RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 22 MARCH 2024 (NO. 1 OF 2024) IN THE CASE 2023. V2-REGGEBORG

As petitioned by:

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

versus

H. K.,
the person concerned,
counsel: A. Jumelet, LL.M.

1. The course of the proceedings

On 10 March 2023, the Disciplinary Court received a written request (with appendices) for disciplinary treatment from ing. B.A.C. van Geest, aforementioned (hereinafter the inspector) against the person concerned as captain of the Reggeborg vessel sailing under the Dutch flag.

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 to submit a statement of defence.

A statement of defence was received from (counsel for) the person concerned on 12 June 2023.

The presiding judge stipulated that the hearing of the case will be held at 11.00 hours on 26 January 2024 at the courtroom of the Disciplinary Court in Amsterdam.

The hearing took place on 26 January 2024. Inspector ing. B.A.C. Van Geest appeared at the hearing for the petitioner, accompanied by his colleague ing. K. van der Wall.

The person concerned appeared at the hearing, together with his counsel.

2. Grounds

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

The Reggeborg had been anchored, with empty holds, at the "*Indian River anchorage D*" shipyard, approximately eleven nautical miles east of Bethany Beach, Delaware, in the United States, since 19 December 2022. On Christmas Eve, 24 December 2022 the person concerned, the chief officer, the second engineer and the bosun met in the mess room to discuss possible locations for the Filipino Christmas tradition of roasting a suckling pig on a barbecue, the following day. Due to the bad weather forecast, the person concerned suggested not to hold a barbecue on deck, but rather in the *lashing store*, where the previous year's Christmas barbecue had also been organised. No *risk assessment* was conducted. The barbecue was ignited the following morning, 25 December 2022, and the suckling pig was laid on the barbecue at 10:00 hours. It was located in the *lashing store* on the starboard side on the *upper tween deck.* The hold ventilation was switched off and the ventilation valves were closed. One door was however open, namely the access door from the *raised quarterdeck* and possibly also the access door to hold number two. From the entrance to the *raised quarterdeck,* a vertical ladder of around 6 metres' height, provided access to the *upper tween deck.* A bucket of water was provided at the barbecue. The second engineer (and

the bosun) were constantly present at the barbecue. The chief officer came to check it from 09.40 hours to 09.50 hours, while the second officer arrived at 10.45 hours. The third officer was present from 10:00 to 10:15 hours and from 10:35 hours on. The OS became unwell at 11:05 hours. The second and third officers left the *lashing store* at that point to fetch a stretcher and to warn the person concerned. The second officer re-entered the *lashing store* carrying the stretcher. At 11:10 hours, the second engineer became unwell, followed by the AB2 at 11:15 hours The person concerned, the chief officer and third officer entered the *lashing store* at 11:15 hours. The second officer left the *lashing store* to collect a hoisting harness, and subsequently remained on deck. The third officer left the *lashing store* to collect blankets, and subsequently also remained on deck. At 11:15 hours, the chief officer doused the barbecue using the bucket of water. By now, a portable fan was being operated in the *lashing store*. The ventilation valves on the *boat deck* and between holds numbers one and two were opened and the chief engineer started the hold ventilation. A hoisting harness was used to retrieve the second engineer, the OS and the AB2 from the *lashing store*, at 11:17 hours, 11:20 hours and 11:25 hours, respectively. The person concerned and the chief officer assisted in this process from the *lashing store*. The chief engineer assisted at the top of the ladder, along with the second and third officers. The person concerned left the *lashing store* at 11:30 hours, followed by the chief officer at 11:40 hours. The bosun also began to feel unwell at 11:40 hours, as did the third officer at 12:00 hours.
The five crew members were evacuated on board a US Coastguard vessel; oxygen was administered, and they were transferred to a fire department boat for transportation to shore. A US Coastguard helicopter flew above the vessel. Onshore, the crew members were advised by the doctor of the Radio Medical Service, whom the person concerned had contacted, to spend a few hours in a hospital for medical assessment, treatment and monitoring. They returned to the vessel at around midnight of the same day.

