MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

ANNUAL REPORT 2018

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GENERAL

The year 2018 was a fairly busy one.

In this year, too, twelve cases where heard. All of the cases heard addressed the question of whether there had been any acts or omissions that came into conflict with the duty of care of the person concerned expected of a good seaman in respect of the persons on board, the vessel, the cargo, the environment and shipping within the meaning of Article 55a of the Dutch Seafarers Act.
Five cases concerned an industrial accident on board (including one fatality), four concerned a grounding and two a collision. There was also a fatal accident during a Neptune ritual.
In nine cases the person involved was the captain and in three cases the first mate was involved.
No fisheries cases were dealt with in 2018.
On one occasion the Disciplinary Board imposed the maximum two-year disqualification and in eight cases a shorter disqualification was conditionally imposed in whole or in part. In two cases the Inspector's objections were declared unfounded and in one a reprimand was sufficient.

Summaries of these twelve cases are given further on in this annual report. These summaries give only an impression of the cases handled.
The full text of the judgements is available in Dutch at www.tuchtcollegevoordescheepvaart.nl and in English at www.mdcn.nl.

On 1 November 2018, A.N. van Zelm van Eldik and P.J. Lensen stepped down from the Disciplinary Court on reaching the statutory age limit of 70. Mr van Zelm van Eldik held the position of presiding judge for over three years and had been the deputy presiding judge since the founding of the Disciplinary Court at the beginning of 2010. Mr. Lensen has also been a member of the Disciplinary Court since its foundation, and prior to that he was a member of the Maritime Court of the Netherlands for 16 years. The Disciplinary Court is grateful to both for all the work they have done for it. With Mr van Zelm van Eldik at the helm, the Disciplinary Court found itself in calmer waters. At the beginning of his term of office as presiding judge, the prospect of relocating the secretariat to The Hague was averted and more recently he fervently defended the interests of the Disciplinary Court when a reorganisation was carried out at the Human Environment and Transport Inspectorate. The undersigned succeeded him as presiding judge on 1 November 2018.
Dr W. van der Velde was appointed on that date as the new deputy presiding judge and is therefore also the first female member of the Board. She fulfils this role in addition to the current deputy presiding judge, Mr J.M. van der Klooster. Mr C. Kuiken was appointed as a new member of the Disciplinary Court. There were no changes in the manning of the secretariat.

During the year under review, regular consultations were held with the Maritime Affairs Directorate, Shipping Department, of the Ministry of Infrastructure and Water Management, and with the Human Environment and Transport Inspectorate (ILT), the shipping domain of that Ministry. Introductory meetings were also held with the new ILT managers and inspectors. This year talks were also held with representatives of the Dutch Association of the Merchant Navy Captains (of which the symposium to mark the 75th anniversary was also attended), Nautilus and the Public Prosecution Service.

Amsterdam, April 2019

Peter Santema, presiding judge

NEW CASES AND SETTLED CASES

In 2018 the Maritime Disciplinary Court of the Netherlands pronounced rulings in twelve cases. Thirteen 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.

In mid-2018, M. Schipper stepped down from his position at the ILT and was succeeded by inspectors K. van der Wall and S.E. Bakker.

The Disciplinary Court did not receive any complaints from interested parties during 2018. 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
2018	13	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 2018

ANNA

RULING OF 25 APRIL 2018
NO. 1 OF 2018
CASE 2017.V5

Person concerned: the captain

On 26 June 2017 fire broke in the engine room of the Dutch seagoing vessel Anna. At the time of the fire, the ship was in the run-up to Rotterdam, about 11 miles WSW from Hook of Holland.
It was accepted as an established fact that a lubricant sprayer had been activated in the engine room that morning and that the person concerned had instructed a cadet to stay in the engine room to shut down the engine according to the "normal procedure". The person concerned should have realised that a lubricating oil mist of small oil droplets could or would have been formed, and that a hazardous atmosphere was present which, with the oxygen in the engine room, could ignite or explode if it came into contact with a hot object.
The Disciplinary Board was of the opinion that the person concerned made the wrong decision when weighing up the various relevant elements, that he should have decided to stop the engine immediately with the emergency procedure and that he should have evacuated the engine room immediately. No factual information could be found in the file or in the discussion at the hearing with regard to the magnitude of the chances of damage to the ship's installation and a shipping hazard as a result of failing to follow the "normal procedure'. The decision he made meant that

