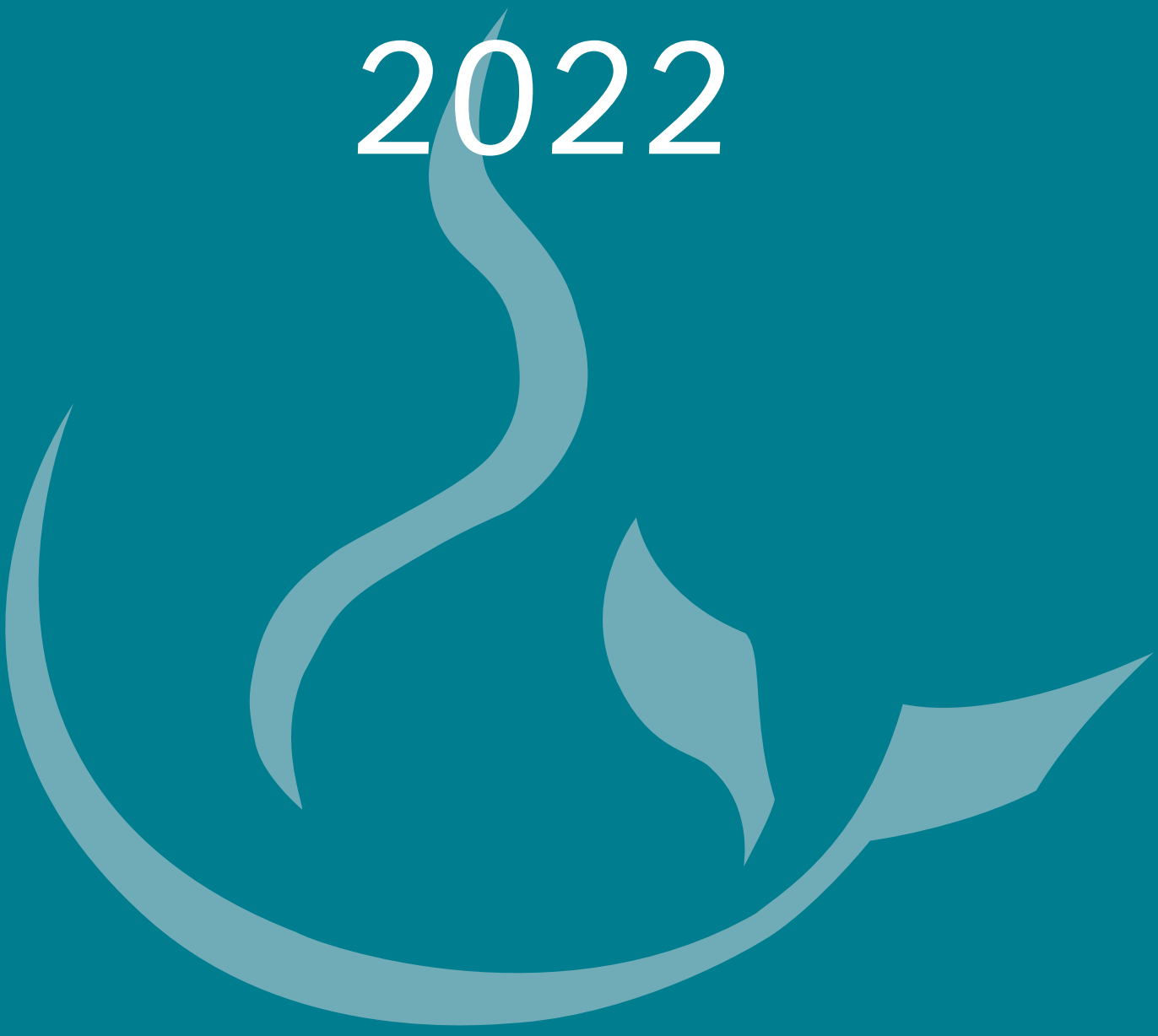
MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

ANNUAL REPORT 2022



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 2022

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GENERAL

We are pleased to present the new annual report of the Maritime Disciplinary Court of the Netherlands.

The absolute climax was without doubt the fantastic get-together to celebrate our 12½ year jubilee on 1 July 2022. After the Covid years, it was lovely to meet so many members and representatives of chain partners in real life again. The workshops were informative and inspirational, and have pointed us in the right direction for future activities!

In spring, a great deal of time was spent preparing for the jubilee event. By autumn, disciplinary cases where once again the order of the day. The Disciplinary Court ruled on 9 cases in 2022, 7 of which were decided by a full tribunal. Rulings were made in 7 cases. In one case, the maximum sanction of 2 years' suspension of the navigation licence was imposed. In another case, a complaint made by a seaman against the captain was ruled to be well founded.