The Reggeborg (IMO number 9592575) is a Dutch cargo vessel sailing for Wagenborg Shipping of Delfzijl. The vessel was built in 2014, is 169.75

metres long and 20.4 metres wide. At the time of the accident, the crew consisted of twelve people in total.

3. The Inspector's objections

3.1 According to the Inspector, the person concerned acted or failed to act as captain 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 accusation consists of the following elements:

1. The person concerned suggested organising the barbecue in an enclosed space.
2. The person concerned did not conduct a *risk assessment* with regard to the barbecue in the enclosed space.
3. The person concerned did not arrange for ventilation of the enclosed space during the barbecue.
4. The person concerned did not arrange for the atmosphere to be monitored (for carbon monoxide) during the barbecue in the enclosed space.
5. Partly due to the aforementioned objections, five crew members became unwell due to carbon monoxide poisoning.
6. The person concerned entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
7. The person concerned also allowed the chief officer, second and third officers to enter an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
8. As a result of the latter two objections, the person concerned exposed himself and all other officers to carbon monoxide poisoning even

though he was aware that someone had already become unwell in a non-ventilated, enclosed space containing a lit barbecue.

3.2 The Inspector cites as regulations that have not been complied with:

ISM code - Chapter 6 - Resources and personnel
6.3 The Company should establish procedures to ensure that new personnel and personnel transferred to new assignments related to safety and protection of the environment are given proper familiarization with their duties. Instructions which are essential to be provided prior to sailing should be identified, documented and given.
6.4 The Company should ensure that all personnel involved in the Company's SMS have an adequate understanding of relevant rules, regulations, codes and guidelines.
6.5 The Company should establish and maintain procedures for identifying any training which may be required in support of the SMS and ensure that such training is provided for all personnel concerned.

ISM code - Chapter 7 - Shipboard operations
The Company should establish procedures, plans and instructions, including checklists as appropriate, for key shipboard operations concerning the safety of the personnel, ship and protection of the environment. The various tasks should be defined and assigned to qualified personnel.

ISM code - Chapter 8 - Emergency preparedness
8.1 The Company should identify potential emergency shipboard situations, and establish procedures to respond to them.
8.2 The Company should establish programmes for drills and exercises to prepare for emergency actions.

Resolution A.1050(27) Revised recommendation for entering enclosed spaces aboard ships

The aforementioned Resolution, procedures, plans, instructions including check-lists, familiarisation, etc., are included in the Shipboard Operation Manual (SOM) of Wagenborg and were available to the person concerned.

STCW code - Part A/section A-VI-3
Mandatory minimum training in advanced fire fighting.
Among other things in table A-VI/3, column 2:
- Ventilation control, including smoke extraction
- Fire-fighting process hazards (….[chemical reactions]…. etc.)

3.3 The inspector's demand is: an unconditional fine of € 2,000.

4. The position of the person concerned

The person concerned denies that he has failed to observe the principles of good seamanship. He felt pressurised by the crew to give permission for the barbecue. Due to the weather conditions, he suggested that the barbecue be held in the *lashing store*, where previous year's Christmas barbecue had also been held. Although the *lashing store* is designated an enclosed space by Wagenborg, the legislation in question mainly concerns the possible presence/permeation of any gases from cargo in hold number two. However, the door to hold number two was open and hold number two was empty. This was therefore not officially a "*high risk job*" in the sense of the SOM. A *risk assessment* should have been conducted by the chief officer, who apparently had failed to do so. The person concerned assumed that the hatches would be opened and that a carbon monoxide detector would be used, alongside a fire extinguisher (the latter was indeed present). In the opinion of the person concerned, the situation occurred due to the ventilation valves of the hold not being opened, to generate sufficient air circulation. The person concerned was insufficiently aware of the risk of closed ventilation valves due to being extremely busy on the morning of the barbecue, working on repeating stability calculations and the ballast water system, as well as "managing" the fact that certain crew members were upset

that they would not be spending Christmas at home as a result of Covid. The person concerned blames himself for not adequately checking that the ventilation valves were open on deck.
At the hearing, the person concerned stated that a barbecue should never again be organised in the *lashing store*.

