RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 27 JANUARY 2023 (NO. 2 OF 2023) IN THE CASE 2022.V7- EN AVANT

As petitioned by:

the Minister of Infrastructure and Water Management
in The Hague,
petitioner,
authorised representative: B.A.C. van Geest and K. van der Wall,
senior inspector ILT/Accident investigation shipping and administrative inspections, Zwijndrecht,

versus

J.G.L. B.,
the person concerned,
counsel: W.M. van Dijk, LL.M.

1. The course of the proceedings

On 29 June 2022, the Disciplinary Court received a written petition for disciplinary proceedings from the aforementioned B.A.C van Geest and K. van der Wall, directed against the person concerned "as captain of the En Avant 30 (Disciplinary Court: referred to below as EA30), but at the time of the conduct temporarily employed with officer duties aboard the Dutch-flagged vessel En Avant 7" (referred to below as EA7). Attached to the petition were 40 annexes and 9 video clips.

On 16 September 2022, a statement of defence was received from the person concerned. On 28 September 2022, the inspector replied to this with two annexes, after which a rejoinder was received from the person concerned on 27 October 2022 with annexes 3a to e, 4 and 5.

The presiding judge stipulated that the oral hearing of the case will be held at 13.30 hours on 9 December 2022 at the offices of the Disciplinary Court in Amsterdam.

The court hearing was held on Friday 9 December 2022. The aforementioned inspectors B.A.C. van Geest and K. van der Wall appeared at the hearing. The person concerned 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 25 August 2021, at around 11.09pm LT, a very serious accident occurred on board the tug EA7. The accident led to the death of a seaman, and a trainee was injured. The accident took place in Centrale Insteekhaven at Moerdijk. The EA7 was performing port assistance, as a stern tug. The ocean-going vessel being assisted was the Tia Marta. The En Avant 4 was involved as a bow tug. The Tia Marta was towed astern out of the Oostelijke Insteekhaven before being turned into the swinging circle of the Centrale Insteekhaven before turning ahead towards Zuid-Hollands Diep. During this manoeuvre, the seaman and the trainee became trapped between the towline and the accommodation. The seaman died of his injuries almost immediately. The trainee suffered two broken ribs.

The EA7 (IMO number 7625483) is a traditional Dutch tug (with 2 fixed propellers), owned by shipping company Muller, in Dordrecht.
Built in the year 1981, the vessel is 22.5 metres long and 6.8 metres wide, has a gross tonnage of 108 T and a power capacity of 1176 KW. At the time of the accident, the crew consisted of four people in total.

3. The Inspector's objections

According to the Inspector, the person concerned "serving as captain of the EA30, but at the time of the conduct temporarily tasked with officer duties on the EA7",
acted 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).

The inspector's objection against the person concerned consists of the following elements:

1. The person concerned was not sufficiently aware of the situation regarding how the EA7 was placed in relation to the Tia Marta and the position of the towline.
2. The person concerned did not adequately convey to the captain of the EA7 on who would pay attention to what and how they would communicate about it.
3. The above objections contributed to this accident and partly as a result, 1 crew member died and 1 crew member was injured.

The Inspector cites as the regulations not complied with:

- STCW Code Part A / Section A-II/2
  - table A-II/2
- Inland navigation regulation
  - Article 2.9 (2)
  - Article 5.6(5), Annex 5.7[1]
  - Article 5.10
- RSP (Regulations on navigational personnel on the Rhine)
  - Article 3.19(1)
  - Article 3.20(1) and (2)

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

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[1] *As the ruling against the captain of the EA7 shows, these articles are wrongly cited.*

4. The position of the person concerned

inadmissible

According to the person concerned, the ILT's petition should be declared inadmissible because he was not part of the crew. The person concerned does argue that this formal defence does not imply that he assumed that he should not have exercised his duty of care as a good seaman.

with regard to the first objection

According to the person concerned, the cause of the accident was a steering error by the captain, which the person concerned could not have foreseen. The captain was ultimately responsible for navigation and was at the helm. He could see personally and keep an eye on the towline from the Tia Marta. The person concerned was outside to keep an eye on the crew members on deck who had to guide the hawser around the bollards, taking care not to snag the hawser behind the straps. His focus was on that, and not on the position of the EA7 relative to the Tia Marta and the position of the towline between the EA7 and the Tia Marta. Looking down from the position of the person concerned while the ship is turning, it is not immediately perceivable that the ship is turning too far.

