MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

ANNUAL REPORT 2017

MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

Damrak 387, 1012 ZJ Amsterdam
Telephone number : 020 - 622 04 77
Email address : secretariaat@tuchtcollegevoordescheepvaart.nl
Website NL : www.tuchtcollegevoordescheepvaart.nl
Website ENG : www.mdcn.nl

MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

ANNUAL REPORT 2017

CONTENTS

GENERAL

The year 2017 was a good year for the Maritime Disciplinary Court.

Twelve cases were heard in court session and were settled with a ruling.
In five cases a grounding had taken place and there was one case involving a collision.
In three cases a ship had embarked on a sea voyage following an incident without having properly investigated whether the ship was still seaworthy and without having informed the Dutch authorities.
Five cases related to a serious accident on board. One of them raised the question of the extent to which the captain is responsible for maintaining a good safety culture on board at all times.

Detailed summaries of all these matters are given below in this annual report.
The rulings were again published – fully but in anonymised form – on the website www.tuchtcollegevoordescheepvaart.nl and – in English – on www.mdcn.nl.

At the end of 2017, the four-year period of appointment of the members and deputy members of the Disciplinary Court came to an end. Fortunately, most members were eligible for reappointment and were also willing to be reappointed, but a number of other members no longer met the statutory navigation requirement. This meant having to bid farewell to the following members: J.M. Bais, A. Dekker, R.J. Gutteling, S.M. den Heijer, H. Romkes and W. Toering. The Disciplinary Court is very grateful to them for their contributions to its work.

With a view to the departure of these members, advertisements were published in various trade journals and interviews were held with interested parties in the course of 2017. As a result, seven new members and deputy members were appointed with effect from 1 January 2018.
The composition of the Disciplinary Court in 2017 is given at the end of this annual report.

Once again, the secretariat of the Disciplinary Court was able to avail itself of the valued services of Mrs L. Batelaan. The staffing of the secretariat otherwise remained unchanged.

In 2017, the Maritime Affairs, Shipping department of the Ministry of Infrastructure and the Environment, now known as the Ministry of Infrastructure and the Water Management, was also consulted on a number of occasions.
Consultations were also held with that ministry's Human Environment and Transport Inspectorate, Shipping domain.

A.N. van Zelm van Eldik
presiding judge

Amsterdam, April 2018

NEW CASES AND SETTLED CASES

In 2017 the Maritime Disciplinary Court of the Netherlands pronounced rulings in twelve cases. Ten new petitions for a hearing under disciplinary law were submitted on behalf of the minister by M. Schipper, the inspector at the Human Environment and Transport Inspectorate of the Ministry of Infrastructure and Water Management.

The Disciplinary Court did not receive any complaints from interested parties during 2017. Neither did the Disciplinary Court conduct any preliminary investigations.

A comparison of the figures with those of previous years is given in the table below.

Year	Petitions of the Minister	Complaints	Preliminary investigations	Number of cases settled by the presiding judge's decision	Number of cases ruling
2010	8	0	4	0	0
2011*	2	1	1	1	6
2012	7	0	2	1	6
2013	10	0	0	0	6
2014*	5	0	0	0	12
2015	10	0	0	0	6
2016	10	0	0	0	6
2017	10	0	0	0	12
Total	62	1	7	2	54

* In 2011 one case and in 2014 two cases were withdrawn by the minister.

RULINGS OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2017

SCHELDEGRACHT

RULING OF 8 MARCH 2017
NO. 1 OF 2017
CASE 2016.V5

Person concerned: the third mate and watchkeeping officer

On 19 December 2015 the Scheldegracht ran aground in shallows at the Langelandsbaelt in Denmark. At the time of grounding, the person concerned was the officer of the watch on the bridge, and had been on duty for over three hours. The following were available on the bridge of the Scheldegracht: the sea chart, the radar echoes of other ships with their AIS data, their own GPS position and an echo sounder.

The ship had been following route H in the lane for northerly traffic in the traffic separation scheme for some time. Another vessel, the St Pauli, was sailing ahead of the Scheldegracht in the same direction. The difference in speed was approximately 5-6 knots. The person concerned decided to overtake the St Pauli on her starboard side and intended to pass her at a safe distance. For that purpose he changed course slightly to starboard. He had read his GPS position in the chart just before that. At that time, the ship was still well inside of the shipping lane. The chart showed that there was shallower water to his easterly, starboard side, indicated with 10 m line. After the change of course to starboard the person concerned continued on roughly the same

course. At a given point in time the person concerned felt the ship juddering, apparently caused by the reduced UKC (squat effect). At that point he reduced speed slightly. He decided to break off the overtaking manoeuvre and intended to go back to port, to route H. However this did not take place because the ship ran aground and came to a halt shortly afterwards. The position of the grounding was within the 10 m line.

The Disciplinary Court's findings were as follows.
After coming on watch the person concerned should have checked the ship's position and course sufficiently frequently using the equipment available to him (radar, GPS, echo sounder) and the sea chart. This included checking the anticipated water depths and shallows. This was even more the case prior to leaving the shipping lane of route H and changing course to starboard.
The person concerned knew the draught of the ship on departure the day before, i.e. 9.70 m aft. The sea chart showed that the transverse distance between route H and the 10 m line on starboard was only approximately 0.8 nm. It was therefore a risk to change course to starboard there and to leave route H. Continuing on the new course resulted in the ship heading for the shallows. It is clear that the person concerned did not take this sufficiently into account and apparently did not have a clear impression of his own position, the vicinity of the shallows or the danger of his navigation.
It can be presumed that if the person concerned had made proper use of the available navigation equipment he would have noticed in time that after a change of course to starboard the ship would soon enter the area with insufficient depth of water for the ship. It must be concluded that the person concerned did not do so and that as a result he did not prevent the vessel from grounding.

The Maritime Disciplinary Court judged that the person concerned had failed in his responsibilities as officer of the watch, which resulted in the vessel grounding. A suspension of the navigation licence was considered appropriate. However, given the circumstances of this case, including the fact that the person concerned had already been punished by his employer by demoting him for two months, the Disciplinary Court decided not to impose a disciplinary measure.

NEDLLOYD BARENTZ

RULING OF 8 MARCH 2017
NO. 2 OF 2017
CASE 2016.V3

Person concerned: the first officer

On 25 March 2015, the seagoing vessel Nedlloyd Barentz was berthed in the port of Ambarli Kuport, Istanbul, Turkey. The monorail crane on the ship was used to unload waste. After this the monorail remained stationary in the outboard position. Several people made a plan to bring the crane inboard using a temporary power supply cable.
It was unclear in which direction the crane would move when this was done. The person concerned took over the operation of the crane. He gave a tap against the joystick of the remote control, after which the crane started to move in the wrong direction. It was not possible to stop that movement. The crane went through the end stopper, shot off the starboard side of the rail and then fell on the deck and hit the railing. This caused serious injury to a seaman who was standing there.

