RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 23 DECEMBER 2022 (NO. 5 OF 2022) IN THE CASE 2022.V5- SYDBORG

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)/Shipping in Zwijndrecht

versus

J.K. v. E.,
the person concerned,
counsel: A. Jumelet, LL.M.

1. The course of the proceedings

On 21 March 2022, the Disciplinary Court received from the aforementioned K. van der Wall (referred to below as: the Inspector) a written petition (with annexes) for disciplinary proceedings. The petition is directed against the person concerned as chief officer of the vessel sailing under the Dutch flag Sydborg.

The Disciplinary Court informed the person concerned about the petition and sent him a copy of it with annexes, referencing his opportunity to submit a statement of defence.

A statement of defence was received from counsel for the person concerned on 2 June 2022. The inspector responded to the defence on 21 June 2022.

The person concerned filed a rejoinder to the reply through his counsel on 7 July 2022.

The President of the Disciplinary Court stipulated that the oral hearing of the case will be held at 11.00 hours on 26 October 2022 at the offices of the Disciplinary Court in Amsterdam. The Inspector appeared for the petitioner at the hearing held at that time.
The person concerned also appeared at the hearing, represented by counsel.

2. Grounds

The petition for a disciplinary hearing was filed in response to the accident described below.

On 3 September 2021, a workplace accident occurred on board the Sydborg in which an apprentice was injured. The accident occurred while loading the ship in the port of Antwerp. During loading, the apprentice instructed the crane operator of the gantry crane on where to place the cargo (fertiliser) in the hold. He did this from the hatches stacked at the rear of the hold. The person concerned – who, as chief officer, was in charge of the loading process – saw the apprentice fall down into the starboard gangway at the level of the stack of hatches. He did not see where the apprentice fell from. The apprentice suffered a fractured fibula, a collapsed lung, head trauma and three bruised fingers in his fall, among other injuries.

The Sydborg (IMO number 9196204) is a Dutch general cargo vessel, owned by Scheepvaartonderneming Sydborg B.V. in Delfzijl and sailing for shipping company Wagenborg Shipping B.V. in Delfzijl (referred to below as: the shipping company).
Built in the year 2000, the vessel has length of 89 metres and a breadth of 13 metres and a cargo capacity of 3590 tonnes. At the time of the accident, the crew consisted of seven people.

3. The Inspector's objection

The Inspector charges the person concerned with acts or omissions that are 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). More specifically, the Inspector refers to the provisions of Article 7.23 of the Working Conditions Decree containing regulations for working at heights. Those regulations have not been followed.

The objection against the person concerned consists of the following elements:

(i) The victim was on board as an apprentice and performed his work on the instructions of the person concerned.

(ii) Although the distance from the top of the hatches to the gangway was about 5 metres and the distance to the top of the tank in the hold was as much as about 11 metres, the person concerned did not consider this work to be working at heights.

(iii) Despite regular safety committee meetings to discuss fall protection, the person concerned did not consider this work as working at heights.

(iv) No use was made of the hatch crane to carry out the work from there. This is a much safer workplace because there is a railing (a collective safety measure) around the walkway.

(v) It was partly because of these omissions that this workplace accident was able to happen.

The Inspector demands the imposition of a suspension of the navigation licence for four months, one month conditionally.

4. The position of the person concerned

According to the person concerned, the starting point should be that the responsibility for safe working on board, including its effective supervision,

lies primarily with the shipowner/employer. Pursuant to Article 63(1) of the 2004 Ships Decree, on board a ship, in terms of performance of the task, this is the captain. The person concerned acknowledges that he may have a delegated duty of care but feels that the safety regulations and their practical implementation were not specific enough and unclear; there was no guideline stating what work was considered to be working at heights. Moreover, there is no causal link: it has not been established that the victim fell due to a failure to observe safety regulations. It is even unclear where he fell from and how he ended up in the gangway.
Special circumstances (the configuration of the ship, the ambiguity that existed because the apprentice was carrying out other work simultaneously, and the very hot weather) are extremely likely to have contributed to the accident.