with regard to the second objection

There was indeed communication between the captain and the person concerned as to who would pay attention to what. This was done in the toolbox meeting and a similar manoeuvre had already been done earlier that afternoon with the same crew operating in the same way. Furthermore, the accusation that there was insufficient discussion about how communication would take place between the captain and the person concerned is not plausible since the person concerned was standing about 2.5 metres away from the captain and direct communication was possible between them.

with regard to the third objection
The person concerned takes the position that the third objection, in view of the defence to the first and second objections, does not require any separate discussion.

5. The ruling of the Disciplinary Court

The admissibility
The ILT's petition is admissible. The formal role taken by the person concerned on board the EA7 can be left aside. Is undisputed that he is captain of another tugboat and had been asked to support the captain – who was still under training – because of his seniority. An officer on duty is subject to disciplinary law and must conduct himself in a manner befitting a good seaman, even if he is not on the crew list. This is the case regarding the person concerned, who himself argues that his formal defence of inadmissibility does not mean that he assumed that he should not have exercised his duty of care as a good seaman.

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

At the start of the assistance task, the EA7 was stern-to-stern with the Tia Marta. Once the Tia Marta had turned in the Centrale Insteekhaven, the EA7 would come head-to-stern, with the towline running over the head bollard. The EA7 would thus sail along behind the Tia Marta, heading forward. During the manoeuvre to bring the ship's head forward and put the towline over the head bollard, the EA7 swung through too far to port and at the same time the towline became taut. The towline ran from the bitt to the middle bollard (more or less level with the bitt, but on the port side of the ship). From the port side middle bollard, the port side towline collided with the front of the accommodation. The seaman and trainee were on the port side in the

gangway between the accommodation and the bulwark. They were trapped between the towline and the accommodation.
I was in the waist checking if all was well at the side bollard, if the hawser was properly behind it. There are pins on a side bollard. The hawser has to be placed under them to prevent it from slipping off the bollard. I was standing in the waist, so I could not clearly see the position of the Tia Marta in relation to the EA7. I was a bit further down to check that the hawser was properly behind the bollard. In the waist, on the side of the bridge wing, I could see the towline, but I could no longer see it beyond the wheelhouse. I was standing a little lower than the wheelhouse. The door was open. It is difficult to estimate position when you are in the process of turning a vessel and you look astern to estimate how far the vessel is swinging once the swing has begun. You ask if I saw anything notable about the towline. From my view, it looked normal. When the hawser was behind the towing bollard, behind the side bollard, the men walked astern [Disciplinary Tribunal: forward?] to walk with the wire. Occasionally, the line may get caught behind the tyres. I just heard that the trainee shouted upwards that the towline was stuck, but I don't remember that. I didn't notice anything strange. I should have seen it when the trainee pulled the hawser from behind the tyre. To my mind, the operation went in a fluid motion. If it was under the tyre, it does take some time to get it out from under it. I did not notice that the hawser had got caught; the length of time it ran was normal.
We had agreed that the captain would do the navigation from the wheelhouse. He had the clearest view of the Tia Marta. I was to stand outside to check that the hawser was well behind the bollard and could not come off. We had done the same manoeuvre in the morning and held a toolbox, and agreed the same and done exactly the same as with the Tia Marta. In my opinion, everything was properly discussed. My job was to stand outside to check that the line was in order, that the men were following it and that nothing was in the way. When I normally do it myself on that vessel I would be steering and have to go outside myself. That was precisely what made it so good for the captain: I could stand outside and give directions if things