The Disciplinary Court concluded that the person concerned was fully aware of the risks indicated in the manual of operating the crane after connecting the temporary power cable. He also took responsibility when he took over the remote control from the boatswain. He operated it with the necessary caution. The person concerned was prepared for the crane to move to the other side, but not for the fact that it might not be possible to stop it. Nor was there any need to make allowance for the fact that the limit switches and mechanical end stoppers would not be to their task. The ship was well maintained and met all safety regulations. It is highly probable that there was a technical fault. Either way, it has not been demonstrated that the accident could have been avoided had the person concerned operated the crane differently. According to the Disciplinary Court there was no better solution available to get the crane out of its outboard position, and leaving the crane in this position was too dangerous. The Disciplinary Court does not share the inspector's view that the person concerned did not sufficiently consider all relevant and available information (in particular that the limit switches would not work) when this should have been done.
The same applies to the second charge regarding the position taken by the person concerned – and under his authority also the boatswain and the seaman – virtually directly under the crane. Viewed in retrospect it would have been better if he had taken the time to assess all conceivable risks of the operation and sent the boatswain and seaman away since their presence was not required during the operation of the crane. However, given the fact that – contrary to the charge – they were not directly under but more diagonally away from the load, it cannot be ruled that the person concerned acted contrary to the care expected of a good seaman in respect of the persons on board, the vessel, the cargo, the environment and shipping.
The Disciplinary Court dismissed the charges against the person concerned.

NEDLLOYD BARENTZ

RULING OF 8 MARCH 2017
NO. 3 OF 2017
CASE 2016.V4

Person concerned: the chief engineer

For a description of the incident, see the above ruling. The person concerned in this case was accused of not having sufficiently considered all relevant and available information.

Here too, the Disciplinary Court concluded that the person concerned was fully aware of the risks indicated in the manual of operating the crane after connecting the temporary power cable. He shared this information with others, including the first officer, who operated the crane after the power cable was connected. He was prepared for the crane could move on the other side, but not for the fact that it might not be possible to stop it. Nor was there any need to make allowance for the fact that the limit switches and mechanical end stoppers would not be up to their task. The ship was well maintained and met all safety regulations. It is highly probable that there was a technical fault. Either way, it has not been demonstrated that the accident could have been avoided had the crane been differently operated.
According to the Disciplinary Court there was no better solution available to get the crane out of its outboard position, and leaving the crane in this position was too dangerous. The Disciplinary Court does not share the inspector's view that the person concerned did not sufficiently consider all relevant and available information (in particular that the limit switches would not work) when this should have been done. Therefore, it could not be found that the person concerned acted contrary to the care expected of a good seaman in respect of the persons on board, the vessel, the cargo, the environment and shipping.
In this case, too, the Disciplinary Court ruled that the objections raised against the party concerned were unfounded.

HOLLAND

RULING OF 21 MARCH 2017
NO. 4 OF 2017
CASE 2016.V8

Person concerned: the captain

On 9 May 2016, the Dutch seagoing tugboat Holland ran aground in the Westergronden north of Terschelling. This grounding was caused by the change of course to port taken by the person concerned as captain and officer of the watch and maintained on the instructions of the person concerned by the navigating officer who took over the watch from him.

The Disciplinary Court found that the ground could be attributed to the person concerned not determining and charting the ship's position for a long period of time. For that reason he had a completely inaccurate image of the situation and did not notice that the Holland was not where he thought it was at the time of the course change or that he was heading for the Westergronden. This shows that the person concerned failed to properly fulfil his duties as officer of the watch; in particular he failed to determine and chart the ship's position frequently enough. There was certainly sufficient reason to do this in the area to the north of Terschelling where the Holland was sailing. The grounding was caused by this negligence.

The person concerned claims that he was distracted by other people on the bridge and the conversations they were holding. This is indicative of incorrect bridge resource management, for which the person concerned can also be held accountable in his capacity of captain and officer of the watch. An officer of the watch must direct his full attention to the bridge watch. Everything that distracts him from this must be prevented or removed.

The person concerned argued that the Brandaris traffic centre, to which he had reported the position of the Holland shortly before the grounding and in which he had given an incorrect position, had not checked the correctness of that report and had not warned that the ship was on a dangerous course. The person concerned also points out that the navigating officer did not check the ship's position either.
It was found that the actions of the Brandaris and the navigating officer – whatever the other merits of the case – did not absolve him of his own responsibility for his navigation. On handing over the watch the person concerned should have ensured that the navigating officer informed himself of the Holland's correct position.

In view of the seriousness of the failure to perform the duties of captain and officer of the watch a two-month suspension of the navigation licence would have been appropriate. However, this disciplinary measure was imposed entirely conditionally since the person concerned had been seriously affected by his failure and had resigned as captain.

AMADEUS AMETHIST

RULING OF 12 APRIL 2017
NO. 5 OF 2017
CASE 2016.V7

Person concerned: the first officer

On 23 February 2016 the coastal trading vessel Amadeus Amethist was moored in the Port of Antwerp. The ship's hatch carrier was to be lowered to the river position under the supervision of the person concerned. The boatswain, a seaman and a apprentice also took part in this work. None of them had done this work before. The supplier's operating instructions were studied well in advance. The hydraulic system of the hatch carrier was operated by the person concerned. Everybody was situated on the starboard side.
The first six steps of the lowering procedure were followed. Step seven was aborted and the eighth step was carried out first. At that point a pin got stuck. It has been struck out. As a result, the crane frame came down and the apprentice was hit on the head. The boatswain and the seaman were also injured.

This demonstrated that the procedure for lowering the hatch carrier was not followed correctly. The cause of the starboard side of the crane frame falling down was the removal of the securing pin, which was in fact holding the crane frame.
It emerged while the work was being carried out that the person concerned was not clear about the correct order of the various steps to be taken to lower the hatch carrier.
In a situation such as this, when a person is no longer sure how to proceed, the person in charge should bring the work to a halt and make enquiries about how to continue with it. The person concerned did not ask anybody for help. In this case, the captain was the right person to ask. Furthermore, this happened in the middle of the day and the ship was moored in the port of Antwerp. It is fair to assume that it was possible to contact the office of the shipping manager in the Netherlands, after which the hatch carrier supplier could also have been consulted.