At around 11:10 hours, the person concerned was informed by the third officer that a crew member had collapsed but was still conscious. The person concerned admits that he subsequently entered the *lashing store* without the use of a respirator, at approximately 11:15 hours. However, at that point in time, he was net yet aware that carbon monoxide was being produced. He was however aware that the atmosphere in the *lashing store* was not as it should be, and immediately vacated the space. In the meantime, the chief officer had doused the barbecue, and a *portable fan* was being operated. The person concerned then immediately gave the order to switch on the hold ventilation, to open the ventilation valves and to evacuate the unwell crew members as quickly as possible. This was an instinctive action for the purpose of the safety of the crew during an emergency situation. Without this action, the situation could have had much more serious consequences.
At the hearing, the person concerned stated that upon entering the hold, he immediately suspected the presence of carbon dioxide, and possibly carbon monoxide.

In the event the Disciplinary Court is of the opinion that the Inspector's objections are declared founded in full or in part, the person concerned requests that the following is taken into account:

- the person concerned is a *first offender* and is due for retirement on 1 December 2023, following an impeccable record of forty years of service;
- as soon as the person concerned became aware of the accident, he acted extremely adequately and took mitigating measures;
- the person concerned is still troubled by the accident and the "*after effects*" (US emergency services out in force including a helicopter and

the need to shift the vessel elsewhere, while a number of the crew remained in hospital), on a daily basis;
- the shipowner may still take measures against the person concerned;
- the person concerned has learned lessons from the accident.

5. The ruling of the Disciplinary Court

5.1 The means of evidence

The Disciplinary Court bases its assessment of the inspector's objections regarding the acts or omissions of the person concerned on the following means of evidence:

A. The statement of the person concerned at the hearing, insofar as it contains the following, in concise form:
I agree with the facts and findings of the inspector, as given in the description of the incident in the petition. I stand by my previous statement, but must add that it is not certain that this was carbon monoxide poisoning, especially considering the fact that they were all able to stand up once there was fresh air, and could independently climb out of the *lashing store* using a safety harness. This may be an indication that it was carbon dioxide. If it were carbon monoxide, the process would have taken much longer. It is therefore an assumption. Nobody informed me that it was carbon monoxide when they were assessed at the hospital. I am aware that any person with carbon monoxide poisoning who does not receive medical treatment, can die the following day. I therefore organised medical advice and a doctor's visit. You have referred to the circumstances in my statement that upon dismissal from the hospital, an explanation was given regarding carbon monoxide poisoning in the letters they had been issued. I can answer that that is possible.
Once I entered the hold, I became aware that a speedy rescue operation was essential. There was not enough time to fetch stretchers or compressed air, or whatever else. Fresh air was required, and they

needed to be evacuated. If I had acted according to the rules, they would not have survived. I had no choice. I knew what was wrong on descending into the hold. I immediately suspected there was carbon dioxide, and possibly carbon monoxide. I consciously entered the hold, because I first needed to check what was going on. I thought I will hold my breath, quickly check what exactly is going on, and quickly exit the hold again. I doused the fire as quickly as possible. I myself went back up to fetch water. I then passed that water to the chief officer. He doused the fire using the bucket of water, but it was not completely extinguished. I subsequently used the bucket again to fully extinguish the fire. I fetched the bucket, because I did not see any buckets of water down there. They were probably already there. One of the ordinary seamen was pounding the chest of another seaman. He believed CPR to be necessary. I told him to immediately stop his actions, as the seaman was not dead. His heart was working normally. Everybody was panicking. I then went above deck to fetch the engineer, as an auxiliary motor needed to be started. I then had the ventilation valves opened in the cross deck, halfway along the ship. The auxiliary motor was soon up to speed. I then ran to the bridge, started the ventilation and ran back down again. They then all regained consciousness. In my view, that was the only correct timing. If I had acted according to the rules and taken compressed air and a stretcher down to them, people would have already died. They now all survived. Once they had all been evacuated, there was one seaman, who was disoriented. We administered oxygen to him. The others also complained of a certain degree of dizziness and nausea. Then followed the pandemonium of the *Coast guard* springing into action. I called the radio medical service in IJmuiden. They advised me to consult a local doctor. I had immediate contact with the doctor on the telephone, who advised that the crew members should be assessed by medical staff in a hospital. I therefore organised that via the local FTS. Five crew members were then evacuated to the shore.