were not right. That did away with the need for him to come out from behind the helm.
After seeing the film footage, I assumed it was a steering error by the captain. I felt he had turned too far. When it happened, I had no idea that there was an issue. My focus was on other things outside. You do not immediately notice if a vessel turns too far when you are standing in the waist because you turn with the vessel. Perhaps you could just keep looking at the Tia Marta, but if I did that I couldn't look down.
I could no longer see the hawser because it ran to starboard. When I still had a view of the towline, we were lying reversed with the stern towards the stern of the Tia Marta and at some point we started turning. Of course, you do see a piece of the hawser when you turn towards it and keep an eye on it. At a given point, the idea is to sail towards it and turn back a little, which is when I lost sight of the towline.
By “it’s OK”, I meant to say that the hawser was properly behind the bollard under the pin. You say that the towline was not yet over the fore bollard when the captain agreed with the pilot to sail ahead. I did not hear that because I was standing in the waist and could not hear the walkie-talkie. I could not see the fore bollard from my position. I do not know what the speed ahead was, but it was an everyday matter and very slow in my opinion. You reverse out of the channel and then you turn. The ship moves astern. You move towards the head bollard when the ship is stopped. Afterwards, I saw that it was 0.8 knots.
I saw the accident happen. I was standing 1.5 metres away from it. It happened very quickly. They walked along with the hawser and suddenly it tightened and they were caught against the accommodation. It seemed to take a very long time, but it actually happened in no time.
You ask whether I think I contributed to the accident. I am not trying to evade my responsibility. I find it difficult to respond to that. Mainly because of the consequences, I find it a difficult question. You ask if I blame myself for anything. Things do go through my mind: if only I had done this, if only I had done that, if only I had been in the wheelhouse, if only I had sailed the vessel myself. Would it have happened as well? I don't know. In the role I had, I

don't blame myself for anything. I was in the right place. I would not have done anything differently, I think.

When I was called by the office (I was on another vessel at the time) I was asked if I would like to join the EA7 for a while to do port assistance. I was told that C. S. was on board as a captain, that he was still under training and that he had just about finished his training and would like to have some extra eyes and ears. I asked how far along he was. I was told that they had been informed by his mentor that he could do everything independently. That is what I was told. You ask whether I considered it my duty to ensure that this manoeuvre was properly executed. I was not the captain. I only considered myself a lookout at that point. We had already done two assists in the morning and that had gone well. The captain came across as very confident, the toolbox was clear. I didn't feel I needed to intervene.
As a captain on the EA7 myself, I would have done this manoeuvre with two opposing engines to go around faster.
You ask whether, if I am on port side and see that the hawser is not in sight (i.e. if it is running to starboard) and I can no longer see the Tia Marta either, this should set alarm bells ringing in my mind. I reply that I did not pay attention to that because I was looking down. You say you assume that if I am a tugboat captain assisting someone else, then I have a helicopter view from there. I reply that if the hawser remains slack, there is not much that can go wrong. I could not see how far to starboard the EA7 was. The position was slightly to starboard though, I did see that on the videos. If he turned any further, there will no longer be any overview at all. I explain that if you want to stay out of the propeller water, it is all right to be a little further to starboard if that is easier.
Of course, I would have given a warning if I had seen that things were not going well.
I did not notice and I do not recall there being a line under the tyre and this being reported by walkie-talkie.
It was perfectly normal that I went to assist at the EA7. It does not happen very regularly, but it has happened before. I did not have to sail the EA30. I

did not go there feeling that I would be surplus to requirements. As I have done it before, it is not always necessary for me to have two men on board. You say that the hawser was fastened over the head bollard and the towline came well over the middle bollard and that when you read the report, I only communicated two things: “it's OK” and “there's a problem”. That's right. You ask whether in that case I took my job a little too lightly as being the captain's eyes and ears. I went outside so there was no need for him to go outside. You say those are the eyes. You say regarding the ears that the communication was on the thin side, the communication to the ship was already not going smoothly and that I failed to fill the void. I reply that when the accident happened, I was outside and did not catch any communication at all. Nor did I realise that we were supposed to berth on the port side first. You ask about the crew in what capacity I was on board. Was I temporarily employed on board with officer duties? No, it didn't feel that way to me.