he left a crew member, a cadet, in an apparently very dangerous situation in the engine room with an atmosphere that could ignite at any moment. This actually took place, as a result of which two crew members suffered serious burns. In view of the seriousness of the conduct a suspension of his navigation licence for two months was imposed by the Disciplinary Court.
The Disciplinary Court took a number of circumstances into account.
The person concerned was unexpectedly confronted with an emergency situation and had to decide and act under great time pressure. In the given circumstances, he was, in a sense, alone. After the fire had broken out, the person concerned had taken very effective action to combat the fire, to inform the traffic control centre and to evacuate the injured crew members from the vessel and to have them transferred ashore. In view of the above, the Disciplinary Court saw good cause to stipulate that the suspension of the navigation licence will be imposed fully conditionally.

FIDUCIA

RULING OF 25 APRIL 2018
NO. 2 OF 2018
CASE 2018.V2

Person concerned: the captain

On 25 August 2017 the Dutch freighter MV Fiducia ran aground in the shallows 'Boels Plade' in Denmark. The ship was on its way from Seville in Spain to Randers in Denmark with a load of 1,400 tonnes of steel.
The person concerned, who made the route and travel preparation, indicated that he consciously chose this shortest route in order to save fuel costs. The person involved considered the risks of a grounding to be minor and also the consequences of a possible grounding (given the flat and sandy soil) to be manageable.
The Disciplinary Court was of the opinion that the person concerned wrongly planned the route over the shallow part of 'Boels Plade' in his voyage preparation. The data on Fiducia draught and water depth clearly showed that the risk of a grounding was very significant. The person concerned had paid no attention at all to the squat and UKC. When the person concerned felt that the ship had started vibrating that night – indicating a low UKC – he should have instructed the chief officer to reduce speed or, if and as far as still possible, to redirect the route around the shallows. The party concerned apparently consciously omitted to do so. The Disciplinary Court did not share the view of the person concerned that a grounding was without risk. The presence of hard objects on the seabed (such as stones, lost cargo, anchors) could not be ignored.
The deliberate acceptance of the very high probability of a ship such as the Fiducia running aground could not, under the normal circumstances and in the absence of any need to do so, in any way be regarded as good seamanship. In view of the seriousness of the established conduct, a suspension of the navigation licence for 10 weeks was imposed, of which 5 weeks was conditional, with a probationary period of two years.

GUARDIAN

RULING OF 23 MAY 2018
NO. 3 OF 2018
CASE 2017.V8

Person concerned: the captain

On Thursday 29 June 2017, the Dutch seagoing vessel Guardian ran aground in shallows near the island of Storfosna in Norway. The ship was so badly damaged by this that at least the engine room and part of the accommodation were flooded and the pumps on board were unable to keep pace with this. The crew eventually abandoned ship via the life raft and nobody was injured. The ship did not sink, but a lot of material damage was caused.
The Disciplinary Court assumed that the grounding could have been avoided if either an alternative route had previously been placed in the ECDIS or if the Guardian – when it was decided to change course because of the swell – had first determined its location before proceeding at 14/15 knots in an area which the captain knew would be shallow. The person concerned could have had the Guardian follow the previous course for a while or, if necessary, stopped the ship until the new course was set in the ECDIS.
The person concerned was held especially accountable for not having prepared the voyage properly, for not having detailed nautical charts as a back-up for the vessel and for leaving the navigation to an able seaman who was not qualified for this. In addition, the Disciplinary Court, unlike the person concerned, considered the route to be difficult and dangerous, if only because of the many islands and shallows and because the shallows in which the grounding took place were not indicated by buoys or other means during the day.

In view of the seriousness of the proven conduct, a suspension of the navigation licence for two months was appropriate. Given that the person concerned and the shipping company had learned a lesson from the incident, the Disciplinary Court saw good cause to rule that the suspension of the navigation licence would be imposed conditionally for a period of one month.

SEA BRONCO

RULING OF 23 MAY 2018
NO. 4 OF 2018
CASE 2017.V7

Person concerned: the captain

On 23 December 2016 a serious accident occurred in the port of Vlissingen aboard the Dutch seagoing vessel Sea Bronco, in which the first mate of the Sea Bronco sustained a serious head injury. At the time of the accident the Sea Bronco was mooring alongside another tug, the Sea Bulldog. A forward spring had already been prepared and a crew member was working on the stern hawser on the afterdeck. The person concerned was using the towing winch to tighten a hawser connected to the towing cable from the back of the bridge. When the hawser tightened the person concerned did not stop the winch quickly enough, which resulted in the hawser snapping. The victim was located on the aft deck of the Sea Bulldog and was hit by the swaying end of the broken mooring line.