We were in the bar the evening beforehand, I believe around 18:30 hours. There was no alcohol or anything else involved. We were discussing what to do about the barbecue. The bosun mentioned that they were planning to build a tarpaulin tent on deck, but there was too much wind and it was extremely cold at that time. The weather forecast was minus eight degrees. The actual temperature was minus four degrees. All of North America was struggling with ice formation on shore. Public life had more or less come to a standstill. I then mentioned that we had organised the barbecue in the *lashing store* last year, when we were close to Spitsbergen. It had been extremely cold and windy at that time, but the ventilation valve and the door to the hold had been opened. I had been down to check, and had opened the door to the hold, and all went well. I suspect that somebody may have closed a door this time, which was opened again later on.
I would normally have checked whether there was sufficient ventilation, but I was busy working on other matters. The ventilation flaps were closed this time, which was the difference versus last time. I should probably have given the order to open all ventilation valves, or something like that, the evening beforehand. But we did not. We simply discussed organising the barbecue there.
The chief officer and myself were actually more concerned with the grain calculations and the ballast water management. That was particularly troublesome at that time. The bypass was not working. Large fines were being issued to the crew for small issues, regarding the bypass in ballast. We wanted to avoid that. We were therefore struggling to inform the harbour masters that although our system was not working, we did have alternative methods. That took up much of our time. The chief officer was also working hard to get the ballast water management system working properly, in order to avoid receiving a fine in the harbour.

There was too much work to be done. That is the simple reason why I did not check whether there was adequate ventilation. This would

never normally have happened. I was also working on my shift transfer and had a cook who was having a complete meltdown. He was screaming in the galley. He had been expressing his frustration for a full hour. The men should have been discharged by mid-December. Me too. I was to go on leave in mid-December, but I was still on board at Christmas. My scheduled replacement was sick. Everyone came to drink coffee at ten o'clock. And at eleven o'clock, the third officer informed the bridge that people were collapsing. I had not been down there to check, all morning. I should have done so, and would have done so, had I not been so busy at work. The barbecue was not really on my mind.

The evening before, when I discussed the barbecue with the chief officer, the second engineer and the bosun, I did not mention, or realise, that it was an enclosed space. If you open all the ventilation flaps and the door, it is not an enclosed space in my opinion. You say that the "Wagenborg *Shipboard Operation Manual*" designates the *lashing store* to be an enclosed space and you ask whether the crew has had access to this *manual*. My answer is that I believe they have seen it. We have a *fleet manual*. That is a large booklet containing a lot of information. It is also digitally available. We refer to it as the "walvis" system. It is available to everyone on board. We each have a special code, allowing us to access all information which is individually applicable to us.

Normally, a *risk assessment* is conducted any time anyone enters the hold, once the ship is loaded. I sign that form on a daily basis. Except this time, and now things went wrong. I really did not give it any thought, as it was normal procedure to conduct a *risk assessment*. The second officer did not have the appropriate form on him, nor did the first officer. They should have. If they had done what they always do, nothing would happened. Perhaps they were a little emotional this time, because it was Christmas day. The chief officer is not interested in Christmas. This was a normal working day for him. Yet he too should have had the form on him.