I was working at Muller through a temping agency. That is still the case. I worked on the same kind of tugs from a young age, but with one propeller from Scheveningen, around 6 years old. After that I went to nautical college. In 2000, I completed engineering officer (SWK) training. Then I started an internship, also on a single-propeller tug. When I was 22, I became a skipper on very small tugs and later I also moved more towards sea towage, which takes me up to the present day.
This accident had a serious effect on me. I still have flashbacks of it quite often. I find it hard to delegate. When new situations arise, I prefer to do it myself. Other than that, things are going well. I am able to do my job. I do think about things differently. I did keep working on ships though. I still work regularly for Muller.

B. The questioning of the person concerned by F.P.C. van der Ham, Labour Inspector of the Inspectorate SZW and inspectors Van der Wall and Van Geest, on 21 December 2021 (annex 34 to the petition), in so far as it includes the answer to the question *“Why did you board the EA7? Not your own ship”*

"I was called by the office to go with the captain of the EA7 to supervise. As an extra pair of eyes. The captain of the EA7 was independently qualified to sail, but wanted someone along with him with experience. That's why I came along."
to the question *"What task did the office give you?"*
"No task."
to the question *"What did you discuss with the captain of the EA7 about what you would do?"*
"Nothing in particular"

C. The questioning of the captain of the EA7 by E.M.P. Terörde, labour inspector of the Inspectorate SZW and aforementioned B.A.C. van Geest on 3 September 2022 (Annex 26 to the petition), in so far as it contains the answer to the question *"We understand that you are learning under the guidance of a mentor, Mr J. B. Is that right? "I am studying for port assistance. I did have the confidence and experience to do the manoeuvre at the time of the accident. This was a frequent activity. My mentor is another captain but the captain of the EA30 and I have also worked together in the past. The captain of the EA30 was available and he went along to provide support and act in the lookout role. This had to be someone who had the seniority to know what to look out for. There is a visibility restriction from the steering position on deck. I always steer from the front console. It is my belief that two officers should be sailing on the EN Avant 7. This lookout role was the management measure to prevent what happened in this case."* To the question *"Can you explain what you are studying for? "For port assistance. You have to learn your way around the port, the waterways. You need to become familiar with the ship's controls. I was new to the EN Avant 7 and every ship has its own ways. There are several moorings. Various manoeuvres are associated with those moorings. You need to start mastering the work, build confidence in it, so that you know how the communication goes. I am now eight months on and able to do the work independently. This manoeuvre was no longer part of*

the training programme. I had the confidence and experience to perform the manoeuvre. I do this more often from that position. It is a common manoeuvre."

to the question *"How does the learning process go? "Actually, I do everything myself. Port assistance work is something I do independently. There is sometimes a driving instructor sitting next to me who no longer applies the brakes, so to speak. Having no other officer on the vessel, I asked for someone there that day. They offered captain of the EA30, a captain with port experience, who I felt could take on the lookout role. I had spoken to the office about that earlier, saying that I thought this was important."* To the question *"Given that you were in training, who was responsible for carrying out the work on board properly and safely?"*

"I have my navigation licence, of course. The term 'training' means having a mentor as soon as you start doing something especially difficult, something new and want guidance in the form of mentoring. I would replace the term 'training' with mentoring. It is an experience-based profession where you learn from someone who has been in the profession for longer. H. is the towing expert. The responsibility was primarily mine. I performed the manoeuvre myself. I already knew that manoeuvre. That same day, we did the same manoeuvre with another vessel in Dordrecht. The captain of the EA30 was with me in the lookout role, which is why I had asked him to join."

to the question *"What can you tell me about the accident? "The pilot suggested going to the head bollard. That meant we would have been fastened to the head bollard. The towline would then be given a turn around the head bollard. The captain of the EA30 had the lookout role. He was on the port side at the same level as the wheelhouse. He stood next to me but outside. The wheelhouse door was open. He was to oversee the deck crew and the towline. He stood there after we undid the shortening. When the order came that we would come in head*

first, the captain of the EA30 went and stood there. We then manoeuvred the vessel to get the hawser in the head bollard. I was in touch with the captain of the EA30. I don't remember if I specifically asked him questions or just made eye contact but he knows what is needed to proceed. The captain of the EA30 said: "It's OK." What I need to know is the position of the hawser and the crew and the whole operation. From the steering position, I cannot see the position of the deck crew. I could see part of the hawser, at least from the Tia Marta to the head bollard and the bow. Not on the side; the middle bollard. If I stretch I can also see the side bollard. The manoeuvre in which the deck crew place the hawser in the head bollard is performed from the wheelhouse, the place where I stand or sit in the wheelhouse when I am sailing, which cannot be seen except when the head bollard is laid. For that moment, the captain of the EA30 was my eyes and ears."