It seems that the person concerned did not stop to consider the situation of the hatch carrier when he was unsure how to proceed, or what would happen if the securing pin was knocked out. He evidently failed to understand how the hatch carrier was built and how the various parts were connected to each other. After inspecting the hatch carrier, whether or not together and in consultation with others, the person concerned should have realised, among other things, that if the securing pins were removed with the hatch carrier in its current position, the crane frame would suddenly fall down a good distance and in one go. Since the person concerned had not realised this, he was not aware of the potentially dangerous situation in which the crane frame was suspended on the securing pins and that this danger would manifest itself as soon as the pins, or one of them, were removed.

The Disciplinary Court finds that the person concerned should have provided more and clearer leadership and that he should have paid much more attention to the safety of the crew members whilst carrying out the work.

The person concerned was aware that the other crew members had not done this work before and that they knew no more than he did about precisely how to go about it. It was precisely for that reason that the boatswain had specifically asked for the person concerned to be there as the officer in charge.
The decision of the person concerned to operate the hatch carrier himself was unwise because this meant that he was unable to maintain an overview of what was happening, what the others were doing and where they were standing. The fact that – as argued by the person concerned – this involved teamwork is not an excuse since this does not absolve him of his responsibility as the ship's officer in charge. It was his duty to ensure that the inexperienced apprentice and the boatswain were not located in the gangway under the crane frame on the starboard side, especially when the crane frame was mounted on the securing pins and people were working on knocking out the securing pin on the starboard side.
The essence of the charge against the person concerned is that he has failed to understand what was expected of him as the ship's officer in charge and with responsibility and to act accordingly. This first concerns continuing the work without consultation or making enquiries and without sufficiently considering and studying the given situation, as a result of which he failed to appreciate the potentially dangerous situation that had arisen and that the danger would manifest itself if the securing pin on the starboard side was removed. The second concerns his failure to ensure that the other crew members were not standing in a dangerous place, which does not absolve them of their own responsibility in this regard. The person concerned had a special duty of care towards the inexperienced apprentice.

A suspension of the navigation licence is an appropriate disciplinary measure for this conduct. Despite some mitigating circumstances that may be taken into account, the failure of the person concerned is so serious that it is not sufficient to suspend his qualification, on a fully conditional basis. A suspension of twelve weeks, ten of which on a conditional basis, was imposed.

The Disciplinary Court concurs with the wish of the inspector that as a result of this accident and this ruling, the importance of the responsibility and duty of care of ship's officers towards the other crew in the context of occupational safety and the prevention of accidents and injuries should once again be brought to the attention of the professional grouping as a whole.

SINGELGRACHT

RULING OF 26 APRIL 2017
NO. 6 OF 2017
CASE 2016.V6

Person concerned: the captain and officer of the watch

In the morning of 20 February 2016, the freighter Singelgracht, carrying wood pulp, left Portland, Maine (USA) for Izmir (Turkey). Despite the completion of a proper voyage plan, the Singelgracht ran aground in local shallows (Jordan Reef) just outside of Portland harbour. According to the statement of the person concerned, this was caused by the fact that he was focusing on the radar screen and was distracted by the jumping of the waypoints entered in that screen. This led to confusion; he was not aware of the ship's actual position and changed course too late/insufficiently.

In the judgment of the Disciplinary Court, it is fair to assume that this could have been prevented if he had set out a parallel index line sooner and paid closer attention to the buoys, for example. The lack of attention to the ship's correct position constitutes culpable negligence, which resulted in the grounding. The Disciplinary Court made reference in this context to the provisions of the STCW-Code for the holding of a bridge watch, Chapter VIII – Section A-VIII/2 – Part 4-1 Performing the navigational watch – Article 25: 'During the watch the course steered, position and speed shall be checked at sufficient frequent intervals, using any available navigational aids necessary, to ensure that the ship follows the planned course.'

A check carried out on board the ship on the orders of the person concerned directly following the incident revealed that seawater was entering the keel tunnel. There was also a report that the void spaces under the main engine were filling up. The intake of seawater was brought under control using the ship's pumps. After the Singelgracht had lain at anchor in a deeper area for one or one and a half days, it sailed to Halifax (Canada) in consultation with or on the instructions of the shipping company. The ship was inspected by divers and emergency repairs were made in Halifax. The person concerned, who had carried out his own stability calculation prior to this voyage to Halifax, has taken the position that the Singelgracht was still seaworthy after the incident, in which context he also made reference to the Westcon report.

The judgement of the Disciplinary Court was as follows. The Westcon report was from after the trip to Halifax. The matter at issue here is that prior to that voyage the person concerned did not have a clear image of the precise scope of the damage. He did not take sufficient account of the fact that the ship had sustained damage in several areas, especially on the ship's bottom, the propeller and the rudder. This damage would not necessarily lead immediately to new leaks, but could have been so critical/serious that the ship's movements could have caused new leaks, with consequences that were not entirely predictable/verifiable beforehand. In other words, the person concerned should have taken reasonable account of the fact that the whole of the ship's bottom could have sustained critical damage, both in terms of (potential) leaks and compromised strength. Without any further investigation he should not have assumed that the ship's seaworthiness was still guaranteed. He should have taken action in this regard, such as having the entire

ship's bottom, rudder and propeller inspected at the anchorage or in the nearest seaport and informing the classification society of the results. By failing to do so he acted contrary to the regulation of Section 4.1a of the Dutch Ships Act, to the effect that before undertaking a voyage the captain is obliged to ensure that his vessel is entirely seaworthy and that all relevant internal and external openings have been sufficiently closed. The fact that the voyage to Halifax was undertaken on the instructions of the shipping company does not absolve the captain of his own responsibility for complying with the regulation.
It was also the captain's own responsibility to make the report to the Shipping Inspectorate in accordance with Section 67.1 of the Ships Decree 2004 following the incident. There is nothing to show that before commencing the voyage to Halifax the captain ascertained that his report (to the shipping company by the shipping company) to ILT/Shipping had been passed on, and he should not have automatically assumed this to be the case.

The Disciplinary Court considered the conduct of the person concerned to be contrary to the care that he, as a good seaman, should take with regard to the persons on board, the ship, the cargo, the environment and shipping traffic (sections 55a and 4.4 of the Seafarers Act in conjunction with, among others, section 4.1a of the Dutch Ships Act and section 67.1 of the Ships Decree 2004).