5. The ruling of the Disciplinary Court

5.1 The evidence

A. The notification of the accident to ILT by e-mail message dated 3 September 2021 21:41:06 from the Captain Owners Department of the shipping company, to the extent that it includes:
"As informed by phone, on board m.v. Sydborg / IMO 9196204 in the port of Antwerp an accident has happened. The apprentice on board has fallen from the hatches into the gangway/weather deck, on his head. He was resuscitated by the crew and taken over by the ambulance staff who stabilised the apprentice and took him to hospital.
The latest reports are that he has a severe concussion and will have to stay in the hospital for several days."

B. The statement of the person concerned at the hearing, in so far as it states:
"As chief officer, I was responsible for management and supervision during loading on 3 September 2021. It was my second term as a chief officer; I had just finished my apprenticeship. For reasons to do with the

ship's stability, I had – standing on the hatches stacked at the rear of the hold, in the hatch crane area – instructed the shore crane operator where to place the load of fertiliser in the hold. I asked the apprentice to take over this task from me. I did not know if he had done this before. He was at the end of his apprenticeship period and had worked with me before. On 3 September 2021 we were lying portside alongside. The crane used for loading was on the quay. As the hatch crane was shaking, I moved it slightly forward and secured it to the stacked hatches. I reported the relocation in the WhatsApp message. In that new, secured, position, there was still only limited visibility into the hold from the hatch crane. That is why people stand on the hatches in front of the hatch crane. At 3.50pm, I conducted a depth check from fore to aft. As I walked backwards through the gangway, I saw the victim fall down; I saw him in the final stages of his fall. The height from deck to gangway is between 2.5 and 3 metres. The place where the victim ended up in the gangway, viewed sideways, was just in front of the stack of hatches.

A safe way to get onto the hatch crane is to climb up from behind in the middle of the stack of hatches. From there, the stack of hatches is about 1.80 metres high – you climb onto the hatch crane from the middle of the stack of hatches. From the hatch crane, you then climb to the space on the hatches in front of it (the hatch crane). In my estimation, this did not involve working at heights. That could be the case according to the safety regulations (working at heights/risk assessment), but those regulations are not clear in that case. Since the accident, I explicitly give orders that supervision should be from the hatch crane or that fall protection should be worn. I am now a year further in my career and have gained more experience. I am now more confident towards shore staff during the loading process. If the arrangements with the shore staff are unclear, I prefer to stop work first to gain clarity from the crane operator rather than having to go somewhere on deck.

C. An official record of questioning drawn up by the Maritime Police in Antwerp, in so far as containing the statement made on 3 September 2021 by the person concerned:
"[...] The cargo was transshipped from a barge lying alongside next to our hold. During loading, I asked [the victim] to assist me with the load supervision. [The victim] was to use hand signals to instruct the crane operator to load cargo to port or starboard to minimise the list. In fact, the crane operator was loading in such a way that our ship listed a good deal. [The victim] gave the gestures from a position on the rear stack of hatches. [...]"

D. The victim's statement attached to the e-mail of 19 October 2021 from the Captain Owners Department of Wagenborg, insofar as it includes: "I had the accident on 3 September 2021. I do not know anything about it, I woke up in hospital. However, I do know that I was assisting the chief officer and that my job was to keep the ship straight (to prevent listing) by giving the crane operator instructions on where to place the cargo. I did this from the hatches aft. For that purpose, I walked from the centre of the hatches towards starboard and back again because the cargo was being loaded from a barge. [...]."

E. The answers given by the person concerned by e-mail on 18 November 2021 to questions from the inspector, in so far as they contain:
"10* Who decided that [the apprentice] would perform his work standing on top of the hatches? *Initially, I instructed the crane operator to try to keep the ship reasonably level. I gave those instructions from the stack of hatches. Since this had the desired effect, I asked [the apprentice] to support me.*
13.* Was consideration given to having [the apprentice] perform the supervisory duties from the hatch crane? After all, there is railing work around this.
[...] I cannot remember why we did not initially use the hatch crane for the work.

14.* Did you consider the work and position from which [the apprentice] supervised loading to be working at heights?
I did not consider the position where I saw [the apprentice] standing on the hatches to be working at heights."

F. The victim's answers to additional questions received by the inspector on 22 December 2021 (Annex 23), in so far as they contain:
"I climbed via the hatch crane [I climbed on top of the stack of hatches]. [The] hatch crane was behind over the hatches. [...] There was enough space to walk across the hatches and it did not seem dangerous. That day it was quite hot, I think more than 30 degrees. [...] I really can't remember exactly what happened. I was up there doing my job and woke up in the hospital."