"I can see part of the hawser from the Tia Marta. I saw that the hawser was loose. The hawser should not be too loose because you do not want it to get into the propeller and the hawser should not become too heavy for the deck crew either. I also saw the direction of the hawser from the Tia Marta. The last thing I saw prior to the accident was that the hawser was lying loose and not in an unusual direction: It was over port side slanting forward. Then the pilot asked if the Tia Marta could turn forward, i.e. the engine put into its forward position. Because I had heard from the captain of the EA30 that the hawser was OK and because I saw a loose line
to the Tia Marta in a not unusual direction and I was slowly turning forward myself to maintain rudder pressure, I gave my approval for the pilot to turn ahead. Then I heard a sound I couldn't place and the captain of the EA30 said: "there's a problem". I didn't know what was going on but I didn't see the deck crew." When asked *"What was agreed?" "I don't remember the pilot saying prior to the manoeuvres that I would be turning to the port side. I thought we would turn to starboard and that was also what my instructions to the crew were. The pilot indicated that we would continue on the path already taken,*

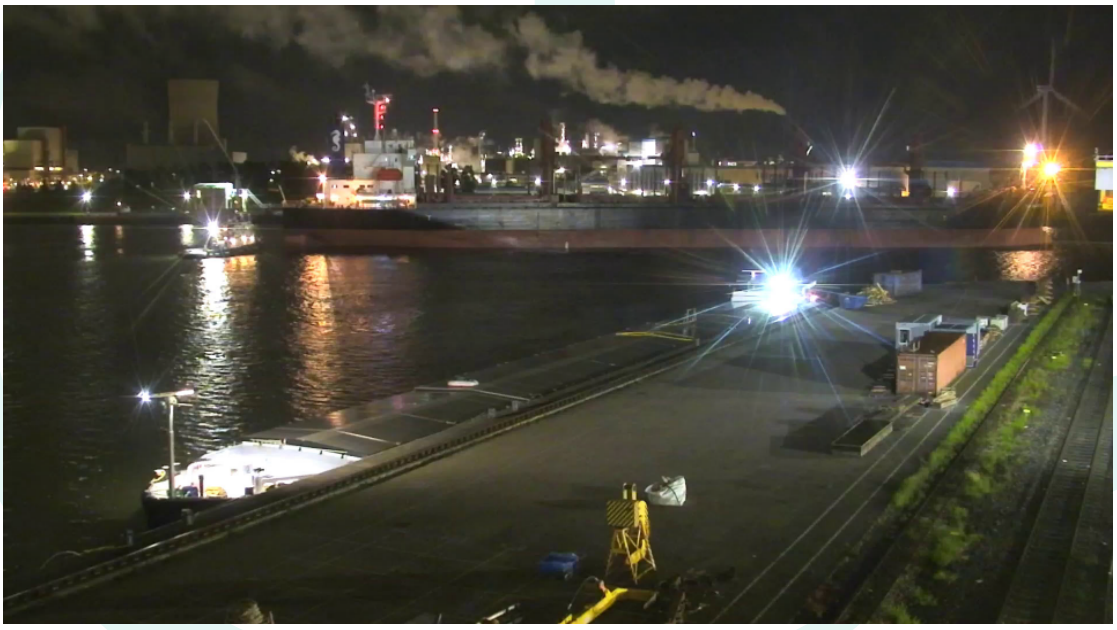
i.e. mooring to starboard. So the instructions to the deck crew did not need to be changed."
To the question *"Who did the crew consist of?"*
"The trainee, the seaman, the captain, that's me, and the captain of the EA30. He was along as an additional officer, lookout."
To the question *"How were the roles divided?"*
"I steered the ship and communicated with the pilot. The captain of the EA30 had the lookout position, on port side, bridge wing. He checked the position of the hawser and the crew. J. was the seaman. He did the deck work with M. I had sent him along with the seaman as a learning opportunity to watch and act. The trainee was additional to the crew."

