RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 22 MARCH 2024 (NO. 3 OF 2024) IN THE CASE 2023. V4-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

M.G. G.,
the person concerned,
counsel: M. Verhagen, 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 second 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 8 August 2023.

The presiding judge stipulated that the hearing of the case will be held at 14:00 hours on 25 January 2024 at the courtroom of the Disciplinary Court in Amsterdam.

The hearing took place on 25 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 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 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 chief officer came to check it from 09.40 hours to 09.50 hours, while the person concerned came 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 person concerned and the third officer left the *lashing store* at that point to fetch a stretcher and to warn the captain. The person concerned 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 and the chief and third officers entered the *lashing store* at 11:15 hours. The person concerned 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 captain and the chief officer assisted in the process from the *lashing store*. The chief engineer assisted at the top of the ladder, along with the person concerned and the third officer. The captain 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 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

3.1 According to the Inspector, the person concerned acted or failed to act as second 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. The person concerned did not recognise the organisation of a barbecue in a non-ventilated enclosed space as being unsafe conduct.
2. The person concerned did not apply the *STOP THE JOB* procedure regarding the organisation of a barbecue in a non-ventilated enclosed space.
3. The person concerned (re-)entered an enclosed space where carbon monoxide gas was being produced and where one person had already become unwell, without the use of a respirator.
4. The person concerned did not apply the *STOP THE JOB* procedure when the captain, the chief officer and third officer also entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.

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 € 500.

4. The position of the person concerned

The person concerned denies that he has failed to observe the principles of good seamanship. The captain and the chief officer had decided that the barbecue would be organised in the *lashing store*. There was therefore no reason for the person concerned to assume that this was unsafe. A Filipino subordinate officer, like the person concerned, who had only been on board for one month, does not challenge such a decision. The person concerned kept the suckling pig rotating on the spit, after he had ascertained that – in his opinion – there was sufficient ventilation and that there were fire extinguishers and two buckets of water in place.

When the person concerned discovered there was a problem, he took immediate action to remedy the situation. He was unaware of the carbon monoxide, but was aware that this was an emergency situation whereby the OS and the second engineer become unwell. He immediately fetched a stretcher.
The person concerned could not withhold the captain and the chief officer from entering the *lashing store*. The person concerned was assigned to fetch a *portable fan*, and also fetched the hoisting harness. He could not issue a *STOP THE JOB*.

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;*
- The person concerned believed to have acted correctly in an emergency situation by immediately offering assistance to his fellow crew members in order to prevent escalation

In the opinion of the person concerned, and official warning is (alternatively) more suitable in this case, and (more alternatively) a provisional fine.

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, translated and 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 and would like to add that when the first colleague became unwell, I was not yet aware that this was due to carbon monoxide poisoning. I believe I did refer to this as soon as I suspected that this could be the problem. By then however, I was concentrating on saving my colleagues.
Normally barbecues would be organised on deck, but this time the barbecue had been moved below deck, into the *lashing store*, because of the bad weather. As the doors were open, I assume there would be sufficient ventilation. The *lashing store* is often used as an access route to hold number two.
We had closed the ventilation flaps in preparation for the loading process.
The captain and chief officer had already made a decision, it was not my place to apply a *STOP THE JOB*. Once things went wrong, they too became aware of that.
I was not involved in the decision to organise the barbecue in the *lashing store* and also not in physically transporting the barbecue below deck. I did not see the captain or the chief officer enter the *lashing store*.

The accident has made me more cautious. The shipowner was mainly relieved that everyone had survived the accident, and has not taken any further measures against me. I still work for Wagenborg.

B. 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.

C. 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."

D. 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."

E. 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 and 2

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.

No *risk assessment* was conducted prior to this charcoal barbecue, whereby the preconditions would be clearly ascertained and communicated for the

purpose of a safe barbecuing process. A minimum requirement for safe barbecuing using charcoal is that there is adequate ventilation.

The captain, the chief officer, the person concerned, the third officer 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 (opting for a space within the vessel and actually barbecuing there) 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 and 2 which pertain to this, are well-founded.

In the case of the person concerned, although he himself was not party to the decision to organise the barbecue in the *lashing store*, on the evening prior to the barbecue, he was however responsible for checking for himself whether there was adequate ventilation (unlike the captain and chief officer who bear that responsibility on behalf of the rest of the crew members). Moreover, the person concerned was himself present in the *lashing store* and was operating the barbecue. He could and should have ascertained that the ventilation was not in order. After all, the ventilation valves were closed. A

STOP THE JOB might have been expected from him at that point, and therefore also from a Filipino subordinate officer.

With regard to the objections 3 and 4

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, the chief officer, the person concerned, and the third officers failed to take such precautionary measures. They entered the *lashing store* without a respirator, and did not apply a *STOP THE JOB.* Objections 3 and 4 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.

The person concerned was unaware of the presence of carbon monoxide. When he saw that the OS and the second engineer had become unwell, he fetched a stretcher and warned the captain. On his return, he became aware that this was an emergency situation which required immediate action. Upon the captain and chief officer entering the *lashing store*, the person concerned was assigned to fetch a *portable fan*, which he did, while also fetching the hoisting harness. The person concerned then assisted in hoisting the OS and the second engineer up onto deck. 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, the chief officer and third officer. If he had indeed done so, the consequences of the situation could have been much more severe.

5.3 The disciplinary measure

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

In view of the seriousness of the demonstrated behaviours, an official warning is certainly appropriate.

As the second officer has less responsibility than the captain and the chief officer in estimating safety aspects, the Disciplinary Court is not imposing a reprimand, but rather an official warning.

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 an official warning 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	V. Bouchla
presiding judge	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.