The Disciplinary Court judged that the person concerned had seriously failed in his responsibility as captain, which jeopardised the safety of the people on board, the ship and its cargo and the surrounding area. In view of the seriousness of the evident behaviours a suspension of the navigation licence as demanded by the inspector – twelve months, with six months conditionally – was in itself appropriate. However there were reasons to strongly mitigate this demand in the favour of the person concerned, such as: (i) the fact that there were no accidents; (ii) the fact that the grounding exhibited behaviour that was (extremely) contrary to the principles of good seamanship but was not a wilful error, whilst the other two charges cannot be viewed (entirely) separately from the role of the shipping company in this matter; (iii) the fact that the person concerned did immediately report the incident to the shipping company and that the shipping company should have passed on the report immediately (and not after days had passed); (iv) the person concerned has been subjected to a serious disciplinary measure for the grounding by the shipping company, which had instructed him to make the voyage to Halifax after the incident, or proposed that he should do this, which does not in any way absolve the person concerned of his own responsibility as captain, but can be assumed to have influenced the (incorrect) decision that the person concerned made in this case; (v) the fact that the person concerned has demonstrated that he understands the error of his ways and (vi) the fact that he has been seriously mentally impacted by the entire event and its repercussions. All things considered, the Disciplinary Court considered it necessary to impose a suspension of the navigation licence for two months, one of which conditionally.

AMADEUS AMETHIST

RULING OF 10 MAY 2017
NO. 7 OF 2017
CASE 2016.V9

Person concerned: the captain

On 31 May 2016, the seagoing vessel Amadeus Amethist collided with its raising wheelhouse against IJzerlaanbrug over Albertkanaal in Antwerp. The wheelhouse was dislocated and seriously damaged. One of the people on board was seriously injured and was taken to hospital.

The Disciplinary Court's findings were as follows. It can be assumed that the accident was caused by a technical fault in the hydraulic pump of the raising wheelhouse, but this could have been prevented if the person concerned had pressed the button sooner, i.e. when the Amadeus Amethist could still have come safely to a halt after it had become clear that the hydraulic system was malfunctioning. According to the person concerned a distance of about 100 metres was needed to come to a halt, well over a ship's length. The fact of the matter is that the person concerned, who had not being sailing with the Amadeus Amethist for long and did not know how long it would take for the wheelhouse to lower normally, put his blind trust in the operation of the hydraulic system and did not press the button until the wheelhouse was about 40 metres away from the IJzerlaanbrug. In the knowledge that the Amadeus Amethist was not equipped with an emergency button to quickly lower the wheelhouse at the time, and without there being a maintenance history for the pump of the hydraulic system being known, he thus took the risk that a technical failure could have caused serious human suffering and substantial financial losses.
The conduct of the person concerned constitutes a violation of the regulation of Section 55a of the Dutch Seafarers Act in conjunction with Section 4.4 of that Act: acting or failing to act on board as captain contrary to the duty of care expected of a good seaman in relation to the persons on board, the ship, its cargo, the environment and shipping.

The Disciplinary Court was unconvinced by the argument of the person concerned that he wanted to maintain a clear view from the wheelhouse for as long as possible. The chief mate with the handheld radio telephone was fore, the waterway at the location was virtually straight and there were no other vessels manoeuvring at the time. Also, an electronic chart was being used. According to the statement of the person concerned at the hearing, he was not affected by the ship that was approaching aft.

In view of the seriousness of the proven conduct, a suspension of the navigation licence for one month would be appropriate. Given that the accident was caused primarily by a technical defect, that the person concerned did not act wilfully and that the accident, not least owing to the media attention, has had a serious impact on him, the Disciplinary Court saw good cause to stipulate that the suspension would be imposed entirely conditionally.

STELLA POLARIS UK 22

RULING OF 12 JULY 2017
NO. 8 OF 2017
CASE 2016.V10

Person concerned: the skipper

On 3 November 2016, the seagoing fishing vessel Stella Polaris UK 22 collided with the shore in the port of IJmuiden. The person concerned was not on board at the time.
During the night of 5/6 November 2016 it was discovered that the net hold and the forepeak of the vessel were full of water. The person concerned was on board as the skipper at that time. An investigation revealed that there was a tear in the hull of the forecastle, followed by a dent.
Without the damage being repaired and without this having been reported to the ILT, the ship put to sea from IJmuiden to Stellendam under the command of the person concerned on 9 November 2016. On arrival there, the person concerned contacted Port State Control/ILT and informed it of the damage and the leakage.
On 6 November 2016 the person concerned carried out a further investigation into the damage to the vessel in IJmuiden.
There was a large horizontal crack in the forepart at the forepeak and the net hold, which ended approximately 1 m in front of the bulkhead position between the net and fish holds. Following on from the tear, towards the stern, there was a deep dent, partly at the level of the fish hold. The tear and the dent were located about 30 cm above the waterline. No other damage in the hull was visible, either above or (during a dive investigation) under water. The visible damage could be explained by the collision on 3 November 2016 in the port, when the top of the vessel struck a sheet pile that was protruding from the water. Once the net hold and the forepeak of the moored ship had been pumped out on 6 November 2016, these holds did not fill up again.
It has not been demonstrated, and nor has a plausible case been made, that the collision caused any damage to the ship's structure other than the tear and the dent in the ship's hull above the waterline and some damaged trusses.

The integrity of the ship's structure, especially that of the holds that were partly under the waterline and which provided the ship's floating capacity, was compromised by the damage. The person concerned was apparently aware that if the ship put back to sea, the big tear would cause the net hold and the forepeak to quickly (mostly) fill up with water again, as a result of the bow wave and the swell. Initially there was also a certain amount of free water surface, which would not improve the ship's stability.
However, the net hold and the forepeak were relatively small compartments: the net hold measuring approx. 9 m^3 and the forepeak even smaller.
The dimensions of the Stella Polaris UK 22 were: 224 BRT, length 29.80 m, breadth 7.90 m and draught 6.25 m. If the two compartments in question were full of water, there was an estimated 13 tons of extra weight. Fifteen tons of diesel had been loaded into a tank in the forecastle.

For the seaworthiness of the ship it was crucial that the bulkhead between the net hold and the fish hold did not fail. Also in view of the construction drawing, there are no concrete indications

that there was a danger of the bulkhead failing. It can be assumed that there was no danger that water could flow into the fish hold along the channels in this bulkhead. Nor was it plausible that the tear/dent would increase in size sailing, whether or not at sea.
It appears that the weather was calm on 9 November 2016.
The autopilot could not be used, but the vessel could be steered by hand.
The electricity in the forecastle was cut off from that of the rest of the ship. It can therefore be assumed that there was no risk that short-circuiting might occur elsewhere on the ship owing to the damage to the forecastle.
The vital functions were apparently not in danger: the use of the propulsion, steering, and anchoring (by letting out the anchor chain). It appears that the ship was fully manoeuvrable using the manual controls. The bow thruster is not used when sailing at sea.