The hold was empty. There was no problem with the atmosphere there. That had already been checked on previous days. However it was not checked that morning. If they had been carrying an oxygen meter, it would have signalled an alarm and they would have evacuated the space. However, they were not carrying an oxygen meter. The second engineer and the bosun were present. Normally the bosun would also have been carrying an oxygen meter. I should have instructed them, but I failed to do so. The chief officer should also have been carrying an oxygen meter.
When I was in the wheelhouse, I was aware that the ventilation valves in the middle were closed. The ventilation valves above the entrance door were the only ones open. It is correct that you then only have one way traffic, though that was adequate last year. These are extremely large ventilation valves.
I did not believe it necessary to also open the ventilation valves in the middle, because there was also a compartment in front of them, for the grain. It is then almost completely closed, and taped off.
I did not hear any gas meter alarm sounding, but I was busy stopping a seaman from pounding another seaman's chest, and also extinguishing the fire. I realised that the only way to save them was to provide fresh air. And we were able to arrange that successfully. That was the only thing needed. I could not wait for any type of equipment, because I had already observed one of the crew member's eyes to be dry and rolling back in his head. I was therefore extremely worried. I was full of adrenaline at that moment in time. I was simply acting instinctively, as it were. I should have spoken more about open ventilation, open flaps or whatever, the evening beforehand, but I failed to do so.
I should have been more concerned, but I was not.
If any one of the crew would have said *STOP THE JOB*, then I believe I would have accepted that, if there was truly a reason to stop. But I was not really aware of it. They did not clearly apply a *STOP THE JOB*. If anyone had any doubts, they did not inform me of them.

In my view, the only way of getting the crew out of the *lashing store* alive, was to start the ventilation. There was no time to waste. Stopping the rescue operation was not an issue in my opinion. We needed to reintroduce fresh air by opening the ventilation flaps and by switching on the generator and ventilators. That is what we did and it worked.
Following the accident, I suffered heart problems at home, having not slept for four days. I had an irregular heartbeat, because it all became too much for me. I suffered this problem for a week, after which it righted itself and my heartbeat returned to normal.
I have learned from the incident. I would never again allow a barbecue in the *lashing store.* It should never be organised there again. I have recently retired, as of 1 December 2023. That was already planned.
Following the accident, I did still sail with a number of the Reggeborg crew members. The second officer was still on board.
The consequences of a fine being imposed will be that I must pay, I assume. And not go on holiday.

B. The statement by the person concerned on 3 January 2023, following (additional) questions from the inspector, insofar as it contains:
"With hindsight, as Captain and/or Chief Officer, we should have made a Risk assessment, the hold ventilation flaps should have been open. And the men in charge of the BBQ should have had a CO, CO2 oxygen meter with them. There was not enough recognition of the hazards. Personally, I believe this was caused by me paying too much attention to emails, transfer, settlement, load planning and crew affairs, etc., and insufficient awareness of the risks. There was no alcohol consumed in this case. In as far as I noticed, the men at the barbecue had drunk 2 cans of beer."

C. The statement by the chief officer on 29 December 2022, following questions from the inspector, insofar as it contains:

"19/12/2022 Vessel at anchor in the area of Delaware bay, USA waiting for berthing Fairless Hills to load cargo.
Cargo hold 2 have 1 bulkhead in the middle, ventilations are closed and sealed, ready for loading cargo. Only 1 lowest entrance in the aft and 1 lowest entrance in the forward hold 2 open for checking lateral.
25/12/2022 Morning time.
08:00 Crew preparing suckling pig and charcoal and other relevant items for grilling pig in the hold entrance hold 2 aft starboard side due to weather outside cold (minus 6) and windy.
Entrance door and door to cargo hold are open all the time, no risk assessment made before decided to grill pig in this entrance.
09:40 I went down to see how is it going, all crew (second engineer /Bosun /A.B /A.B2 /O.S /Apprentice) are OK, They are enjoying to preparing pig cause Christmas holiday.
Started fire on charcoal already.
I saw portable extinguisher is standing by in the area. Then I came up to my cabin.
11:10 Captain called me on the phone that the O.S fell down in the entrance. Immediately, I went to entrance. The second officer was there as well, they took enclosed space rescue equipment out of hospital (stretcher and lifting harness).
I checked the O.S, his breath and heartbeat and found ok. His eyes are fading/vague but still recognize people. I lay his in the stretcher and order crew to bring blanket cause he feel cold. But still reply.
Captain was there at that time and asking the O.S simply question.
Suddenly, the second engineer slowing lying down floor then A.B2 down also.
The bosun and the A.B aware and they climbed up. I ordered to put portable ventilation to supply fresh air to the entrance. The second officer and third officer and Chief engineer were doing that while I still in the hold entrance and try to help 3 victims. Portable fans running and supply air to the entrance.