D. The questioning of the trainee by T. van der Wal and A. Siegersma, labour inspectors of the Inspectorate SZW, on 1 September 2021 (annex 25 to the petition), in so far as it includes answers to

the question "What can you tell us about the accident? "While towing, the seaman and I had been standing on the foredeck. When we were given permission to bring the towline to the bow, the seaman and I walked along the starboard side to the aft deck. Meanwhile, the captain had turned our ship, causing the towline to slacken and lie in the water. The seaman and I lifted the port side line out of the water and put it around the bollard located at the level of the aft side of the superstructure. I then walked further forward, pulling the towline away from the outside of our ship behind a rubber car tyre, which is what it had got caught behind. While I was doing that, the seaman walked behind me towards the foredeck. About that time things went wrong, the towline suddenly tightened, causing the seaman and I to be pressed against the ship's superstructure by the towline." To the question *"In your experience, what went wrong, where and at what point did it go wrong?" "I have no idea. The hawser tightened all at once and then it happened."*

E. The "Report of Findings" of aforementioned Inspector Van der Wall, drawn up and signed on 20 September 2021, in so far as it contains: "In this official report, the camera images taken with the cameras present at the Moerdijk Port Authority with the numbers C33, 4213, 4211, 4201, 3206 and 4217 were analysed. The available images from 25-08-2021, 22:29:58 hours to 26-08-2021, 00:00:44 hours, were obtained under Section 19 WED, under a warrant. The information and documents obtained are named in the Official Warrant Report 19 WED with reference AMB-002-01 and included in the investigation file.
From the CCTV footage:
I made some screenshots. The relevant screenshots have been incorporated in photo attachment (DOC-016) and placed in the case file. I will describe what I saw for each film below.(...)4211 Wuppermann-2021-08-25 22.52-23.20, accident 23.12 4
I saw that:(...) The distance between the EA7 and Tia Marta widens. I know in my official capacity that the towline had been used to place figure eights on the bitt in order to obtain a shorter towing connection when leaving Oostelijke Insteekhaven. Now these figures of eight are removed from the bitt, so that the full length of the towline can be used for the remainder of the voyage;
- The EA7 then turns with her bow towards the stern of the Tia Marta, with the towline running on the port side of the EA7);
- The towline is tight, at least from 15 minutes and 35 seconds to 16 minutes and 49 seconds. During this period, the EA7 turns to face the stern of the Tia Marta (see screenshot 19 to 29 of photo sheet DOC-016);
- After 16 minutes and 49 seconds on the EA7, a person appears at the port side middle bollard. From the images, it is not possible to tell exactly who this person is and what he is doing. It is plausible, given the statements of the crew members, that this person is doing something with the towline (see screenshot 30 of photo sheet DOC-016);

- After 16 minutes and 55 seconds, this person disappears from view again as he walks towards the bow;
- After about 16 minutes and 55 seconds, the EA7 has turned too far (see screenshots 31 and 32 of photo sheet DOC-016);
- After 17 minutes and 10 seconds, the towline tightens and the bow of the EA7 abruptly pulls towards the Tia Marta (see screenshot 32 of photo sheet DOC-016);
- *Explanation: The reasonable presumption is that the accident happened between 16:55 and 17:10 (duration of the film. The actual time when the accident happened is in that case between 23:08:54 and 23:09:09;*



Screenshot 31 - CAM 4211, after 16:56 film
The EA7 turned too far to port, causing the towline to conflict with the accommodation/superstructure of the EA7. The towline is not under tension here.

Screenshot 32 - CAM 4211, after 17:10 film
The EA7 turned even further to port. This is the moment when the towline becomes tight/under tension. This is also when the accident happens/just happened. That is at 23:09:09 (hour:min:sec), or just a few seconds before.

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.