The Disciplinary Court concluded that it has not been plausibly demonstrated that from the viewpoint of seaworthiness and safety it was not safe to put to sea with the ship from IJmuiden to Stellendam on 9 November 2019, especially since the vessel was sailing close to the coast in calm weather – in keeping with the weather forecasts – on a route with a duration of 5 - 6 hours. Accordingly, it has not been demonstrated that making this voyage under the command of the person concerned was contrary to his obligations as a skipper by virtue of the principles of good seamanship.

The Disciplinary Court did however see good cause to note that the person concerned should have had an emergency repair carried out in IJmuiden by fixing a plate to the tear and the dent, after which the ship could have made the voyage with an empty (dry) net hold and an empty forepeak.

This was a case in which the vessel had obviously sustained damage leading to a suspicion that this could affect the vessel's safety.
Pursuant to Article 17.1 of the Fishing Vessels Decree, the person concerned, as the skipper, was obliged to report this damage to the ILT as soon as possible. He had ample opportunity to do this whilst in the port of IJmuiden. It can be assumed that the person concerned deliberately acted contrary to this rule. This rule is not for nothing: once a report has been made the ILT is able to investigate the damage and the ship's seaworthiness before it puts back to sea. This concerns the primary importance of safety when sailing at sea, not least the safety of the people on board. Violation of this rule therefore constitutes an act of the person concerned that was contrary to his obligations as the skipper according to the principles of good seamanship.
The foregoing does not however alter the fact that in this specific case it has not been demonstrated that the ship was unseaworthy for the voyage from IJmuiden to Stellendam. That circumstance did not in any way exempt the person concerned from complying with this rule. As the Disciplinary Court has found in previous rulings, it is not a matter for the individual skipper of a fishing vessel to decide when he keeps to the rules and when he does not.
The person concerned has acknowledged at the hearing that he should have notified the ILT in IJmuiden and has stated that he would do this straight away if it happened again.
The Disciplinary Court felt it sufficient to impose a fully conditional fine, in the expectation that the person concerned had learned his lesson.

MERWEBORG

RULING OF 03 NOVEMBER 2017
NO. 9 OF 2017
CASE 2017.V1

Person concerned: the captain and officer of the watch

The cargo vessels m/v Merweborg and m/v Estland approached each other on 26 January 2016 at around 09:00 UTC in the estuary of the Finnish Gulf at opposite or intersecting courses; the Merweborg was sailing at a speed of approximately 12.4 knots from east to west, when the Estland, sailing from west to east, approached her starboard side at a speed of approx. 8.9 knots. Based on the data obtained via the AIS, the CPA at 09:00 UTC was 0-0.2 nm.
Helsinki VTS (vessel traffic services) attempted – in view of the danger of collision – to contact the Merweborg on VHF channels 60 and 16 and DSC (digital selective calling), but the initial attempt was unsuccessful. Helsinki VTS heard that the Estland was also attempted to contact the Merweborg on channel 16. Shortly after that, at around 09:03 UTC, the Estland was seen to turn hard to starboard, followed by a less obvious change of course to starboard by the Merweborg.
During the contact that was subsequently made between Helsinki VTS and the Merweborg at around 09:05 UTC, the person concerned – who was the captain and the officer of the watch on the ship – said that he had been clearly aware of the situation for the whole time. Unlike Helsinki VTS, he had not heard any call from the Estland. He also apologised for failing to respond to the previous call made by Helsinki VTS.

The person concerned put forward the defence that the distance between the two ships at approx. 09:00 UTC, based on a starboard-starboard passage, was amply sufficient; he even mentioned a CPA of 0.8 nm.
However, the Disciplinary Court found that in view of the available radar and AIS data, the accuracy of this had not been demonstrated and could not be verified. This position of the person concerned has not been sufficiently substantiated in view of the observations and findings of the Finnish shipping authorities, combined with the sharp change of course made by the Estland at approx. 09:03 UTC. The person concerned has invoked the nautical equipment on board the Merweborg, but has not submitted a printout of the onboard data of the Merweborg. There is also no other support for his defence.
The person concerned has not denied that he initially failed to respond to the VHF calls of Helsinki VTS, which is also indicative of not being sufficiently alert to the observed situation. He did not hear or reply to the calls of the Estland at all, which is what prompted the Estland to make a sharp change of course in order to be on the safe side.

Viewed as a whole, the Disciplinary Court rejected the explanation of the person concerned as being incorrect, and it was presumed that the observations of the Finnish shipping authorities were correct. It followed from these observations that there was a risk of a collision and that, in order to prevent a collision, the person concerned failed to change the course of the Merweborg significantly from that of the Estland promptly and widely enough, whereas the situation so required. The person concerned, as the captain of the Merweborg, which was required to take

evasive action, has thus acted contrary to regulation 8a and 8b of the Convention on International Provisions for the prevention of collisions at sea, 1972.
Although the person concerned failed to act in accordance with the standards of good seamanship, for which he can be held accountable, it appears that the situation was ultimately kept under control. That is why the Disciplinary Court confined itself to issuing a warning. The passage of time since the incident and the medical issues of the person concerned were also taken into account in his favour.

NOORDERLICHT

RULING OF 03 NOVEMBER 2017
NO. 10 OF 2017
CASE 2017.V2

Person concerned: the captain and officer of the watch

On 18 September 2016 the sailing passenger vessel Noorderlicht grounded in Trygghamna, a bay in the northwest of the Isfjord, which is located on the west coast of the Norwegian island Spitsbergen (Svalbard). The person concerned was the ship's captain at the time. In addition to him, there were 22 people on board, including 17 passengers, who were taking a cruise on the Noorderlicht. The person concerned put into Trygghamna owing to the bad weather (strong wind); there was less wind in Trygghamna, and few or no waves. After entering the harbour the person concerned lowered the two raised sails, the fore trysail and jib. It did not prove possible to completely lower the fore trysail because the lines of the lazyjack got caught. For this reason the sail had to be raised again or the lazyjack had to be untied, neither of which was an easy task. The crew tried to solve this problem. The person concerned also went to help. For that purpose he left his position at the helm, without having somebody else take over the helm. By the time he returned to the helm the ship had changed course and had entered shallows. Going astern did not solve the problem: the ship had grounded with about two thirds of the hull resting on the seabed. It was not possible to refloat the ship with its own engine power. In view of the approaching bad weather (strong wind, southwest veering to west 8-9 Bft) and the presence of passengers on board, the person concerned decided to ask the Norwegian coastguard for assistance. The government vessel Polarsyssel, which was located about 7 miles away at the time of the call, came to provide assistance. The Noorderlicht was pulled free using a small boat deployed by the Polarsyssel. This went fairly smoothly because the tide was rising. A crisis organisation had been set up ashore, and the necessary measures had been put in place to deploy helicopters and provide accommodation for the people to be collected from the vessel. It did not prove necessary to use these facilities because there was no need to collect anybody from the vessel. The Noorderlicht, which had not shown any signs of leakage at the time, went to anchor close to the location of the grounding. The holds and bilge alarms were monitored during the night, and the following morning. Since the Noorderlicht was still not making any water, the person concerned continued the voyage. In this regard the person concerned stated that he knew how strong the ship was, which he had rebuilt with his partner in the nineteen-nineties and which dated back to 1902, and that he was virtually certain that only the reinforced keel beam had grounded on the rocks. In his opinion the Noorderlicht was still seaworthy after the grounding and the safety of the passengers was not at risk. To support this assertion he cites the diver's inspection carried out on 23 September 2016 and the annual maintenance service in December 2016, during which it was established that only minor damage had been sustained.

