RULING OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS OF 22 MARCH 2024 (NO. 4 OF 2024) IN THE CASE 2023. V5-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

G. H.,
the person concerned,
counsel: J.M. de Boer.

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 third 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 20 July 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.

As the hearing of the case was not possible on 25 January 2024 (the person concerned was at sea), the presiding judge moved the hearing to 26 January 2024, on which day the hearing did indeed take place. 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 a WhatsApp connection), together with his counsel (via an online video connection).

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 second officer arrived at 10.45 hours. The person concerned 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 officer and the person concerned 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 chief officer and the person concerned 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 person concerned 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 second officer and the person concerned. 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 person concerned 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 third 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 second 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. Nobody regarded the *lashing store* to be an enclosed, non-ventilated space. Everybody believed it to be a safe and responsible space for the organisation of the barbecue. The ship's management had opted for the location instead of an alternative, which meant that there must have been assessment of the risks. The person concerned was confident that the persons who had control of the barbecue, would have made the necessary preparations.

The person concerned was not aware that carbon monoxide was being produced. The person concerned followed the chief officer below deck, at the moment in time that it was only known that a crew member had fallen, and immediately returned above deck to fetch blankets and to throw them into the *lashing store*. The person concerned did not return to the *lashing store* after that. It was only when the bosun and a seaman came above deck and communicated that the air was not good, that crew members realised that the atmosphere was suspect in the *lashing store*, and that a life-threatening situation had arisen. From that point on, the option of bad air in the *lashing store* was taken into account and a coordinated operation begun, the purpose being to tackle the risks recognised at that time. The person concerned was required to conduct the tasks assigned to him, which he did effectively. Together with the bosun, the person concerned was assigned by the captain to open the ventilation valves and to remain standby above deck, together with the chief engineer. The person concerned did not play such a role that the operation would take place or not, on his initiative. All the ship's management present took the decisions with regard to accessing the hold and initiating evacuation.

Based on the above, the person concerned requests that the Disciplinary Court does not impose any disciplinary measure in his case.

The counsel for the person concerned also requested attention for the following. He does not believe this accident to have been a simple “enclosed space incident”, in which everyone is aware of how to limit the damage, but rather that this accident requires the attention of all players in the nautical sectors. Counsel informs the court that, in the late 1990s, the former General Committee for Prevention of Working accidents among Seafarers (ACVAZ) determined that the greatest and most underestimated enemy of safety on board is the lack of safety awareness on the work floor. Counsel also believes this to be the case on the Reggeborg. According to counsel, written instructions and operations are of little use. He believes that improvement of the safety and risk awareness lies with the partners in the sector. Counsel thereby refers to the *Marine Guidance Note* MGN 406 (M+F) of the British *Maritime and Coastguard Agency*, which covers the subject of use of barbecues on board vessels. Counsel believes that this advice should be common knowledge on board all vessels and therefore requests that the inspector and the social partners repeatedly and continuously include the subject of improvement of safety and risk awareness on the agenda and in publications. Counsel hopes that the decision of the Disciplinary Court can contribute to this situation.

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.
I was keeping watch on the bridge the evening before the barbecue. I was relieved at around eight o'clock, at which point I went to rest. On getting up in the morning, I proceeded to the bridge and then to the barbecue. I briefly went outdoors to fetch a speaker and then returned to the hold. The OS suddenly fell over while walking, hitting his forehead on the ground. When I approached him, he informed me he was feeling sleepy. I went above deck to the *deck office* and called the captain. I was then informed that the OS had lost consciousness, but this was not true with hindsight. I called the captain again. He informed me that he was coming and that he had summoned the chief officer. When they arrived, I went below deck with them. I was immediately sent back up to fetch blankets. On return, I threw the blankets down to them. On hearing that the air was not good, I did not return to the hold. On seeing the second colleague sit down, I informed the bosun that he should open the hatches and help the captain. We then returned to help evacuate people from the hold. The chief engineer was present, and together we supported the people being evacuated from the hold. The cook then also came. He helped transport people to the hospital. Emilio was administered oxygen. He had fallen. I then stayed in the *deck office*, with the other crew members who were feeling unwell and who were sitting there. I eventually went to the bridge to help the captain. There I became nauseous and suffered a headache. I was then informed that I too should be evacuated ashore, and I was transported to the hospital together with the rest. There, I was administered oxygen for a while.
Beforehand or when starting the barbecue, I had no doubts about organising the barbecue in the *lashing store* instead of on deck. I did not regard it to be an unsafe space for organisation of the barbecue. I was not present during planning of the barbecue the day beforehand, and it had already been lit when I arrived at the barbecue. I assumed it was all well organised.

As far as I can remember, the door from the *lashing store* to the hold was open, but I cannot be absolutely sure about that. Behind that door was a ladder to go down into the hold.
I was not aware that Wagenborg regarded the *lashing store* to be an enclosed space. I do not know of any *fleet news* in which that is described.
I can no longer remember whether I told the captain that the OS had fallen or was unconscious. It is too long ago. When he fell, it was as if he had been switched off. He didn't trip. He was simply walking.
A month before the accident, I attended the *enclosed space drill.* I no longer know exactly how the *drill* worked. I don't think we did any practical exercises.
During normal work, we use oxygen metres to monitor the air when there is cargo on board.
When the first colleague fell, I did not immediately link that to a possible carbon monoxide poisoning. By the time the second colleague became unwell, I was already above deck and I no longer returned back down. At that point, there was eventually a respirator upstairs, but not below deck.
The effect of the incident on me personally is that I nowadays tend to mistrust those who are higher than me in rank. I'm not sure if that's a positive thing, but I always ask a lot of questions whenever I'm ordered to do something. I also pay careful attention to what other people are doing nowadays. I have also stopped people from doing their work. I blame this on the people who were above me in rank. I did not recognise the situation as being hazardous, and that is a mistake which I should never have made, and which I will never make again. But the fact that the situation occurred, is not simply my fault. I acted in good faith according to the people who outrank me, who had discussed and prepared the barbecue together. I assumed their expertise in good faith, that all was in order. However that was not the case, and not only my life was put in danger but also that of others. I

also endangered my own life and that of others. I am aware of that, but I do blame them.
I am now working as third officer for Wagenborg, on the Avonborg. We are currently en route to Charleston.
The consequences of a fine being imposed would be € 500 being deducted from my account.

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 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 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 and second officer, the person concerned 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.* 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 third officer.

This constitutes a violation of the regulation of Section 55a of the Dutch Seafarers Act in conjunction with Section 4.4 of that Act: acting or failing to act on board as a 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.

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 and second officer, and the person concerned 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. He then re-entered the *lashing store* and immediately returned above deck to fetch blankets and to throw them into the *lashing store.* He subsequently stayed above deck. When the bosun and the seaman came upstairs and communicated that the air was not

in order, he was ordered by the captain to open the ventilation valve, before helping hoist the OS and the second engineer out of the hold. 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 and the first and second 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 third 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 third officer has less responsibility than their captain and the first 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
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.