The Disciplinary Court also judged that in view of the pulling power of the winch and the safe workload of the hawser being used, this combination as a whole should not have been used to draw the two ships together. Furthermore, the hawser was turned twice around the drum, which not only increased the risk of the hawser getting caught and broken if it came between the turns of the steel towing cable, but should also have been noticed by the person concerned.

While the work was being carried out on deck the person concerned failed to ensure that all of the prescribed personal protection equipment, especially the helmet, was being worn correctly. While the towing winch was being used, the person concerned also failed to ascertain that there was nobody in the vicinity of the tightened hawser in order to rule out the risk of injury in the event of the hawser breaking.

Insofar as the person concerned has invoked partial force majeure, the Disciplinary Court considered this to be unfounded. First, it followed from the statements by the seaman and in particular the witness heard at the session that the tow winch operated by the person concerned continued to turn when it was already under tension and that the mooring line subsequently broke. In addition, it was not plausibly demonstrated that there was a sudden gust of wind as a result of which the breaking of the mooring line could be (partly) explained.

The Disciplinary Court judged that the person concerned had seriously failed in his responsibilities as captain. During the session – more than 15 months after the accident – the mate indicated that he still had cognitive limitations as a result of the accident. He was not able to speak properly for a long time. Also, the able seaman only narrowly escaped from being hit by the broken mooring line.

In view of the seriousness of the proven conduct, a suspension of the navigation licence for twelve weeks was imposed. Given that the person concerned realised the seriousness of the incident (he did not sail for a few months because he felt personally insecure and he came to the Netherlands to render account for what had happened), the Disciplinary Court saw reason to stipulate that the suspension of the navigation licence should be imposed for a period of six weeks on a conditional basis.

ACHTERGRACHT

RULING OF 04 JULY 2018
NO. 5 OF 2018
CASE 2017.V9

Person concerned: the captain

On Saturday, 14 November 2015, the then 21-year-old Filipino trainee/cadet S. died as a result of an accident. The accident took place in open sea on board the Dutch seagoing vessel Achtergracht. A few days earlier the Achtergracht had passed the equator. This was the first time for S., who was doing his internship on the Achtergracht, was the youngest of the 15 crew members and had not made any previous sea trips. Together with the chef, to whom the latter also applied, he therefore underwent the Neptune ritual. In the final part of the ritual he had to walk blindfolded over a wooden plank and make a jump at the end of it. Before the blindfold was put on, the wooden plank had been placed over the gangway from the hatchway coaming on the container rail, possibly with the end slightly outboard. This creates the suggestion that a jump should be made overboard from the gangway. After the blindfolds had been put on, however, the gangplank was pulled back to the hatch, up to about 2.5 metres from the edge, so that the jump inboard would end on the hatch. Before S. crossed over the gangway blindfolded and guided by a few crew members, he was first turned around several times. At the end of the plank he was encouraged by the bystanders to jump. The person concerned and the boatswain were ready to catch him between the end of the gangway and the edge of the hatch, but because S. – whether or not as a result of turning – jumped sideways, he slipped between the two, after which he fell forward with his head on the gangway approximately 2.5 metres below. S. died an hour later as a result of the resulting skull and brain damage.

The Disciplinary Court noted that none of those present at the Neptune ritual wanted this fatal accident or was prepared for it to happen. However, this accident should and could have been prevented. For example, when choosing to carry out the ritual on the hatch crane deck, adequate fall protection must be provided. This was not the case here: the screen to the lower side of the gangway was only formed by the person concerned and another crew member, who – wrongly – did not take into account that the blindfolded and possibly out of balance S. could make a sideways movement instead of jumping straight ahead. It was by no means unforeseeable that a fall of a blindfolded person from the hatchway deck to the lower deck/gangway, approx. 2.5 metres, could have a fatal outcome.
By failing to take measures that were reasonably required with a view to the safe performance of the ritual at this location (the hatch crane deck), the person concerned, as captain of the Achtergracht, did not behave as befits a good seaman towards the still young S. In so far as the person concerned argues that he did not have the authority to do so as captain, this is a sign of a misconception regarding his position as captain of the ship. His authority is not limited to the working hours and the assigned activities, but also extends beyond them and also applies to the performance of a ritual such as the one at issue here, even if it is initiated and carried out by lower-deck crew members.
The argument of the person concerned that he was not the only person (at the ritual) present with