The person concerned admits that he failed to inform the ILT/Shipping of the incident. He offers as an excuse for this that he did not know that this was compulsory and that he believed that the captain of the Polarsyssel, who he regarded as being the representative of the governor of Svalbard, had no objection to his continuing the voyage. He did however report the incident to Register Holland on 20 September 2016.

The Disciplinary Court's findings were as follows. It is an established fact that the person concerned can be held accountable for the grounding of the sailing passenger vessel Noorderlicht. He wrongly left his position at the helm without ascertaining that it was safe to do so at that time. He thus acted contrary to the principles of good seamanship. This is exacerbated by the fact that there were quite a lot of people on board, including 17 passengers, which makes this a serious error. The person concerned continued the voyage the following day, without the underwater hull first being properly inspected. No matter how certain the person concerned was – based on his knowledge of the ship's construction – that the grounding had not affected the ship's seaworthiness, and despite the fact that this subsequently proved to be correct, his unilateral decision to continue the voyage with 22 other people on board without first having the outside of the underwater hull properly inspected is condemned in the strongest terms. As he acknowledged during the hearing, he could not be 100% sure of the condition of the ship's bottom after the grounding and being pulled free. He should have put safety first and either arranged an underwater inspection himself or asked the competent authorities how to proceed. On this point, too, he acted contrary to the principles of good seamanship. The same applies to his failure to comply with the obligation to notify; since there had been an incident that could give rise to doubts about whether damage or a defect had been caused to the underwater hull, which could have affected the safety of the vessel, the person concerned should have informed the Dutch shipping inspectorate; by failing to do so he frustrated the ability of the public authorities to intervene. The claim of the person concerned that he was not aware of the notification requirement is not an adequate excuse. It has not been plausibly demonstrated that the permission of the Norwegian authorities was obtained to continue the voyage without having the underwater hull inspected.

The Disciplinary Court judged that the person concerned had failed in his responsibilities as captain. This applies first and foremost to the – in the words of the person concerned – stupid mistake that resulted in the Noorderlicht running aground and also to the decision to continue the voyage without having the underwater hull thoroughly inspected after the ship had been refloated and the non-compliance with the obligation to notify (contrary to section 67.1 of the Ships Decree 2004). On these points the person concerned did not act in a manner befitting a responsible captain/officer of the watch, which meant that the safety of the crew, the vessel, its cargo, and the environment were jeopardised. Especially in view of the presence of a large number of people on board, including passengers, the person concerned could reasonably be required to comply strictly with these regulations.
In view of the seriousness of the evident behaviours a suspension of the navigation licence for a period as demanded by the inspector of six months, of which three conditionally, was in itself appropriate. However, this was departed from in the favour of the person concerned. The following circumstances have played a role in this regard: (i) the person concerned had not had any previous convictions under disciplinary or criminal law for marine law violations; (ii) the person concerned acknowledged that he acted wrongly and has learned from what happened; (iii) the person concerned was not currently sailing and (iv) the adverse effects of the grounding were relatively limited. All in all, a suspension of the navigation licence of four months, three of which on a conditional basis, was deemed appropriate in this case.

HEKLA

RULING OF 15 NOVEMBER 2017
NO. 11 OF 2017
CASE 2017.V3

Person concerned: the captain and officer of the watch

On 15 March 2016 the freighter Hekla grounded in the Kolding Fjord in the approach route to the port of Kolding, Denmark, to what was the starboard side of the waterway for this ship. The Hekla's captain was keeping watch on the bridge at the time of the grounding. He was steering the ship manually. He was following the electronic chart on the ECDIS. There was a radar device operating on the bridge. The echo sounder was switched on. The mate was also on the bridge and was keeping lookout. It was dark. The weather conditions were excellent.
The person concerned was well acquainted with this route and sailed without a pilot.
The ship was loaded and in IJmuiden it had a draught of 5.6 m forward and 5.35 m aft, averaging 5.475 m, which is slightly more than the permitted draught according to the summer deadweight of 5.40 m.
The ship may have been slightly lower in the water owing to the fresher water in the Kolding Fjord. The person concerned estimated this extra lowering at 10 cm.
The depth of water in the channel where the ship grounded was 6.80 m. The detailed chart on the ECDIS screen, which the person concerned was watching before and during the grounding, showed a line on the starboard side of the channel with a number 6 where the water had a depth of 6 metres. There were three green buoys more or less over that six-metre line.
This ECDIS chart showed the planned route with waypoints and a course line entered by the person concerned during the voyage preparation. Past the third green buoy the ship had to turn to starboard to enter a narrower channel.
After passing the second green buoy the ship ran aground, with the bows over the six-meter line. There are several possible causes for this grounding. According to the person concerned, he did not turn too soon to starboard, and had also greatly reduced speed to 4.5 knots. The file does not contain any further information about the ship's course and speed. The petitioner, the person concerned and the shipowner all agree that the grounding was caused by suction phenomena. The Disciplinary Court's findings in this regard were as follows.

The channel between two six-metre lines was shown in the chart. The three green buoys to starboard were more or less on the six-meter line. It follows that the marked waterway did not have the same depth of 6.8 m all along. This was less close to the green buoys. It seems that the seabed rose there. The Hekla passed the second green buoy at a short distance; the person concerned estimated the diagonal distance at 10 m. This also means that the Hekla was at the same short distance from the six-metre line at that time. The bows of the Hekla rose up just past that buoy. The seabed was soft and muddy there. It can be assumed that the seabed may have increased, possibly gradually, from that six-metre line. The bows of the Hekla had a depth of 5.60 m, with 10 cm extra to make allowance for the fresh water making this 5.70 m. For the average draught that is 5.475 m plus 10 cm = 5.575 m. The water depth under the ship, particularly under the bows, was therefore very limited.