Captain order to open cargo hold ventilation fore and aft hold 2. Chief engineer start 2nd auxiliary for more power.
Crew lower bucket of water and I extinguish charcoal fire. In the meantime, cargo hold fans were running. 3 victims condition getting better since that moment. They said they can climb up.
To be sure, me and captain put lifting harness over the victim one by one connect with rope the crew on top can held while victim climbing out.

D. The statement by the second officer on 29 December 2022, following questions from the inspector, insofar as it contains:
"1040- Just woke up then I go to raise quarter deck to help prepare the food but no one is around. So I decided to go roam around then I found them in ventilation cargo hold no 2 aft part stbd. Door is wide open and well ventilated.
1045- I go down and everything fine fire extinguisher and two bucket of water on standby & I can breath normal, then I replace second engineer in turning the piglet.
1050- O.S replace me took the handle continue turning the piglet.
1100- I was standing in front of the door facing cargo hold then I hear AB shouting to the OS are you ok? and no response from the OS and he lying down on the floor. I check him also no response and 3mate go out inform chief mate and master. while AB, AB2 and second engineer is with him I decided to go out take the stretcher.
1105- back in the scene with the stretcher then we move the OS to the stretcher. right after we move the OS, the second engineer collapsed in front of me & minute later AB2 also dizzy ask him to seat down.
1110- chief mate & master on the scene with the first aid kit needed second engineer and AB2 is responding and OS still lying down. and I go out take harness also bosun and AB go out.
1115- Lower the harness start ventilating area using this big portable fan.

1120- Chief mate and master put then on to second engineer and he start climb out slowly, Chief engineer/3m and me pulling the rope to help him climb.as he reached on deck assisted him go to deck office, then we pull the OS he also can climb slowly next was AB2 to pull. Cook also assisted us."

E. The statement by the third officer on 29 December 2022, following questions from the inspector, insofar as it contains:
"1105 I'm standing leaning against the rack of lashing chains. The OS tried to pass me and falls over forward, hitting his forehead on the floor without tripping or attempting to break his fall. He immediately sits up with his back against the chains. I ask him "are you okay?". His confused answer is "yes, I feel sleepy". The rest of the crew in the space then realises that there is something wrong with the OS and they come to help. At that point, I exited the space and headed for the deck office.
1110 from the deck office, I called the bridge to report that the OS has fallen but is conscious. I also requested assistance. After hanging up the phone, I saw 2/O going for a stretcher and I thought I heard that the OS was unconscious (this proved to be a mistake). I called again to report this and was informed by the captain that the captain and 1/O were on their way.
1115 1/O arrived on deck with the red first aid bag and went below, I lowered the bag on a rope and followed him. Once below, I was requested to fetch blankets from the ship's medical room. I threw them down and remained on standby above. The captain joined me on deck and entered the space. The bosun and the AB exited the space. They both indicated that the air was not good. I therefore requested that the bosun open the ventilation. The captain then came out, and requested that I assist with the ventilation. The bosun, the AB, the apprentice and I opened the ventilation and could hear that it started up.

Between 1115 and 1215, the bosun, the AB, the apprentice and I returned to the entrance of the space. The chief engineer was also present. A ventilator with hose was operating for ventilation purposes. 1/O called out but could not be understood due to the ventilator. 2/O exited the space to fetch a harness to help the crew exit, and then returned to the space. I fetched a portable radio for communication with 1/O. The crew members were extracted from the space 1 by 1. The chief engineer and I provided support for the safety harness while they climbed the ladder."