At the start of the assistance task, the EA7 was stern-to-stern with the Tia Marta. Once the Tia Marta had turned in the Centrale Insteekhaven, the EA7 would come head-to-stern, with the towline running over the head bollard. In this way, the EA7 would sail along behind the Tia Marta, in a forward direction, maintaining the tow connection. During the manoeuvre to bring the ship's head forward and put the towline over the head bollard, the EA7 swung through too far to port and at the same time the towline became taut. The towline ran from the bitt to the middle bollard (more or less level with the bitt, but on the port side of the ship). From the port side middle bollard, the port side towline collided with the front of the accommodation. The seaman and trainee were on the port side in the gangway between the

accommodation and the bulwark. They were trapped between the towline and the accommodation. The seaman was at the forefront and died almost immediately from his injuries. The trainee was slightly further back and broke two ribs.

with regard to the first objection
The first objection is well-founded. The person concerned had been asked to support the still-in-training captain because of his seniority. For this reason, he could be expected to go beyond the duties agreed with the captain. The person concerned was therefore partly responsible for the whole manoeuvre and had to keep an eye on whether it was done properly. As such, it was the duty of the person concerned to also pay attention to the position of the towline and the position of the tug in relation to the Tia Marta. He would then have seen the EA7 turning away from the Tia Marta and would have had to ensure that the line wire relative to the bow of the EA7 would never run to the starboard side of the EA7. He could then have given early warning when the hawser threatened to disappear behind the accommodation. It is also noteworthy that the intern stated that he pulled the towline out from under a tyre, but the person concerned did not see this while his primary duty was to watch the deck crew and guide the towline. That means that his observations were far from optimal.

with regard to the second objection
The second objection is well-founded. In particular, there was a lack of proper agreements on communication. The person concerned had a lookout function and could therefore be expected to keep the captain of the EA7 constantly informed about how the manoeuvre was going and to give him instructions, for example by saying “don't steer further to port” or “don't turn too fast”. The person concerned should have realised based on his experience that there was danger and the ship was running at a dangerously wide angle. The person concerned, as an adviser with seniority, should have filled gaps in the initiatives taken by the captain of the EA7. However, the person concerned did nothing. The person concerned and the captain of the

EA7 barely communicated with each other during the manoeuvre. The person concerned only told the captain of the EA7: it's OK" and "there's a problem". This course of events shows that the person concerned did not sufficiently agree with the captain of the EA7 on who would pay attention to what and how they would communicate about it.

with regard to the third objection
The third objection is well-founded. As shown by the considerations regarding the first and second objections, a contributory factor in the accident was the fact that the person concerned was insufficiently aware of how the EA7 was situated in relation to the Tia Marta and the position of the towline, and that the person concerned did not sufficiently coordinate with the captain of the EA7 on who would pay attention to what and how they would communicate about it. A case can be made that if the person concerned had used his seniority and been alert, he would have been able to give the captain of the EA7 timely instructions.

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 captain/ship's officer 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 finds that the person concerned seriously failed in his responsibilities/duties as captain of the EA30, but at the time of the conduct was temporarily employed with officer duties on the EA7, resulting in the accident.

Given the seriousness of the conduct established, and the consequent indirectly caused death of the seaman and injury to the trainee, a suspension of the navigation licence for the duration mentioned below is appropriate.

In view of the fact that the person concerned was insufficiently instructed by the shipping company, the Disciplinary Court sees good cause to order a partial conditional suspension of the navigation licence.

6. Practical recommendations

For practical recommendations, the Disciplinary Court refers to the November 2022 report of the Dutch Safety Board ("Crushing by towing wire with a fatal outcome – lessons from the accident aboard the tug En Avant 7").

7. The decision

The Disciplinary Court,

- declares the inspector's petition admissible;
- rules that the objections against the person are well-founded;
- suspends the navigation licence of the person concerned for a period of four months;
- stipulates that of this suspension, a period of two months will not be imposed unless the Disciplinary Court stipulates otherwise in a subsequent ruling based on the fact that the person concerned has once again behaved contrary to his duty of care as a good seaman in respect of the persons 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 P.C. Santema, LL.M., presiding judge, C.R. Tromp, R.E. Roozendaal, J. Berghuis and R.J.N. de Haan, members, in the presence of V.

Bouchla, LL.M., as secretary, and pronounced by P.C. Santema in public session on 27 January 2023 at 10.00 am.

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.