online due to corona measures. The Inspector appeared at the hearing and Mr B. van Geest, senior inspector of the ILT, also appeared.
The person concerned did not appear. Leave was granted to proceed in default of appearance against him.

2. The accident - brief description

The petition for a disciplinary hearing was filed as a result of the accident described below.

On 23 November 2019, a serious accident took place aboard the freighter Zealand Rotterdam. A/B (able bodied seaman) F. Jr. B. C. (hereinafter: the A/B) lost his life as a result of that accident.

The accident took place when the crew were preparing to unload cargo from the vessel Zealand Rotterdam using their own unloading equipment. During this process, the A/B climbed onto the cargo grab of a loading/unloading crane of the Zealand Rotterdam. He did this in order to attach the hook of that crane to the O-ring at the top of the grab. After he had disconnected the O-ring and/or the grab cable, the crane hook struck him with a swinging motion, probably/possibly due to a rolling movement of the Zealand Rotterdam, which vessel was at that point in time lying at anchor at the roadstead of Mumbai, India. This caused the A/B to lose his balance and he fell a distance of about five metres. He landed on the main deck. The fall left him badly injured. He died of his injuries shortly thereafter.

The accident was reported by the shipowner to ILT on 24 November 2019.

3. The Inspector's objection

3.1 The Inspector holds the person concerned – the master of the Zealand Rotterdam – accountable for the following as a consequence of this accident.

a. The person concerned, as master, attended the toolbox meeting for the day on the morning of 23 November 2019. The unloading of the cargo was not discussed at the time because it was not yet known that unloading would take place that day. When this became clear later in the day, the person concerned failed to hold an additional toolbox meeting.
b. The person concerned did not fill in or issue a work permit for working aloft.
c. The person concerned communicated the order to unload to the chief officer verbally and did not attach any further consequences/instructions to this.
d. The person concerned passed on the problem of the pressure of time to make the vessel ready for unloading – imposed by the agent – directly to the chief officer. He thus endangered the safety of the crew.
e. At an earlier stage, the person concerned had failed to take any measures to make the O-ring secure for sea in a lower position. By doing so, he could easily have created much safer working conditions.

3.2 The Inspector finds that by acting this way the person concerned has acted in breach of:
a. the regulation of the STCW convention as amended in 2010 (part A / part 5-6 no 107) that '*Officers with responsibility for the planning and conduct of cargo operations shall ensure that such operations are conducted safely through the control of the specific risks, including when non-ship's personnel are involved*' ;
b. Section 4.4 of the Dutch Seafarers Act;
c. Articles 342 and 343 of the Commercial Code.

4. The position of the person concerned

The person concerned did not put forward a defence. However, there is an accident report signed by him (Annex 30 to the petition), as well as a master's statement (Annex 37). In this statement he reports the accident suffered by the A/B on 23 November 2019 at approximately 16.40 hours LT. It further states that the victim headed to the hospital with the agent's vessel at 17.40 hours. The A/B died during transport.

Questions of the Inspector about the circumstances of the accident were answered by the shipping company's agent (compliance manager).

5. The assessment of the petition

A

Attached to the Petition is an e-mail message with an attachment dated 24 November 2019 (12:20 hours) to the ILT from the (compliance manager/DPA of the) agent of the shipping company - Q-Shipping B.V. - reporting the accident on board the Zealand Rotterdam in Mumbai. The report states that the A/B died of his injuries en route to the hospital.
The shipping company's agent also submitted a 'Record of Maritime Industrial Accidents' form. This states the A/B's date of birth; nationality: Filipino; date of enlistment: 21 February 2019 and the date and time of the accident: 23 November 2019 at 16:40 hours Answers to the following questions in the form were given as noted below:

5.7 What was the victim doing at the time of the accident?
Assisting with unlashing cargo grab and to connect the cargo grab to ship's crane hook.
5.9 Who was in charge at the time of the accident?
Chief officer and bosun
5.10 What were the work instructions?
To prepare and to connect cargo grab to ship's crane hook
5.11 What went differently than expected?

Unexpected swell of 0.5-0.7 meter and therefore ship started to roll. 8.1 What measures could have been taken to prevent this accident? Wearing a safety harness according the safety system instructions for working aloft, better instructions and briefing to the crew before job commence, better risk assessment and "better social" control of the crew if their colleagues are working according instructions and are using the available PPE.