an officer rank and that it was therefore not fair/reasonable that only he was accused of a disciplinary accusation does not hold either. Here, too, he misconceived his position as captain and ignored the fact that safety on board the ship is primarily the responsibility of the captain. Moreover, the measures/provisions necessary to adequately cover the hazards associated with the ritual (a safety plan) should reasonably have been taken at an earlier stage than during its implementation. Those who undergo the ritual must be able to rely on their safety having been considered. All the more so since this applies to young people without much experience on board a ship.
In view of the seriousness of the negligence, a suspension of the navigation licence for the duration proposed by the inspector was appropriate in all respects. The fact that this was departed from in the favour of the person concerned was due to the fact that the person concerned showed remorse at the hearing and showed that he is well aware that care for the safety of the crew in general and for vulnerable cadets in particular must henceforth be given the highest priority. A severe measure did not appear necessary to press this home, even less so since the person concerned was suffering from something that is the last thing he wanted to happen. Another factor was that the person concerned had a good record of service and had not previously been punished for neglect in the area of safety. Finally, the fact that he would have to appear before a criminal court was taken into account in favour of the person concerned. All things considered, the Disciplinary Court considered it necessary to impose a suspension of the navigation licence for six months, three months of which conditionally.

SYMPHONY SKY

RULING OF 04 JULY 2018
NO. 6 OF 2018
CASE 2017.V10

Person concerned: the captain

On 11 June 2017 a collision took place between the Dutch seagoing vessel Symphony Sky and the Danish fishing vessel Frisk Fisk. The Symphony Sky was on its way from Gdansk to Pasajes. That afternoon it had been anchored at Skagen's roadstead for bunkering.
Weather conditions were good, daylight, wind SW4, light sea, no swell and good visibility.
The chief mate was the officer in charge of the Symphony Sky watch from the departure of the anchorage. The person concerned was also present on the bridge, as was a lookout.
The person concerned was accused by the inspector of not having sufficiently monitored the situation in his supervision of the navigation of the vessel, carried out by the chief mate, and therefore of not having taken timely action to rectify the errors of the chief mate, resulting in a collision.
The investigation of the Disciplinary Court showed that although the person's watch started at 20:00 BT according to the schedule, the person concerned and the chief mate had agreed that the latter would take over the navigational watch after departure from the anchorage, that the person concerned would in the meantime carry out administrative work elsewhere on the bridge – where the person concerned could be consulted if necessary – and that it was only when the person concerned had finished this work that he would take over the navigation watch from the chief mate again.
These were good and clear agreements and the person concerned and the chief mate also acted accordingly. The person concerned did not interfere with navigation after departure and had no view of it from his desk seat; in particular, he had no view of the fishing vessels approaching from port. There was no reason for the person concerned to doubt the ability of the chief mate to correctly maintain a navigation watch from departure onwards.
The Disciplinary Court was of the opinion that the person concerned had no obligation or reason to supervise the navigation by the chief mate in any way or to monitor the situation around the vessel. The person concerned could be consulted by the chief mate if he considered it necessary. This was not done. It was not demonstrated that the person concerned should have noticed that there was a risk of collision. It was only when the person concerned went to the front of the bridge an completion of his administrative work that he saw the dangerous situation with the Frisk Fisk on a collision course. The person concerned intervened immediately and appropriately. In the given situation, the person concerned could not be held responsible for the conduct of the chief mate prior to that time and his possible failure to take timely measures to prevent collision. The person concerned could be held liable for the fact that the Symphony Sky did not perform an evasive manoeuvre, such as a sharp turn to starboard. He did not have to intervene any sooner than he did. This was not altered by the fact that the person concerned was the captain.
It was concluded that the person concerned could not be held accountable for having acted in violation of the standard of good seamanship. The accusations made against him by the applicant were declared unfounded.