Summaries of the settled cases are given further on in this annual report. These summaries give only an impression of the cases handled. The full text of the rulings can be found in Dutch at www.tuchtcollegevoordescheepvaart.nl and in English at www.mdcn.nl.

Several meetings were held with the Maritime Affairs Directorate, Shipping Division, of the Ministry of Infrastructure and Water Management, and with the ILT Inspectorate.

At the end of the year, we bade farewell to our member Hindrik van der Laan, to our permanent secretary Edwin Kleingeld and to Lotte Batelaan, who worked as a freelancer for many years at our secretariat. We were pleased to welcome the replacement members of the tribunal, in Robert Boeijen, Vincent Engel, Wim Postma and Andele Taekema.

Amsterdam, April 2023

Peter Santema (Chairman)

NEW CASES AND SETTLED CASES

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
2019	3	0	1	0	7
2020	12	0	0	0	5
2021	5	1	1	0	14
2022	12	0	0	0	7
Total	107	2	9	2	99

* In 2011 one case and in 2014 two cases were withdrawn by the minister.

RULINGS OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2022

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.

HEGEMANN II

RULING OF 20 JULY 2022
NO. 1 OF 2022
CASE 2021.K1-HEGEMANN II

Person concerned: captain

In this case, the complainant, a seaman, was involved in an accident on the Dutch trailing suction hopper dredger Hegemann II, on 7 July 2019. He was discovered prostrate in the vicinity of the vessel's pump room stairs, suffering pain in his head, neck and back.

The person concerned, the captain of the vessel, had examined the complainant and decided that he did not require acute medical attention. The vessel then continued unloading and dredging, and the person concerned did not take any further action to offer medical assistance or to consult the Emergency Manual.

It took a further five hours for the complainant to be removed from the vessel and transferred to a hospital.

The complainant submitted a complaint against the person concerned, in which he accused him of inadequate, indifferent and negligent action with regard to the accident, while offering very limited care. According to the complainant, the person concerned did not consult the Emergency Manual, seek medical advice or mediation from the Radio Medical Service (RMD) or contact the DPA. According to the complainant, this exposed him to physical and mental pain/stress for an unnecessarily long time (five hours).

The person concerned denied these accusations and stated that he had taken adequate and diligent action under the given circumstances.

The complaint was ruled to be well founded.
The concern for good seamanship includes the ultimate responsibility of the captain for the safety of and assistance to a crew member who suffers an accident.
The person concerned was confronted with a workplace accident of which the cause was not entirely clear. All indications were that the complainant had fallen down the stairs to the pump room shortly before. The complainant himself was unable to clarify the exact nature of the accident, and there seemed to have been some degree of loss of consciousness. The chief officer/engineer was initially unable to establish contact with him, because the complainant was coughing severely. A fellow seaman/AB referred to the complainant as being short of breath and confused. The complainant himself complained of pain in his back, neck and head. Although no external injuries were observed, and the complainant was still able to move and eventually managed to get up with the help of others, the possibility of internal injuries could not be ruled out.

Under such circumstances, whereby there was limited medical equipment on board (extensive equipment is not required for the vessel, as it can and must return directly to shore in case of an accident) and a physical examination was not possible, the person concerned should have consulted a doctor/medical body regarding his observations/findings, also as reassurance to the complainant, and should have immediately sought medical assistance and contact with the Radio Medical Service in order to determine the (severity of) the situation together with that service, and to establish any further steps to be taken. This is prescribed by the Emergency Manual in the event of a fall from a height, and any suspicion of back injury.

However, the person concerned had not immediately sought medical assistance. After the complainant was found at the bottom of the stairs, it took about 4.5 hours before he was examined by ambulance staff and taken to hospital for a medical examination.
The Disciplinary Court ruled that the person concerned failed in his duty as captain. As a result of the omissions referred to above, he did not act as befits a responsible captain in the event of a working accident on board the vessel.
However, the person concerned did not leave the complainant to fend completely for himself. The captain was (eventually) able to gain contact with a local project manager, who had immediately organised an ambulance. He also monitored the complainant's condition in the meantime. It was not plausible that the delay caused or exacerbated any injury. Moreover, the complainant was an experienced person who proved to have the necessary communication skills, at the Disciplinary

Court hearing. The signals he gave out on the day of the accident gave cause to assume that his condition might not be so bad. These circumstances weighed to the advantage of the person concerned in the choice of settlement by the Disciplinary Court.

