RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 22 MARCH 2024 (NO. 2 OF 2024) IN THE CASE 2023. V3-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

D. T.,
the person concerned,
counsel: O. Yesildag, 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 chief officer 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 26 July 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 (via an online video connection), together with his counsel (who was present in the courtroom).

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 captain, the person concerned, 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 captain 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 person concerned came to check it from 09:40 hours to 09:50 hours, while the second officer came to check 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 captain. 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 captain, the person concerned and the 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 person concerned 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 captain and the person concerned assisted in the process from the *lashing store*. The chief engineer assisted at the top of the ladder, along with the second and third officers. The captain left the *lashing store* at 11:30 hours, followed by the person concerned 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 captain 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

The Inspector's objections

3.1 According to the Inspector, the person concerned acted or failed to act as chief officer 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. Despite his doubts, the person concerned accepted the captain's proposal that a barbecue be held 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 captain, de second and de 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, the captain and the two 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 € 1,000.

4. The position of the person concerned

The person concerned denies that he has failed to observe the principles of good seamanship. The idea to organise the barbecue in the *lashing store* came from the captain, and the person concerned agreed to this, despite his own doubts. The captain is responsible for ensuring safety on board.
The person concerned acknowledges that he did not conduct a *risk assessment* and states that, with hindsight, he should have done so.
The person concerned acknowledges that he had not adequately realised the risks of barbecuing in an enclosed space. He believed there would be sufficient ventilation, because the access door from the *raised quarterdeck* and (according to him) also the access door to hold number two, was open. He therefore did not arrange for the atmosphere to be monitored using a carbon monoxide meter. Another factor is that this was the first voyage for the person concerned as an officer and that he was working hard on all kinds of matters on the bridge.

On entering the *lashing store*, the person concerned was unaware that carbon monoxide was being produced. After all, the captain had called in at 11:10 hours, communicating that a crew member had fallen at the entrance to the *lashing store*, after which he immediately proceeded there and entered without the use of a respirator. When the second engineer and then the AB2 became unwell, the person concerned immediately ordered a portable fan to be utilised. The hold ventilation was then also switched on and the ventilation valves opened. The person concerned then exited the *lashing store* to fetch a gas meter and then re-entered the space, where he extinguished the fire using a bucket of water. This measure stopped the production of carbon monoxide and disposed of any gas present in the space.

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;*
- as soon as the person concerned became aware of the accident, he acted extremely adequately and took mitigating measures;
- 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 statements.
On 24 December 2023, the crew began roasting a suckling pig. Due to the cold weather and wind outdoors, we organised the barbecue in the small *lashing store.* I was concerned about the fire hazard (we have materials such as jute, sequoia and plastic on board) but I saw two buckets of water in place. I was not concerned about the atmosphere. I did not express my doubts to the captain, because I had checked the barbecue.
The door from the *lashing store* to the hold was open. The hold was empty, which removed any doubts about the fire hazard. I did not have the atmosphere monitored during the barbecue.
The *lashing store* is the entrance to the hold. We use the space almost every day, or pass through it every day.
On board, the *lashing store* is considered to be an enclosed space, but everyone agreed that it was to be used.
I have seen the Wagenborg *Company fleet manual* of February 2018, in which the *lashing store* is designated an enclosed space.
I grabbed the oxygen meter from the office before switching on the ventilation. The meter sounded as I was going below deck, but I did not look at the screen. I believed that the fire would no longer be under control once the ventilation was switched on. I therefore used a bucket of water to extinguish it.
The oxygen meter was sounding.
I still work for Wagenborg. The shipowner has never blamed me so far and has never taken any measures against me. The only aspect which the shipowner wished to improve is that all officers must follow the *ship safety training course*, in order to improve safety on board in general.
I have not had contact with any other crew members following the accident. Following the voyage on the Reggeborg, we have been working on different vessels.

B. The statement by the person concerned on 29 December 2022, following questions from the inspector, insofar as it contains:
"no risk assessment made before decided to grill pig in this entrance"

C. 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 breathe 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."

D. 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."

E. 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."

F. The statement by the captain on 29 December 2022, following questions from the inspector, insofar as it contains:
"Arriving at the bridge to take over the watch at 0800, we mainly discussed the upcoming grain trip, after unloading at Sorel. Wagenborg Canada, requested to look into various options, and it was eventually to become the final option of 13200 ton with 1800 ton being unloaded in Malta. This option was just inside the limits following a little manipulation with the ballast tanks. On the bridge, a dongle allows me to make the necessary grain calculations on a laptop. The stability computer is in the Deck Office. We casually discussed the barbecue during the watch transfer on the bridge. The chief officer was aware of the fact that the BBQ was in place and would start at around 1000.
The access door to the fan room was open during the BBQ and the access to the hold was open at the back of hold 2. However, the hold ventilation flaps were closed, both on the boat deck above the access door to the hold and on the cross deck midships.
I had plenty to do that morning, with transfer orders, vessel administration to be completed and load planning for the grain trip. There was a coffee break on the bridge at 1000, I no longer remember who was there, but in any case the chief engineer and I believe also the chief officer. We discussed all kinds of things, including the BBQ, it was also known that the bosun, 2nd engineer and Filipino seamen had started it.
The bosun and the second engineer were in charge of the BBQ. The chief officer was not actually involved, although he was aware of what was going on. He was busy adjusting the ballast reports following a repair to the ballast tank manhole in the hold which had been leaking and had been repaired. Ballast therefore needed to be pumped in and