G. The victim's answers to additional questions received by the inspector on 29 December 2021 (Annex 29), in so far as they contain:
3. When the hatch crane was moved, where were you? (Eg. on top of the hatches, or in the gangway)
As I wrote earlier, I was not in the area when the hatch crane was moved. At one point, the chief officer and I climbed onto the hatches together via the hatch crane. Once we were there I was instructed to take over from the chief officer, who was busy giving directions (signals) to the crane operator when loading the ship.
Before leaving me behind, the chief officer instructed me on the best way to give signals to the crane operator. Minimising the ship's list was also discussed."

H. In Safety Committee meetings, at which the person concerned was present, the following was discussed: on 29 March 2021: "Discussed the proper use of PPEs,"; on 28 April 2021: "the safe use of fall protection" and "use proper PPE for the work"; on 27 May 2021: "Use of standard PPE and situations when to use additional PPE's" and "Crew uses proper

PPE's"; on 26 June 2021: "Discussed when a fall arrest harness is required and the dangers of not wearing one."

I. The Shipping Risk Identification & Evaluation version 1.4, insofar as it contains:

07:28	If risk of falling exists (height>2.5m), are adequate fences and railing fitted? (height railing > 1m above working surface)	Injuries by falling from a height.	Monthly check by officer
07:30	In case provisions can not be fitted, are adequate fall protection PPE available at the disposal of workers?	Injuries by falling from a height.	Safe Work Procedure Working at Heights available
08:11	Is suitable fall protection available and being used?	Accidents by falling from a height.	Checked by officer

J. The ISM-SMS, insofar as containing:

"The following work permits must be used:
- (...)
- Working at Heights
(...)

Working aloft/overside	- Use of work permit "Working at heights"	- SMS Work permit "Working at heights"

- Complete Work Permits for:
o Working on heights (over 2.5 mtr. height)"

5.2 The findings

The content of the evidence referred to above has led to the following conclusions being drawn in this case with an adequate measure of certainty.

The victim was working as an apprentice on board the Sydborg on 3 September 2021. The Sydborg was loaded with fertiliser from a barge next to the Sydborg that day in the port of Antwerp using a gantry crane. As the Sydborg listed heavily in the process, the person concerned, who was in charge of the loading process as chief officer on board, ordered the victim to give instructions to the crane operator, just as the person concerned had done himself before. Those directions were given from the stacked hatches aft of the hold in front of the hatch crane. The hatch crane, which has a railing, was not used because there was insufficient visibility into the hold from there. Therefore, the space on the hatches was used for the hatch crane. From that location, however, there is a height of (much) more than 2.5 metres on three sides: to the port and starboard gangways and to the even deeper hold. Only the height aft of the hatches was less than 2.5 metres, i.e. 1.80 metres. Given that height of more than 2.5 metres on three sides, the safety rules for working at heights should have been observed. All the more so in this case because of the nature of the work: checking where to load in the hold and giving instructions about it (by means of signals) to the shore crane operator. It is fairly conceivable that this will not always ensure sufficient concentration on a person's own – safe – position on the hatch deck.

It is sufficiently plausible that the victim fell from the stack of hatches. First, there is the victim's own testimony (i) that he climbed on top of the stack of hatches via the hatch crane, (ii) that there was enough space there to walk over the hatches and (iii) that he performed his task up there and then come to at the hospital. The shipping company sent that statement to the Inspector on 19 October 2021. On the day of the accident, the shipping company had already reported, in keeping with the victim's statement, that the victim had fallen into the gangway from the hatches. Also given the nature of the

injuries, there is insufficient reason to doubt that report and the victim's own statement – not withdrawn or corrected by the shipping company afterwards. That the place where the victim ended up in the gangway was not right next to the stacked hatches but just diagonally in front of them does not constitute sufficient grounds for doubt.
It is also sufficiently plausible that the accident was related to the failure to observe safety rules for working at heights. In this case, where work was to be carried out at a height of more than 2.5 metres without any fencing, those regulations entailed wearing fall protection equipment. Furthermore, the mere fact of (i) recognising the need to observe safety rules in a situation like this and (ii) enforcing them has a preventive effect. Nothing suggests that this would have been any different and the fall involving these injuries would have occurred even if the safety rules had been observed. For this reason alone, precisely how the fall occurred is not decisive in this case. Therefore, even if the victim had not fallen from above the hatches but when climbing the side of them, this does not diminish the culpability of not observing and monitoring the compliance with the safety rules. Nor are there any indications of such an alternative scenario that differs from the shipping company's report and the reading of the victim, who, as mentioned above, stated that he climbed onto the hatches via the hatch crane (and does not mention climbing along the side of the hatches).