The Disciplinary Court also appreciated that the person concerned was a "first offender" who had learned from the incident, which had not been an easy experience for him. The Disciplinary Court therefore considered it sufficient to impose a reprimand.

STAVFJORD

RULING OF 20 JULY 2022
NO. 2 OF 2022
CASE 2021.V5-YYDEN

Person concerned: the chief officer

This case concerned a coalition between the Stavfjord motor vessel and the Buster, a Danish fishing vessel, near Skagen on 16 May 2021.

The inspector accused the person concerned of failing to keep a proper lookout, of ignoring the relevant COLREG rules for giving way, of failing to take measures to prevent a collision and, after the collision, of not reducing speed and going round to quickly reach the affected fishing vessel. The demand was to impose a suspension of the navigation licence for a period of 8 weeks, 4 weeks of which conditionally.

The person concerned did not put forward a defence regarding the required disciplinary reprimand, and leave was granted in default of appearance against him.

The Disciplinary Court ascertained the following. The person concerned saw the Buster approaching on the starboard bow and was monitoring the Buster on the radar and the Ecdis. When the Buster was about five miles away, the person concerned began to plot the Buster. The person concerned believed that the Buster was doing about five knots and assumed that the Buster would not change course, and would cross behind the Stavfjord. The skipper of the Buster was sailing at a speed of five to seven knots. There was no lookout on the Stavfjord bridge at the point of impact. The person concerned was suffering from abdominal pain, had gone to the toilet before the collision and had fallen asleep for a good ten minutes.

The objections were declared well founded.
As the chief officer on watch, especially with the fast-moving Buster in sight, the person in question should have kept a good lookout, given way, taken measures to prevent a collision and, after the collision, gone round to give assistance to the Buster. He was negligent on all these points.

In view of the seriousness of negligence towards his responsibilities as chief officer, the Disciplinary court imposed a six-week suspension of the navigation licence as well as a fine of € 2,000.00. This sanction was more severe than proposed by the inspector, due to the seriousness of the negligence. The fact that no personal injuries occurred and that the damage was limited were factors taken into account in favour of the person concerned. Furthermore, the answers given by the person concerned showed him to be aware of the error of his ways.

This incident confirms that keeping a good lookout and continuing to follow the started radar plot are a must. The absence of a navigator on the bridge is to be avoided at all times during close encounters. The 'Colregs' regarding the duty to divert should also be strictly adhered to, even in case of any doubt or tight CPAs (closest point of approach).

BEAUMAIDEN

RULING OF 11 NOVEMBER 2022
NO. 3 OF 2022
CASE 2022.V2-BEAUMAIDEN

Person concerned: captain

This case concerned the grounding of the Beaumaiden vessel off the Danish island of Bornholm on 18 October 2021. The person concerned was on watch on 17 October 2021 from 20:00 to 24:00. There was no lookout on the bridge during this period. He went to lay down on his bed at around 23:40 hours and fell asleep. He had not called the 3rd officer to wake him for his watch from 00:00 to 4:00 hours. The ship sailed for about four hours with an unmanned bridge, on autopilot, before grounding off Bornholm, at a speed of ten knots.

The inspector accused the person concerned of having consumed approximately one litre of wine, both prior to and during his watch, of not having organised a good lookout during the hours of darkness, of having switched off the BNWAS "because it was annoying to have to press a button every few minutes", of having left the bridge at least twice during his watch, leaving it unmanned, and of not having returned to the bridge in the end, resulting in the vessel sailing with an unmanned bridge for about four hours. The inspector also accused the person concerned of having incorrectly completed the work/rest hours lookout records, of having committed forgery in the *Statement of Facts* written by him, of not having made entries in the vessel's logbook during his watch and of failing to effectively listen to the VHF canal 16, due to him listening to music on the radio at a very high volume. The demand (amended at the hearing) was to impose a 9-month unconditional suspension of the navigation licence and 6-month conditional suspension of the navigation licence on the person concerned and to enforce the outstanding 4-week conditional suspension of the navigation licence imposed on the person concerned in case 2019.V1.

The person concerned acknowledged all the objections raised by the inspector, except for the objection concerning forgery in *the Statement of Facts* written by him.
The person concerned asked that account be taken in the ruling of the fact that he had followed a treatment programme for his alcohol problem when he returned home and that he has since completed that programme.
Counsel for the person concerned indicated that he felt compelled to draw additional attention of both the Disciplinary Court and the inspector to "the deliberate indifference of a large segment of the maritime sector to legal requirements, such as posting a lookout and activating the watch alarm". Counsel for the person concerned further argued that putting "what is expected" in writing and signing for "truthfully completed" and "agreement" is commonplace.