out, and this needed to be reported to the authorities. That is what he was doing as far as I know. He was also working on the grain trip, and planning loads for the coming coal trip. Also in preparation for the coming coal trip, the holds needed to be cleaned in the freezing weather in Sorel. As the grain would then be loaded there. I am not aware whether the chief officer was in the starboard fan shaft before the BBQ began.
Following the coffee break on the bridge during which we discussed all kinds of matters, the third officer came to the bridge around 1100 to report that the OS had become unwell. That he was not well. I immediately proceeded to the ventilation room, where I found 3 persons lying and/or sitting on the deck. The O/S, A/B2 and the second engineer. And the third officer and bosun standing, under the influence of CO2 and/or CO.
I immediately realised that the charcoal fire needed to be extinguished, and that a bucket of water needed to be fetched and the space required ventilation! The 2nd officer fetched a portable hold fan with flexible pipe. The chief officer used the bucket of water to initially douse the charcoal fire, after which I fully extinguished the fire using the same bucket of water.
The portable fan did not work adequately. Insufficient flow. In the meantime, I very quickly instructed the chief engineer to start the 2nd auxiliary motor and 2 or 3 people to open the ventilation flaps of the holds on the cross deck (3rd officer, bosun and apprentice) but I'm no longer sure exactly who, in any case the bosun and apprentice. ASAP!
The chief officer used the bucket of water to initially douse the charcoal fire, after which I fully extinguished the fire using water.
And the fan room flaps on the boat deck. As soon as they were open, I started the fans for the hold 2 on the cross deck, on exhaust. I then immediately returned to the ventilation room on starboard aft. On arriving there, I saw the O/S, who I had left in a stable recovery position, was conscious again, the youngest of the three.

Soon after the hold fan started, AB2 also regained consciousness and so did the second engineer a few moments later. The bosun and third officer had never lost consciousness, as far as I know. I could then feel the required airflow in the ventilation room. Everybody needed to be evacuated ASAP. Using a safety harness and line via a roll, the chief officer and myself evacuated everyone from the room. The chief engineer stood at the top of the ladder and held the line taut.
Everyone had now regained consciousness and all were able to climb out of the hold independently, using the safety line and harness, up the hold ladder which is approximately 6 metres. All persons were evacuated to the deck office. The men in question complained of nausea, dizziness, needing to vomit. And O/S immediately went to his cabin for a shower (defecation). I administered oxygen to AB2, who felt the worst, at approximately 2 litres/minute.
Note: as soon as I arrived in the room, I immediately noticed that the atmosphere was not as it should be.
I immediately exited the room, once I had placed the O/S in a stable recovery position. O/S had lost consciousness, with rolling eyes and defecation.
I was extremely worried! A/B was performing CPR on the O/S. I immediately had him stop this. O/S was breathing and his heart was pumping.
The crew members who had been taken ashore and returned on board had serious CO carbon monoxide poisoning, and had been administered oxygen in two hospitals. Their hospital release papers gave an explanation with regard to carbon monoxide poisoning.
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 realisation of the risks."

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 captain, the person concerned, the 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.

As chief officer, the person concerned should have conducted a *risk assessment*, but he failed to do so. It was his task, despite his young age, his first voyage as chief officer and his trust in the captain. Moreover, the person concerned was present in the *lashing store* from 9:40 hours to 9:50 hours, and should/must have been aware that there was a lack of good ventilation (with an entrance and an exit). He should therefore have made arrangements for ventilation of the space, as the hold ventilation was switched off and the ventilation valves closed. With hindsight, the person concerned admits that he himself should have conducted a *risk assessment* and that he was insufficiently aware of the risk of barbecuing in an enclosed space.

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 captain, person concerned, 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 there was a (coordinated) 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 first entering the space, the person concerned was unaware that the crew members had become unwell as the result of carbon monoxide. After all, the captain had only informed him that a crew member had fallen at the entrance to the *lashing store*. He did however immediately order a *portable fan* to be installed. On the second occasion that the person concerned entered the *lashing store* with a carbon monoxide meter (which was sounding the alarm) and extinguished the fire using a bucket of water, the space ventilation was in operation and the ventilation valves had been opened. The crew members who had become unwell regained consciousness at that point, which was the reason why the respirator was no longer required. 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 captain, 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 chief officer, 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.