F. The statement by the second engineer on 29 December 2022, following questions from the inspector, insofar as it contains:
"As a 2nd engineer onboard I do the engine safety rounds at 8;00hrs before any jobs planned for the day. Raitings were already prepared all the things for starting the barbecue at the hold entrance. Me and apprentice came around at 9;30 hr to help those guys pre-bbq preparation. As soon as I was there, we then started to lit the fire for the charcoal situated near the entrance right under the stairs. The people inside the hold entrance at the moment we started the fire of the charcoal were Me, bosun, 2 AB's, OS and the apprentice (6 persons). Everything started smoothly and no any signs of danger at all. We have a couple of buckets of water standby next to us and started to turn or cook the suckling piglets. We breath normally and very confident that everything is under control and start enjoying ourselves with playing music. There was adequate air coming inside the space. At around 10:00 hr we started to cook the suckling pig. Around 10;10 3rd off came and 20-30 mins later 2nd off also came inside. Chief officer came inside and stayed for around 10 mins to check how was going on in the bbq and then he then leave for some time and back again. At around 11:30hr the OS feel already dizziness and start to lose his control and fell down to the floor immediately, so we then started to rescue him inside and some guys go out to inform the master and all other crew which is not inside the scene. I was one

of those who rescue the first casualty (OS) until his breathing become sufficient and then 5 mins after one AB begun to lose control and shaking sitting down with difficulty of breathing but still conscious. The moment that I saw them weaken their body is the moment that I feel dizziness and I started to lose my body control and just sitting down and try to recover myself back. That time I was not aware of any actions that my colleague they made until around 5 mins later I saw everybody were trying to get us out of the scene safely. I was very thankful that everyone trying their best as they can to make us go out safely."

5.2 Considerations

With regard to the objections 1 through 5

The Disciplinary Court advocates the organisation of social events on board. Such events can promote the well-being of the crew. A barbecue is an example of a social event. It is often organised. However, due care is essential. The open deck is the designated location for the organisation of a barbecue.

As the weather conditions were not conducive to barbecuing on the deck in this specific case, while barbecuing was extremely important due to the roasting of a suckling pig being an important Christmas tradition for the six Filipino crew members on board, an alternative location was sought on board.

However, the person concerned did not conduct a *risk assessment* prior to this charcoal barbecue, whereby the preconditions are clearly ascertained and communicated for the purpose of a safe barbecuing process. A *risk assessment* must also be conducted in the event of risky activities taking place during leisure time. A minimum requirement for safe barbecuing using charcoal is that there is adequate ventilation.

The person concerned, the chief officer, second and third officers and the second engineer opted for (or agreed to) the *lashing store* as the location, i.e. a space within the vessel (without having the atmosphere checked). With a view to their position and training, they should have recognised and designated the *lashing store* to be an enclosed space. After all, there was only one opening for entry and exit via a vertical ladder, and one door giving access to hold number two, this space was in itself inadequately ventilated and *"not designed for continuous worker occupancy"* in the sense of Resolution A.1050(27) and the *"Wagenborg Shipboard Operation Manual".*

On the following day, a barbecue was indeed organised in the *lashing store* (without the use of a carbon monoxide meter), resulting in five crew members becoming unwell as a result of carbon monoxide poisoning.

These actions and failure to act (not conducting a *risk assessment*, opting for a space within the vessel, actually barbecuing and not using a carbon monoxide meter/monitoring the atmosphere during the barbecuing process) constitute 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 ship's officer contrary to the duty of care expected of a good seaman in relation to the persons on board, the ship, the cargo, the environment and shipping traffic. Objections 1 through 5 which pertain to this, are well-founded.