The objections were ruled to be well founded, with the exception of the charge of forgery. The Disciplinary Court started by stating that the person concerned had an exemplary role as captain and must therefore refrain from consuming alcohol before and during watchkeeping and navigation of a vessel.

By not keeping watch and not navigating due to drunkenness, the person concerned seriously endangered the safety of those on board and of shipping traffic, and left the vessel and cargo to their fate. Had the vessel and another vessel approached each other on intersecting courses, this could have had disastrous consequences even before grounding.

Although counsel for the person concerned sought to argue that the person concerned acted in this way because he felt compelled to do so by "the culture in the industry", there was no evidence of this.

The Disciplinary Court understood that counsel was looking to broaden the case and draw attention to the correlation between crew size, watchkeeping, lookout and rest hour records. However, the Disciplinary Court did not further address that issue because in this case there was no violation of the *safe manning* regulations (even according to the person concerned), but rather a drunken captain who failed in his duty to keep a proper lookout.

Objection number eight was ruled to be unfounded, as the person concerned had adequately corrected the inaccuracy given in his previous statement (that he had called the *third officer* at the end of his watch) in his subsequent statement (in which he admitted not having called the *third officer*).

In view of the degree to which the attitude and behaviour of the person concerned were responsible for violation of the standard, the Disciplinary Court ruled the measure required by the inspector to be insufficient. The consumption of alcohol by the person concerned in his role as captain led to an unsafe social climate on board for at least some of the crew, even before the incident. 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.
Since the person concerned had, before the end of a probationary period, which was set at two years by the Disciplinary Court in case 2019.V1 (Alana Evita) on 20 November 2020, once again behaved contrary to his duty of care as a good seaman towards those on board, the ship, the cargo, the environment or shipping traffic, the Disciplinary Court imposed unconditionally the conditional four-week suspension of the navigation licence still outstanding from that case.

However, the Disciplinary Court does not see the fact that the person concerned has since completed an alcohol rehabilitation course to be a reason to rule otherwise, in view of the seriousness of the conduct, the fact that the person concerned was at fault again after the measure imposed on him in the Alana Evita case, and the dangers to which the person concerned exposed the crew, ship, cargo, environment and shipping traffic as a result of his conduct.

Practical recommendations

The safety of the ship and its crew requires social safety on board.
It is therefore recommended that shipping companies hang the complaints procedure at locations on board which are visible and accessible by all crew members, as prescribed in Standard A5.1.5 On-board complete procedure of the Maritime Labour Convention, in order to give crew members the opportunity to report any complaints to a confidant or to the Inspectorate, without the captain's knowledge if necessary.

There is a legal prohibition against performing duties on board while under the influence of alcohol, in connection with the safety and security of the ship and the protection of the marine environment. It is also recommended that shipping companies adopt a policy of not allowing alcohol consumption on board even outside the performance of these duties, or only to a very limited extent.

SCHOTSMAN

RULING OF 2 DECEMBER 2022
NO. 4 OF 2022
CASE 2022. V3 -SCHOTSMAN

Person concerned: captain

This case concerned a trailing suction hopper dredger, the Schotsman, which ran aground at a draught of 6.40 m or 6.05 m in the Westerschelde, close to buoy VH-2, just north of Breskens, on 16 February 2021.

The inspector accused the person concerned of the following:

1. the person concerned planned the route through a (navigation) area for which, on the navigation charts on board, it was not clear whether the water depth was more than the current draught of the Schotsman;
2. the person concerned did not include in the voyage plan, other than for the Hoofdplaat, any note on draught and UKC (Under Keel Clearance), i.e. even at the location of buoy VH-2;
3. the person concerned did not immediately report the grounding to ILT and the Classification Society, despite this being pointed out by an employee of RWS, who boarded the Schotsman immediately after the grounding;
4. the person concerned did not even report the grounding to his shipowner/the DPA;
5. the person concerned noted in the report to the Classification Society that the grounding took place at low speed, whereas film footage from Marine Traffic showed that the speed to be between 8 and 9 knots and the Classification Society was therefore misinformed;
6. the person concerned continued to make voyages with the vessel after the grounding, without informing the necessary authorities (ILT and the Classification Society);
7. the person concerned navigated using the Timezero map plotter, even though it is not an officially approved navigation device.