RUYTER

RULING OF 4 JULY 2018
NO. 7 OF 2018
CASE 2018.V3

Person concerned: the captain

On 10 October 2017 The Dutch seagoing vessel Ruyter was on its way from Lomonosov (St Petersburg, Russia) to Warrenpoint (Northern Ireland) with a cargo of timber. The person concerned was on watch from 20.00 to 24.00 hours.
The ship ran aground on the Northern Irish coast at 23.20 hours.
The Disciplinary Court established that for an extended period of time, approximately one hour, the ship had sailed on a straight course and at high speed towards Rathlin Island and ran aground on the rocky coast. From this and from the fact that the two navigating officers discovered immediately after the grounding that there was no one on the bridge, it could be deduced that the person concerned, who had not been on the bridge long before the grounding, had not been engaged in navigation, had not been keeping a lookout, had not noticed that the vessel was heading straight for the rocks and had not taken any measures to prevent a grounding. No crew member was posted as an extra lookout.
After the grounding, the person concerned did nothing at all, while the ship was in an emergency situation. The chief mate had to take command of the vessel.
When the ship was underway to Warrenpoint, the engine room fire alarm sounded. Apparently this was caused by the propeller shaft generator. Measures were once again taken, again under the command of the chief mate. Even then, the person concerned remained completely uninvolved.
The person concerned has shown himself to be a poor navigation officer and a poor captain. The person concerned did not give any explanation for his behaviour whatsoever, either in writing or orally, not even at the hearing of the Disciplinary Court. The Disciplinary Board did not consider that a sufficient degree of certainty – as required for such a serious act – has been gained to the effect that the person concerned was in an apparent state of drunkenness during his watch (and thereafter).
The person concerned has acted in breach of the provisions of the STCW Code on navigational watchkeeping, in particular the obligation to maintain a proper lookout and not to leave the bridge at any time and of Regulations 2 and 5 of the International Regulations for the Prevention of Collisions at Sea, 1972 (precautionary measure in accordance with good seamanship and a proper lookout).
In view of the seriousness of the conduct of the person concerned the Disciplinary Court imposed a suspension of his navigation licence for two years.
In doing so, the Disciplinary Board took into account the fact that the person concerned has been convicted by a criminal court in Northern Ireland for (1) not keeping a proper lookout and (2) not providing an adequate lookout during the hours of darkness, imposing on him two fines of 500 euro. Account was also taken of the fact that the person concerned had been relieved of his duties.

STAVFJORD

RULING OF 12 SEPTEMBER 2018
NO. 8 OF 2018
CASE 2018.V1

Person concerned: the first officer

On Monday, 13 November 2017, the seagoing vessel Stavfjord, belonging to Scheepvaartonderneming Stavfjord B.V. (Delfzijl) grounded off the coast of Nólsoy, a part of the Faeroe Islands. The Stavfjord, with nine crew members on board, was at that time underway with a cargo of gravel from Årdal and Tau in Norway to Sund on the Faroe Islands. The person concerned was duty officer. He had called up a pilot and subsequently received instructions from a pilot boat to go to pilot station Charlie. His intention was to follow these instructions. However, it emerged that he was not properly aware of the position of Stavfjord. As a result, the Stavfjord was able to steer straight for the coast of Nólsoy and ground. The grounding caused a leak in the forepeak. The person concerned did not make a statement about the event and did not respond to calls.
The Disciplinary Court concluded that the person concerned failed to properly fulfil his duties as duty officer; in particular he failed to determine and chart the ship's position frequently enough. For that reason he lacked situational awareness. This resulted in the grounding.
In view of the seriousness of the negligence, a suspension of the navigation licence for one month was appropriate. Taking into account (i) that the consequences of the negligence in this case were limited to some material damage to the vessel and (ii) that the shipping company (as a result of the incident) had apparently parted company with the person concerned, the Disciplinary Court saw reason to rule that the suspension of the navigation licence was to be imposed on a fully conditional basis. This sanction was in accordance with the Inspector's demand, which was communicated to the person concerned beforehand.