This vicinity of shallow waters, with the addition of the limited UKC, seems to have caused suction phenomena that affected the grounded vessel, which resulted in the ship being pulled to starboard between the buoys and over the six-metre line into the shallows, where it grounded.

The Disciplinary Court did not share the opinion of the person concerned that he cannot be held responsible for the grounding. The person concerned was officer of the watch on the bridge and was steering the vessel. His approach to navigating the ship shows that he did not take sufficient account of the suction phenomena that could have been expected: close to the second green buoy and therefore close to the six-metre line, with a marginal UKC.

There was no need whatsoever to navigate in this way: the breadth of the channel was amply sufficient to turn much further away from the six-metre line and there was no other shipping. The grounding could indeed have been prevented.

It followed from the foregoing that, in the judgment of the Disciplinary Court, the person concerned had not acted as befits a good seaman with a view to the ship, the people on board, the environment and other shipping traffic.
The ship did not sustain any damage because it rose up in the mud and the seabed at that position was soft. No environmental damage was caused.
The Disciplinary Court ruled that, in view of the seriousness of the conduct, a suspension of the navigation licence for two months was appropriate. In view of the facts that the person concerned took the correct measures on and around the ship after the grounding and no actual damage was caused, the Disciplinary Court saw good cause to stipulate that the suspension of the navigation licence would be imposed fully conditionally.

ALMA

RULING OF 20 DECEMBER 2017
NO. 12 OF 2017
CASE 2017.V4

Person concerned: the captain

On 18 May 2016 the container feeder Alma was at the CCT terminal in the port of Moerdijk, where the ship was unloaded and then loaded again with containers. The loading was carried out with two rotating CCT shore cranes. On board, the containers were secured with twistlocks, which were placed and closed by the Alma's crew. CCT inspectors were in contact with the crane operators by radio telephone. One man cage, owned by CCT, was present. This made it possible to transport the seamen using the shore crane. If properly positioned, the man cage could also be used by the seamen to work safely at heights, for which purpose a fall arrester was hooked between the steel cable in the man cage and a safety harness that they wore.
During a period of approximately one hour, various unsafe work situations arose – as can be seen in the film images – including crew members working at heights without any fall protection or safety harness or in which a seaman was located under or in the vicinity of a container that was being placed on board with a crane, or under the man cage.
An accident took place at approximately 20:45 hours. A container had not been correctly placed on the twist locks. To correct this, a shore crane lifted one short side of the container with a spreader, to make a space under that container and above the container under it. A seaman started working in the gap in between. At a given point in time he laid down on the lower container. The crane operator then lowered the top container, crushing the seaman and causing his death.

In the judgment of the Disciplinary Court, the person concerned, who was the captain of the ship and was resting in his cabin during the loading of the ship, could not be held responsible for the tragic accident and the death of the seaman. The action taken by the seaman – lying in the opening between a positioned container and a container lifted slightly on the one side, apparently to adjust a twist lock – was extremely dangerous, all the more so since it was not clear whether he could be seen there by the inspector or the crane operator. There was nothing to show that this had happened before; neither has a plausible case been made that anybody, the inspector in particular, asked him to do this. It can be ruled out that the inspector and the crane operator were aware that the seaman was where he was when the uppermost container was lowered onto the seaman. There is nothing to show that there was any communication between the seaman and the inspector shortly before that point in time. The dangerous actions of the experienced seaman could not reasonably have been foreseen by the chief mate, who was situated further aft and did not have a view of the scene of the accident, or the person concerned.

The Disciplinary Court also found that the charge made by the petitioner against the person concerned related not so much to the accident, but more to the way in which the crew worked when loading the ship with containers. More generally, the charge that the instructions of the safety management system regarding working at heights and loading and unloading containers were not fully complied with and that the person concerned did not adequately supervise compliance with

those instructions.
Section 63.1 of the Ships Decree 2004 stipulates: The captain of a vessel for which a safety management certificate is required, shall ensure that the safety management system prescribed in the ISM-Code is operated on board the vessel.
Therefore, the question to be answered was what the person concerned could be held specifically responsible for in this regard.

The Disciplinary Court first made a number of comments on this.
(a) In accordance with what the petitioner has put forward, responsibility for working safely on board is held primarily by the shipping company/maritime employer of the crew. This should be expressed not only by drawing up procedures and work instructions in the context of an ISM safety management system, but also by ensuring that there are sufficient qualified crew members and that the necessary safety equipment is provided in order to make it possible to actually work in accordance with those procedures and instructions and for this to be effectively supervised.

Consideration could also be given to concluding operational agreements with charterers, containing stipulations that have implications for the tasks and activities of the crew and the associated working conditions; it must also be possible to carry out these tasks and activities safely. The charter that had been completed for the ship meant that it had to be unloaded and loaded very frequently, with a relatively short shipping route in between. This was a demanding schedule for the person concerned as captain and for the whole crew. According to the charter, the twist locks had to be positioned by the crew.
It is the responsibility of the shipping company/ISM Company/maritime employer to ensure that work on board is carried out in accordance with the safety management system and to supervise this.
(b) The person concerned has shown that working safely was very important to him. Following the start of the charter he made efforts to ensure that a man cage would be used for loading and unloading and that the man cage contained the correct safety harnesses and fall arresters. He also saw to it that new crew members were familiarised and instructed.
(c) During the work on board the chief mate bore initial responsibility for maintaining supervision during the loading work and for correcting seamen who fail to work in conformity with the safety regulations and instructions. In view of the ship's schedule, the captain had to rest during that period. The mate also had various other tasks during the loading work.
(d) In keeping with the agreements made with it, CCT should have used a shore crane to place the man cage in such a way that the seamen could work from it with the fall arrester in accordance with the instructions. If it proved necessary to adjust the positioning of a container, the container in question should have been lifted and turned away in its entirety using a shore crane. To that extent, the cooperation of CCT was needed to work in accordance with the agreements.

The following was then considered.
The captain's task as outlined above and in accordance with Section 63 of the Ships Decree 2004 entails verifying that the instructions and work instructions of the safety management system are complied with as required. This means that he must also maintain supervision himself. To the extent that supervision with compliance is partly maintained by ship's officers, the captain must ensure that they keep him properly informed. He must also ensure that the safety committee regularly reports to him on compliance aspects.

With regard to the actual compliance with the work instructions for loading and unloading and for working at heights there was even more reason for this since – as argued by the person concerned himself – CCT in Moerdijk worked roughly and quickly and not always safely. This approach to work resulted in a container not being positioned properly on the twist locks, and this had to be corrected.
An additional reason to continuously check compliance with the work instructions was that the ship was loaded and unloaded at CCT three times a week. It is a generally acknowledged fact that with the course of time people who are frequently involved with working in dangerous situations become accustomed to this and less aware of the dangers and the need to continue to take appropriate safety measures.