In his capacity as chief officer in charge of the loading process, the person concerned had a (cf. Article 1 Ships Act under d, and Article 31 paragraph 1 Seafarers Act) duty to ensure that the apprentice could work safely when he instructed him to carry out that loading process. He should also have ensured compliance with the regulations applicable in that regard. The person concerned should have been extra alert to this, especially since the victim was an apprentice. Instead, after first giving instructions to the operator of the shore crane himself from the stack of hatches (with hand signals), he left to deal with de-ballasting and asked the apprentice to take over giving instructions to the crane operator from the stack of hatches from him, without fall protection.

The ISM-SMS and Risk Assessment included safety regulations for working at heights. These safety regulations were regularly discussed in the safety meetings at which the person concerned was present. It is established that the person in question did not comply with these safety regulations or monitor the victim's compliance with them, according to his statement, because he did not consider the work in question on the hatches as working at heights. However, that view is incorrect. The fact that performing work from a pile of hatches (not fitted with a fall protection device) with a drop height of (much) more than 2.5 metres on three sides was not explicitly mentioned as an example of working at heights does not detract from the fact that not only the captain but also the person concerned should have been aware of this as the duty officer in charge of the loading process, who instructed the victim to assist in this.

Regarding compliance with the requirements of the Working Conditions Decree, the following remains. By virtue of Article 2 of the Working Conditions Act, this decree also applies to seafarers performing work wholly or partly outside the Netherlands on board seagoing vessels entitled to fly the Dutch flag under Dutch law. Article 7.23 of this decree imposes an obligation on the shipowner/employer to choose suitable work equipment if temporary work at heights cannot be carried out safely and under suitable ergonomic conditions on a suitable work floor. The shipping company/employer determines how this obligation is incorporated in practical regulations. On board, however, this must be implemented by whoever is responsible for the work being carried out at the time. That is primarily the captain who can also delegate this task and responsibility to, in this case, the chief officer.

The failure of the person concerned to comply with the safety regulations and the associated supervision 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.

The Inspector's objection is therefore well-founded.

5.3 The disciplinary measure

The Disciplinary Court finds that the person concerned has failed in his responsibilities/role as chief officer where it concerns supervising compliance with the safety regulations when working at heights.

In view of the seriousness of the negligence a suspension of the navigation licence for the duration mentioned below is appropriate. That duration is shorter than the Inspector's demand. Account has been taken of the measures previously imposed in somewhat similar cases and, in addition, the following circumstances, among others: it was only the second enlistment as chief officer of the person concerned and;
the ISM-SMS, the safety meetings and the Risk Assessment only broadly addressed working at heights (and did not include a separate paragraph on working from the hatches, while this was not specifically discussed at the safety meetings either). Therefore, and for the rest, the person concerned is not found to have been grossly negligent. Moreover, he has drawn lessons from the event. The accident suffered by the victim seriously affected him; he is having a hard time with it and has contacted the victim. For the same reasons, the Disciplinary Court sees good cause to stipulate that the suspension of the navigation licence will be partially conditional.

6. Practical recommendations

Following on from the decision in this case, the Disciplinary Court sees cause to make the following recommendation:

It is recommended to explicitly mention in the safety protocols and draw attention to in the safety meetings that working on/from hatches not secured

on all sides poses safety risks, and a height of more than 2.5 metres falls under the concept of 'working at heights', which is subject to safety regulations. From a safety point of view, loading supervision is (therefore) best done from the hatch crane. If that is impractical and the space on the (stacked) hatches is used for that reason, a fall protection device is required.

7. The decision

The Disciplinary Court,

- rules that the complaint against the person concerned is well-founded;
- suspends the navigation licence of the person concerned for a period of six (6) weeks;
- stipulates that of this suspension a period of four (4) weeks will not be executed 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.

Duly delivered by J.M. van der Klooster, presiding judge, C.R. Tromp, O.F.C. Magel, A.J. de Heer, LL.M., 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 23 December 2022

J.M. van der Klooster
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.