ZILLERTAL

RULING OF 12 SEPTEMBER 2018
NO. 9 OF 2018
CASE 2018.V4

Person concerned: the first officer

On Wednesday, 10 January 2018 a collision took place – 3.5 nm NW off "Skagen W" Lighthouse – between the Dutch seagoing vessel Zillertal (belonging to shipping company K&T Holland C.V. I) and the seagoing vessel Edmy sailing under the flag of Cook Island.
The person concerned was the only watchkeeping officer on the Zillertal's bridge at the time of the collision, because he had ordered the extra lookout to carry out an inspection of the gangways and the toilets. The person concerned had himself gone to the chart room, where he updated the ship's log. According to his statement, he had previously seen the Edmy slowly approaching the port side of the Zillertal.
This state of affairs showed that the person concerned did not properly fulfil his duties as officer on watch; in particular, he did not fulfil the obligation to maintain a good lookout at all times. In this case, this was all the more objectionable because of the presence of other shipping traffic. Furthermore, there were vessels changing course. The fact that the person concerned went to the chart room and did not constantly keep an eye on the approaching Edmy was also contrary to his duty to be alert at all times to the existence or development of the risk of collision. He should also have taken measures to avoid the risk of collision that came about.
In view of the seriousness of the negligence, a suspension of the navigation licence for three months was appropriate. In view of the fact that there have been no previous violations and that the consequences of the failure in this case were limited to material damage to the ships, the Disciplinary Court saw good reason to impose part of the suspension of the navigation licence – 1 (one) month – conditionally. This penalty was in accordance with the Inspector's demand, which was communicated beforehand.

ARAGONBORG

RULING OF 12 SEPTEMBER 2018
NO. 10 OF 2018
CASE 2018.V5

Person concerned: the first officer

On Wednesday 20 September 2017, an accident occurred on board the Dutch seagoing vessel Aragonborg. One crew member – the second mate – was seriously injured. At that moment the ship was unloading in Farnsund, Norway. On that day, the second mate was instructed to launch/lower the MOB boat as an exercise. To do this, he first wanted to unhook the hook of ship's crane 3 (partly lashed to the deck). For some reason, the hook could not be lowered, even after raising and lowering the hoisting cable a couple of times. The second mate then reported the problem to the person concerned and to the captain. The person concerned then agreed with the captain that he would take stock of the situation. On deck the second mate told him he wanted to solve the problem by slightly raising the crane jib. For this purpose the second mate wanted to go on top of the crane in order to have a clear view of the distance between the upper side of the crane jib and the lower side of the bridge wing. The person concerned saw that the hoisting cable was hanging very slackly. The person concerned therefore suggested that the cable be raised and lowered first, but because this meant that the cable would be wound tightly on the drum, this was stopped. A suggestion to turn the crane slightly outward did not present a solution either. The second mate therefore asked the person concerned (repeatedly and emphatically) whether he could continue with his intention to raise the crane slightly. After first having considered the matter, the person concerned eventually granted this permission, with the instruction to proceed very carefully. According to the person concerned, at that moment he did not know how tightly or loosely the hoisting cable was on the drum and could not assess the danger visually; he did not have a clear view of the situation and there was no visual/eye contact with the chief mate; only radio contact. The second mate gave the order by radio to slowly lift the crane. With a lot of noise the hook came loose. As a result, the steel hoisting cable suddenly tightened and struck the upper body of the second mate, who was seriously injured and lost consciousness as a result. He was taken to hospital by helicopter. It turned out that he had suffered a broken shoulder, cerebral swelling and a neck injury. He eventually recovered.

The Disciplinary Court took the view that that the second mate had acted irresponsibly by going (on his own initiative) to the top of the crane, in the vicinity of a slack hoisting cable, and then ordered manoeuvres aimed at freeing the jammed cable/crane hook. In accordance with the instructions in the 'Shipboard Operation Manual', in the context of this – also for him – unforeseen circumstance of a jammed cable/crane hook, he should first have held a 'safety briefing', together with at least the chief mate (the person concerned). It has neither been claimed nor demonstrated that the situation was so urgent that there was no time for reflection.