The video images made on 18 May 2016 during a period of approximately one hour prior to the accident show that the safety instructions for working during loading and working at heights were not complied with on a very large number of occasions: the seamen were placing the twist locks – also at heights on the containers already loaded on board – without making use of fall arresters. They were not wearing a safety harness on which to connect the fall arrester. There were various times at which the seamen were close to containers that were being loaded with a shore crane; in some cases they were under or virtually under a hoisted container or man cage. There were times when personnel jumped from bay to bay and climbed down a container without any safety equipment.
The method used to adjust the positioning of the container involved in the accident was unsafe: the container was not completely lifted up and turned away so that the location was free to carry out the adjustment safely; on the contrary, the approach taken led to an immediately dangerous situation.
The first mate, the most appropriate person to supervise the work of the seamen during loading, stated that he had seen some of them, but not all of them. He had other tasks to perform and in many cases could not see the work being done by the seamen. It seems that he did not intervene or confront the seamen on their behaviour. He further stated: 'Working safely went well at the beginning of this charter but gradually, as a result of pressure from the shore organisation, the boundaries were pushed and we found ourselves in a grey area in which we allowed more and more leeway. There comes a time when you gradually find yourselves doing more without properly considering whether everything is going well. After the accident we were in agreement that we had allowed too much and since then we have all got back into line. Safety must always come first, the rest is secondary, even if the people ashore get annoyed or keep chasing us up. People will always push their boundaries, and we have those moments too. That sneaks in a bit; you feel a certain pressure; everything has to be done quickly. There must be no delays. Crew members are not allowed to ignore even one safety instruction, but it still happens.'

In view of the video images and the statement of the chief mate, the Disciplinary Court considers that a plausible case has been made that the approach to work caught on video was not exceptional but, on the contrary, had become the normal course of events. It must therefore be concluded that the safety management system was structurally and frequently not being applied in full.
The Disciplinary Court came to the conclusion that the person concerned should have included it among its tasks to regularly check the loading and unloading work in order to gain a clear impression of how it was being done. This is not necessarily precluded by the need to take sufficient rest. It seems that the chief mate did not tell the person concerned that the safety regulations were

being structurally ignored. There is nothing to show that the person concerned specifically and emphatically asked the chief mate whether the seamen had kept to the rules. There is nothing to show that the person concerned thus kept himself informed of the course of events during loading and unloading on the basis of reports of the safety committee. It can be inferred from the above that the person concerned did not sufficiently inform himself about how the work was actually being done, despite the fact that this was one of his tasks.

The use of the man cage with a fall arrester was essential to be able to work safely at heights. Its use required the man cage to be moved at the right time by a shore crane and placed near where the seamen had to work. If it was necessary to move the man cage in accordance with the crew's work instructions, this was to be done by the shore personnel. There is nothing to show that agreements on this were made with CCT and kept in practice. The same applies to an agreement with CCT on how to correct an incorrectly positioned container in such a way that the container in question was to be completed lifted up and turned away from the location. It appeared that no proper arrangements had been made for communication between the crew, in particular the seamen, and the staff of CCT, especially the inspectors, during loading and unloading. It seems that the direction of the use of the man cage and the method used to correct an incorrectly positioned container was not under the ship's control but was in fact determined entirely by the CCT personnel. Other than that, only one man cage was available, while at the same time containers were being placed in two places (fore and aft) with a shore crane.

It can be concluded from the above that the person concerned was fully aware of the importance of working safely, that he certainly made efforts to ensure that work was done safely, especially by providing safety equipment and instructing the crew, but that he did not do enough to ensure that the work was indeed carried out in accordance with the safety regulations and to ensure if necessary that this was done at all times. A good safety culture on board is of the greatest importance: creating and maintaining this is the direct responsibility of the captain.
It seems that this safety culture was not in place in practice, and had not been for a longer period of time. The work was being carried out structurally unsafely. The person concerned could and should have noticed this and put it right. The person concerned thus failed to sufficiently take a lead in bringing about and maintaining the desired safety culture in order to fulfil his statutory tasks pursuant to Section 63 of the Ships Decree 2004 and also his obligations according to the principles of good seamanship.

The Disciplinary Court judged that the person concerned had seriously failed in his responsibilities as captain for a longer period of time. This justifies a suspension of his navigation licence. The following was taken into account. The safety awareness and intentions of the person concerned were good in themselves. He certainly made efforts to ensure that the work was carried out safely. The person concerned has been greatly affected by the accident. Further measures have been taken in response to this. The above preliminary comments were also taken into account. It has not been demonstrated that the shipping company/maritime employer or the chief mate had also been called to account for this. The Disciplinary Court regards the facts and circumstances of this case sufficient cause to impose a fully conditional suspension of the navigation licence for three months.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2017

PRESIDING JUDGE

A.N. van Zelm van Eldik
Former vice-president of the District Court in Rotterdam

DEPUTY PRESIDING JUDGES

J.M. van der Klooster
Senior justice at the Court of Appeal in the Hague

P.C. Santema
Senior judge A District Court in Rotterdam

MEMBERS

E.R. Ballieux
Captain

R.J. Gutteling
Former captain

E.R. IJssel de Schepper
Captain

H. van der Laan
Captain

P.J. Lensen
Chief Engineer

R.A. Oppelaar
Captain

R.E. Roozendaal
Captain

C.R. Tromp
Captain

J.M. Bais
Skipper in marine fishing

A. Dekker
Skipper in marine fishing

H. Romkes
Skipper in marine fishing

W. Toering
Skipper in marine fishing

DEPUTY MEMBERS

J. Berghuis
Captain

S.M. den Heijer
Former marine engineer

T.W. Kanders
Ship's officer

O.F.C. Magel
Captain

D. Roest
Captain

P.H.G. Schonenberg
Ship's officer

J. van Vuuren
Captain

D. Willet
Chief Engineer

S. Kramer
Skipper in marine fishing

J.L. Schot
Skipper in marine fishing

P.L. van Slooten
Skipper in marine fishing

J.W.T.C. de Vreugd
Chief marine engineer in marine fishing (deep sea fishing)

A.J. de Heer
Former shipowner

C.J.M. Schot
Shipowner

J. Preesman
Former hydraulic engineer

T.S. de Groot
Registered pilot

R.J.N. de Haan
Registered pilot

T. Hamburger
Hydrographer

N.P. Kortenoeven
Hydrographer

SECRETARY

E.H.G. Kleingeld

DEPUTY SECRETARY

D.P.M. Bos