Moreover, the person concerned did not demonstrate the sense of control and leadership that should be expected of a captain. It was his responsibility to organise the barbecue effectively and to prevent accidents from occurring. It was his suggestion to organise the barbecue in the *lashing store* (there was not any apparent crew pressure) and with this in mind, he should have given instructions for a *risk assessment* to be conducted whereby, as he himself has stated, ventilation valves and the use of a carbon monoxide meter would have been involved. In terms of the ruling, it makes no difference whether carbon monoxide or carbon dioxide was involved.

The person concerned has himself declared that, with hindsight, he should not have assumed that ventilation valves would be opened and that a carbon monoxide meter would be present. The person concerned had established incorrect priorities, having been involved in other work on the bridge rather than checking whether the space was adequately ventilated and monitored using a carbon monoxide meter. The person concerned has also admitted that he did not have sufficient supervision and has also stated that a barbecue should never again be organised in the *lashing store*.
Contrary to the arguments of the (counsel for the) person concerned, there is no reason why the legislation in question should only pertain to the possible presence or permeation of any gases from the cargo in hold number two and not to barbecuing with charcoal in the enclosed space in question, the *lashing store*.

With regard to the objections 6 through 8

If it is ascertained (in a *risk assessment*) that there may be a health risk as a result of entrance to an enclosed space, the precautionary measures of paragraph 5 through 9 of Resolution A.1050(27) must be followed. The Disciplinary Court strongly emphasises the importance of taking such precautionary measures to prevent accidents. The person concerned, the chief officer and second and third officers failed to take such precautionary measures. They entered the *lashing store* without the use of a respirator. Objections 6 through 8 which pertain to this, are therefore also well-founded.

However in this specific case in which the person concerned conducted an instinctive rescue operation, the Disciplinary Court will not take these objections into account when determining the degree of disciplinary measure applicable to the person concerned. The disciplinary measure is therefore less than the Inspector's demand. The Disciplinary Court explains this as follows.

On arrival in the *lashing store*, the person concerned recognised the emergency situation. There was no time to waste. He assessed the situation correctly, that the ventilation valves needed to be immediately open and the victims evacuated as quickly as possible, which could not be done alone. In such a hectic situation, it is not reprehensible that the person concerned did not first fetch a respirator (which was located elsewhere), and that he did not withhold the chief officer, second and third officers. If he had indeed done so, the consequences of the situation could have been much more severe.

5.3 The disciplinary measure

The Maritime Disciplinary Court judges that the person concerned failed in his responsibilities as captain, resulting in five crew members becoming unwell due to the effects of carbon monoxide.

In view of the seriousness of the demonstrated behaviours, a reprimand is appropriate.

6. Focal points for professional practice

Following on from, but also separately from, the decision in this case, the Disciplinary Court sees cause to draw attention to the following points:

Generally speaking, any risky activities, such as barbecuing with the use of charcoal, must be preceded by a *risk assessment*, whereby the preconditions for safety must be ascertained and communicated. When conducting any risky activities, there must be monitoring of compliance with the preconditions.

Furthermore, the Disciplinary Court advises that the *Marine Guidance Note* MGN 406 (M+F) of the British *Maritime and Coastguard Agency* be followed specifically when organising a barbecue, not only "*on the job*" but also a barbecue as a social event. This includes the following:

- *2.1 The use of barbecues/pig roasts on board vessels presents additional dangers. This guidance sets out practical steps to minimize the risk of fire or explosion. An appropriate risk assessment should be made when using this type of equipment.*
- *2.2 All ships intending to use barbecues should have a safety procedure in place and this guidance will help (…)*
- *3.1.2 The appliance should be sited on an open deck in a well-ventilated position (...)*
- *4.1 Due to the production of carbon monoxide when charcoal is burned, charcoal barbecues should not be used inside enclosed spaces, even if ventilation is provided (...)*

7. The decision

The Disciplinary Court,

- declares the objections well-founded;
- imposes the measure of a reprimand on the person concerned.

Duly delivered by W. van der Velde LL.M, presiding judge, R.M. Boeijen and C.R. Tromp, members, in the presence of V. Bouchla LL.M, secretary, and pronounced in the public hearing on 22 March 2024.

W. van der Velde
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.