The Disciplinary Court shared the opinion of the Inspector that the person concerned also acted imputably wrongly in this matter. After becoming involved in solving this problem through the second mate's justified report of the crane hook being jammed, he should also have considered the associated risks in consultation with the other people present/involved, in particular the not inconceivable danger of a loosening or suddenly tightening hoisting cable. The fact that the

problem of the jammed crane hook occurred in the context of an activity assigned to the second mate and that the person concerned , who had only been 'called in to help', did not have a clear overview of the situation, unlike the second mate, did not constitute an adequate excuse for the person concerned failing to actively monitor the correct observance of the safety regulations.
The same applied to his statement that the second mate more or less drew up his own plan and insisted on approval of his intended action (to have a manoeuvre carried out on top of the crane to release the crane hook). It is precisely in situations such as this that use must be made of the existing authority structure on board, in which the person concerned was able to exercise authority over the second mate and could have ordered him to properly identity the safety risks first and in consultation.
In view of the seriousness of this negligence, a suspension of the navigation licence for 6 weeks was appropriate. Account was taken in the favour of the person concerned that his share in the occurrence of the incident was relatively small. Also taking into account that the person concerned was very shocked by what happened and had demonstrated that he was aware that he must never again allow a person to go on top of a crane in the vicinity of the steel hoisting cable under the described circumstances the Disciplinary Court saw good reason to impose the suspension of the navigation licence on a fully conditional basis. This penalty was in accordance with the Inspector's demand, which was communicated beforehand.

ATLANTIC DAWN

RULING OF 31 OCTOBER 2018
NO. 11 OF 2018
CASE 2017.V6

Person concerned: the captain

On 14, 15 and 17 October 2016, work was carried out in a tank on board the Dutch seagoing vessel Atlantic Dawn, while it was anchored off the coast of Saudi Arabia. The tank was first cleaned and chipped where necessary and then painted with a two-component paint. On the morning of 17 October 2016 the boatswain was the only one at work in the tank.
A cadet kept watch outside the tank and was in contact with the boatswain through oral communication and a lifeline. After the coffee break the boatswain first collected a faulty and dangerous cable from somewhere with a bare socket and a lamp, which he connected to a power outlet, after which he entered the tank. At a given point in time the boatswain lost consciousness in the tank. It can be assumed that the boatswain was then in the front compartment of the tank. After The cadet raised the alarm, it took the crew apparently almost half an hour, to get the unconscious boatswain out of the tank. He was dead on arrival at the hospital. Although only a limited investigation has been conducted into this matter, it can be assumed that the boatswain became unconscious and then died as a result of electrocution due to the use of the dangerous cord with its fitting. The person concerned is not being held responsible for the presence on board or the use of the dangerous cord, nor for the electrocution or death of the boatswain. Furthermore, it has not been shown that harmful vapours/gases in the tank, in particular from the two-component paint, or a lack of oxygen, played a role in the loss of consciousness or death of the boatswain.
The inspector's objections were aimed at whether this work should have been carried out on board, in particular whether it could be safely carried out. The tank was a confined space in the sense of the SWI (safe working instructions) no. 25. This entailed additional risks, especially when entering without the use of breathing apparatus: there had to be a constant supply of oxygen for the person or persons present there and harmful vapours/gases – in particular from the two-component paint used – had to be removed. This required a suitable ventilation system. Also, the atmosphere in the tank had to be properly tested beforehand, namely with a multi-gas detector for oxygen, hydrocarbons and if possible also for relevant harmful vapours/gases.
The Disciplinary Court had doubts about whether a ventilation system with fan and hoses was actually installed and used in the tank during the work. On the other hand, the Disciplinary Court could conclude with a sufficient degree of certainty that such a ventilation system with hoses was not used at the time.
If it were assumed that a ventilation system consisting of this fan and those flexible hoses, the end of which was suspended in the tank, was in operation during the work, then the Disciplinary Court – having regard to the capacity of the fan, the size and arrangement of the tank and the vent pipe – was of the opinion that this ventilation system was sufficient for an adequate supply of fresh air and the removal of harmful vapours/gases.
The Disciplinary Court assumed that the first mate performed two measurements on each of the three working days mentioned: before work started at 8.30 hours and after the coffee break at 10.35 hours. Only two oxygen measurements per day were carried out. This frequency of measure-

ment cannot in itself be considered sufficient. It would have made sense to do an oxygen measurement after every work interruption. On the other hand, the Disciplinary Court was of the opinion that, if the ventilation system was constructed and operated as indicated in the defence, there would be no fear of a shortage of oxygen in the tank. An additional risk of working in this tank was the limited space and compartmentalisation. As this accident clearly showed, it was particularly difficult in an emergency to provide adequate assistance to someone in the front compartment of the tank and to evacuate them quickly from the tank. With a properly functioning ventilation system, there was little chance that anyone in the tank would become unconscious due to a shortage of oxygen or due to harmful vapours/gases from the paint. It could be assumed that if the ventilation system failed, both the person in the tank and the watch would notice this immediately. The use of a bare-ended dangerous power cord, which most likely led to electrocution, was not permitted, and its use with the fatal consequence cannot be considered as something that could reasonably have been taken into account. Against the background of these circumstances, it went too far for the Disciplinary Court to say that working in this tank (or even carrying out an inspection in it) was unsafe due to its size and layout and in view of a possible emergency situation and should therefore not have been permitted.