B

The Zealand Rotterdam log (Annex 6 to the petition) shows that the Zealand Rotterdam was anchored at the roadstead of Mumbai, India on 23 November 2019. At 07.40 hours that day the daily toolbox meeting was held in the presence of the person concerned as master, the chief engineer, the chief officer and the second engineer (annex 45). The log shows that the vessel weighed anchor at 11.35 hours and sailed approximately 12.5 miles in the direction of Mumbai, after which it anchored again at 14.15 hours approximately 6 miles off the coast. The local agent appeared on board at about 15.00 hours. Instructions were given that the vessel had to be made ready for departure.

C

Attached to the Petition as Exhibits 7 to 23 is an exchange of e-mails between the Inspector and the Shipping Company's agent. Questions were asked by the Inspector and answered by the shipping agent. The Inspector has summarised these questions and answers in annex 24.
The following (among other things) emerges from those answers - and from the photographs and drawings attached to the petition:

- the master was informed (verbally) by the local shipping agent on 23 November 2019 at about 15:30 LT that unloading was to take place in barges that were to come alongside;
- the master informed the chief officer - on duty at the time -

about this verbally, whereupon the chief officer informed the bosun, who was on watch at the time.
- during the toolbox meeting on the morning of 23 November 2019, it was not yet known that unloading would take place that day;
- when this activity came up in the afternoon at 15.30 hours LT, no additional toolbox meeting was held; nor was a prior risk assessment carried out;
- the following reason for this was given: *'Crew knew the information about unloading for a less than an hour before discharging is started and [chief officer] who was supposed to held the risk assessment had be urgently involved to draught survey so he had no a possibility to arrange it.'* ;
- the chief officer, after informing the bosun, started to record the draught marks at 15.45 hours, while the bosun and a number of seamen prepared the cargo cranes;
- this involved attaching the crane hook to the grab;
- the grab was located on a platform, approximately 2.5 metres above the main deck, between hold 1 and hold 2 on the port side of the Zealand Rotterdam; platform stanchions are attached to that with rope strung through them, which can be reached using fixed ladder;
- the grab itself has a total height of approximately 4 metres; the grab's O-ring was secured with a sling at the very top of the grab; after hooking up the crane, the sling had to be released; the person carrying out this work at the top of the grab is located approximately 5 metres above the main deck;
- for attaching the crane hook to the grab/releasing the O-ring at that height - which was an unexpected/unplanned activity that day - the master should have issued a '*working aloft or outboard permit*'; no such work permit for working aloft was issued that day;
- The A/B - who climbed onto the gripper via steps welded to the grab - was not wearing a safety harness and was not equipped with a fall arrest device; an explanation for this was given when asked: *'most probably due to the reason he wanted to help immediately and not to loss time going first back to the store to pick-up a safety harness'*;

- both the securing for sea and detachment of the O-ring could also be done at a lower position, i.e. from the grab platform; the length of the grab cable allows for this;
- the photographs of the location where the grab is seen on the platform do not show any stickers or pictograms indicating that fall protection must be worn when climbing the grab.

D
Attached to the petition are statements of persons including:
- the chief officer, who states: *'During accident I was in ships office'*;
- the crane operator, who stated that, after the A/B had hooked the crane and disconnected the grab cable, the vessel made a heaving motion, causing the crane block to strike the A/B, who consequently fell down onto the main deck;
- a seaman and the bosun, who also stated that the A/B fell because the crane block struck him as a result of a rolling movement of the ship;
- an A/B present in the crane cabin, who stated that - after the A/B had hooked the crane hook and then released the messenger line - he lifted the hook 10-20 cm on the instructions of the bosun, after which the A/B *released securing sling's pin from grab's o-ring. Cargo block's moved suddenly and hit to [*the A/B*]*, who consequently lost his balance and fell down to the main deck.

E
The ISM Manual, document 4.5.1.00, attached as Annex 45 to the petition, states that the master is responsible for issuing work permits. The permit for working aloft (document 4.5.1.17) states that the master or the officer responsible must fill in this permit. It also states, as a check-point, that a safety harness must be worn, attached to a lifeline.

F
A (copy) CSR *(continuous synopsis record)* is attached to the petition (as Annex 3). This shows that the Zealand Rotterdam - IMO number 9477440 -

sailed under the Dutch flag, belonged to Zealand Rotterdam and had as its international safety manager Q-Shipping B.V., located in Rotterdam.

6. The ruling of the Disciplinary Court

6.1 Based on the statements, findings and documents referred to above under 5, viewed in conjunction with the accompanying photographs and drawings, the following can be assumed - with a sufficient degree of certainty - in this disciplinary case.