On the basis of the above, the Disciplinary Board concluded that – assuming that the ventilation system with the fan and hoses was in operation – it did not appear that the work in the tank could not be safely carried out and that it should therefore not have been carried out.

The inspector's allegations against the person concerned were therefore unfounded. No disciplinary measure was therefore called for.

NIEUWE DIEP

RULING OF 28 DECEMBER 2018
NO. 12 OF 2018
CASE 2018.V12

Person concerned: the captain

On Sunday, 4 March 2018 an accident occurred in the port of Terschelling on board the State vessel Nieuwe Diep, in which the boatswain was struck by a breaking mooring line. The mooring line struck against his helmet and hearing protector/headset, causing him a fright but leaving him otherwise unharmed. To be on the safe side, the crew member was taken to the hospital.
At the time of the accident the Nieuwe Diep was in the process of mooring. This was hampered by quantities of ice between ship and shore. First the stern was pulled to shore by a capstan on the stern. After an unsuccessful attempt to pull the vessel alongside with a mooring line from the forecastle, the imminent victim tried the same, without being instructed to do so, with the capstan on the work deck and a mooring line from there to shore. At that point the mooring line snapped. The person concerned had not yet at that time indicated to the crew that the mooring was complete. There was no communication between the person concerned and the boatswain, not even when it was not possible to get the starboard ship closer to the shore and he decided to consult with the mate.
According to the Disciplinary Court this showed that the person concerned, who was responsible for mooring as captain, although there were special circumstances due to the great ice conditions, did not organise a toolbox in advance and did not give any instructions to the deck crew at all, not even when the mooring gradually proved to be difficult. It can be assumed that if the person concerned had done so, the boatswain would not have used the (stronger) capstan on the work deck to pull the vessel closer to the shore. Also, not only the boatswain would have been charged with using mooring equipment.
The Maritime Disciplinary Court judged that the person concerned failed in his responsibilities as an acting captain, which resulted in the accident.
Given the circumstances in which the person concerned was working on a vessel other than his own as acting captain, that no serious injury occurred, that the victim was probably only transported to the hospital because of his medical history (and that no report would probably have been made otherwise), that the shipping company was primarily responsible for the safety culture on board (and that seemed to have failed here) and that the person concerned himself has learned lessons from this incident, the Disciplinary Board considers it sufficient to impose a reprimand.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2018

PRESIDING JUDGE

A.N. van Zelm van Eldik
until 1 November 2018
Former deputy presiding judge of the District Court of Rotterdam

P.C. Santema
from 1 November 2018
Senior judge A 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
until 1 November 2018
Senior judge A District Court in Rotterdam

W. van der Velde
from 1 November 2018
Lector Maritime Law at Maritiem Instituut Willem Barentsz

MEMBERS

E.R. Ballieux
Captain

E.R. IJssel de Schepper
Captain

C. Kuiken
from 1 November 2018
Ship's officer

H. van der Laan
Captain

P.J. Lensen
until 1 November 2018
Chief Engineer

R.A. Oppelaar
Captain

R.E. Roozendaal
Captain

C.R. Tromp
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)

DEPUTY MEMBERS

A. Aalewijnse
Chief Engineer

J. Berghuis
Captain

G. Jansen
Chief 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

J.K.J. Bout
Skipper in marine fishing

H. Hakvoort
Skipper in marine fishing

H.J. IJpma
Skipper in marine fishing

H. Schaap
Formerly skipper in marine fishing

A.J. de Heer
Former shipowner

C.J.M. Schot
Shipowner

E. E. Zijlstra
Hydraulic engineer

J. Preesman
Former hydraulic engineer

T.S. de Groot
Registered pilot

R.J.N. de Haan
Registered pilot

T. Hamburger
Hydrographer

N.P. Kortenoeven-Klasen
Hydrographer

SECRETARY

E.H.G. Kleingeld

DEPUTY SECRETARY

D.P.M. Bos