6.2 On Saturday 23 November 2019, the mv Zealand Rotterdam. (then still sailing under the Dutch flag) was at anchor at the roadstead of Mumbai, India. In the afternoon the local agent reported to the person concerned (the master) that barges would soon be coming alongside into which they were to unload their cargo using the Zealand Rotterdam's own cranes. The person concerned passed on this report verbally to the chief officer, who in turn informed the bosun. The chief officer then went to record the draught marks in person, while the bosun went with a number of seamen to prepare the deck cranes of the Zealand Rotterdam. The person concerned did not point out that a (supplementary) toolbox meeting should be held first, or in any event that a risk assessment should be carried out. This was probably because unloading was expected to start within an hour, so there was no time to lose. That must also have been why the A/B did not collect a safety harness first. Without fall protection he climbed onto the cargo grab to attach the crane hook to the grab's O-ring. When that was done, the sling with which the O-ring was secured, had to be unfastened. When performing these actions, the A/B was approximately 5 metres above the main deck. A work permit must be issued by the master or the officer responsible for the operation for work at that height. It does not appear that the person concerned, who did not do this himself, pointed this out to the chief officer. Once the A/B had hooked the crane hook and loosened the fastener of the O-ring, the crane hook - whether or not under the influence of a rolling movement of the vessel and/or the slight lifting of the hook - collided with

him in a swinging motion. As a result, he lost his balance and fell about five metres. He died a short time thereafter from the injuries he sustained.

6.3 A fatal accident such as that which occurred here can be prevented by taking appropriate safety measures – by the master or, on his instruction, by other officers. This includes first and foremost a risk analysis before the start of the work. According to the *safety management manual*, this risk analysis should have been carried out within the framework of an additional toolbox meeting and/or by using forms and matrices. In this way, potential hazards could have been clearly identified and so could the responsibilities for monitoring compliance with the safety regulations. These safety regulations included the presence of a work permit for the work aloft. As part of the process of issuing this permit, the regulations stipulate that checks should be made on the use of a safety harness and adequate fall protection equipment, among other things. That work permit was not issued in this case.
The victim did not use the prescribed PPE (personal protective equipment); he was not wearing a safety harness and was not equipped with a fall arrest device, and it does not seem that anyone supervised the use of these necessary safety devices. Nor does it seem that the – by no means imaginary – danger of a swinging movement of the crane hook, in combination with the presence of a crew member on top of the grab, or on the steps of the grab, was recognised. To the extent that the swinging motion of the crane hook was a result of the ship rolling, this should also have been taken into account, also considering the fact that the vessel was approximately 6 miles off the coast in the open sea (Indian Ocean), where rolling could be expected, which constituted an additional risk when hitching and unhitching the grab.

6.3 In addition, the Inspector rightly pointed out that the person concerned could have achieved safer working conditions at an earlier stage by having the O-ring of the gripper secured for sea at a lower position.

6.4 The negligence alleged by the Inspector against the person concerned, as evidenced above, constitutes a violation of the regulation of Section 55a of the Seafarers Act in conjunction with Section 4 (4) of that Act: an act or omission by the master contrary to the care which he, as a good seaman, is required to observe in respect of the persons on board, the ship, the cargo, the environment and shipping traffic. There has also been a breach of the other requirements referred to by the Inspector in this regard (see 3.2 above).

7. The disciplinary measure

The Disciplinary Court judges that the person concerned has seriously failed in his duty as master. This includes a duty of care for the safety of the crew members. The duty of care includes preventing exposure to (potentially) unsafe situations, as well as organising supervision of compliance with the safety regulations to be observed, including in this case the wearing of a safety harness and the use of fall protection when working aloft. The breach of this duty of care led to a fatal accident in this case. The fact that the Zealand Rotterdam had to be unloaded unexpectedly and quickly is no excuse. It was his responsibility as master to counterbalance this pressure by stating and ensuring that unloading could only take place once the preparatory work on board had been carried out safely. The person concerned has not shown that he was aware of this responsibility. He can be held seriously to account for this. In view of the seriousness of the negligence a suspension of the navigation licence for a period of 3 (three) months and in addition a fine of € 2,500 are appropriate. This is the same measure as imposed on the chief officer. The culpability of both persons largely coincides.

8. The decision

The Disciplinary Court,

- upholds the objections raised by the Inspector against the person concerned, in accordance with the considerations set out in points 6 and 7 above;
- imposes as a measure a fine of € 2,500 (twenty-five hundred euros), stipulating that this fine must be paid within three (3) months of today's date;
- suspends the navigation licence of the person concerned for a period of three (3) months

Duly delivered by J.M. van der Klooster, presiding judge, H. van der Laan, D. Willet, D. Roest and G. Jansen, members, in the presence of V. Bouchla, LL.M., as secretary, and pronounced by J.M. van der Klooster, LL.M., in public session on 3 March 2021.

J.M. van der Klooster
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.