The person concerned considered the incident to be insignificant and that the objections should be declared unfounded.
With regard to the navigation, the person concerned did not dispute that he had planned the route through a (navigation) area for which, on the navigation charts on board, it was not clear whether the water depth was more than the current draught of the Schotsman, but stated that the exact depth in situ could not be determined from hard data and that he attached value to his many years of experience. There was possibly an incorrectly placed sand deposit at the site (hump). According to the person concerned, for a ship that almost always sails in relatively shallow waters, it could not be ruled out that a route may occasionally be chosen that, in hindsight, was unwise at the tide position in question. The person concerned also did not dispute that, except for the Hoofdplaat, the voyage plan did not include a note on the draught and the UKC (Under Keel Clearance), i.e. also not at buoy VH-2, but the person concerned did not believe he was legally obliged to do so.
Regarding the non-approved Timezero chart plotter, the person concerned argued that this does not mean that the chart plotter should not be used for navigation purposes.

With regard to the reports, the person concerned admitted that he did not immediately report the grounding to ILT and the Classification Society, despite this being pointed out by an employee of RWS (the third objection), but he claimed that the objection did not mention any time limit within which the grounding should have been reported.

The 5th objection was ruled to be unfounded by the Disciplinary Court, because the shipping company had reported to the Classification Society that the grounding had occurred at a low speed and it was not proven that this could be attributed to the person concerned.

The 7th objection was ruled to be unfounded, because it was not contrary to good seamanship to make use of all available means for navigation purposes, while the Timezero chart plotter was one such available piece of equipment. While Timezero was not approved as a primary means of navigation, there was no evidence that the person concerned had only used Timezero for navigation purposes.

The 1st objection was ruled to be well founded, because the evidence showed (with a sufficient degree of certainty) that the route was planned through a (navigation) area for which, on the navigation charts on board, it was not clear whether the water depth was sufficient to navigate safely with the current draught of the Schotsman. The water depth given on the paper sea chart was between 5 and 10 metres, while the vessel's draught exceeded 6 metres and the water level at the time of grounding was approximately 4 decimetres, and declining to 3 decimetres. The person concerned stated that he knew there were many shallows at this location and that he was aware of the sand depositing activities in the navigation area. He made a note of the depth soundings for his own use, but did not have the soundings for the day of the grounding. The person concerned should therefore have asked for a current water level in shallow waters outside the fairway for this particular sailing area to know whether the water depth was sufficient or should have waited for higher water or taken a different sailing route.

The 2nd objection was ruled to be well founded, because the evidence showed (with a sufficient degree of certainty) that, except for the Hoofdplaat, the voyage plan did not include a note on the draught and the UKC (Under Keel Clearance) i.e. also not at buoy VH-2. The voyage plan had not been updated in years. Making a voyage plan means setting an overall course, which had been checked to ensure safe sailing within certain margins – predetermined in the voyage plan. Voyage plans should include draughts, UKC, water levels and chart depths. Contrary to the claim of the person concerned, noting this information is indeed required by IMO Resolution A.893(21). Furthermore, it may be correct that this requirement was not easily enforceable during the dredging itself, but that was not what the Schotsman was doing during the incident. The preparation for the trip was flawed.

The 3rd and 4th objections, in combination with the 6th objection, were ruled to be well founded, because the evidence showed (with a sufficient degree of certainty) that the vessel continued to make voyages after the grounding, without immediately informing the ILT and the Classification Society and the ship owner/DPA. The Ships Act, Article 9(2), states that grounding must be reported "upon entry into a Dutch port". The Ships Decree, Article 67(1) states "as soon as possible".

If the grounding is not reported (on time), the authorities cannot take any action at their discretion, such as coming to the aid of the vessel and crew.

The Disciplinary Court imposed a suspension of the navigation licence for 3 weeks. This measure was conditional, because the person concerned had immediately informed the vessel traffic service (Common Nautical Authorities) (and in doing so had complied with the vessel's own Safety Management Manual) and had taken adequate measures to refloat the vessel, successfully within a reasonable period of time. The vessel had not suffered any damage.

Practical recommendations

At all times, the captain should inform the Classification Society and ILT before making subsequent voyages after the occurrence of an incident (grounding), when the incident involved the hull or the machinery and electrical installation.

In order to avoid routine-based navigation if the vessel makes the same round trips in the same area, the captain must carefully check the voyage plan and waypoints, taking into account changes in the positions of the buoys in the navigation area and adjusting this information in the voyage plan where necessary.

A chart for use as a means of navigation is only valid if it has been issued by or on behalf of an authority, hydrographic service or other relevant official body. Any means of displaying maps may be in support of navigation, but shall never serve as a primary means of navigation as referred to in Solas Ch V, reg 19-2.1.4.

SYDBORG

RULING OF 23 DECEMBER 2022
NO. 5 OF 2022
CASE 2022.V5-SYDBORG

Person concerned: the chief officer

This case concerned a workplace accident which occurred on 3 September 2021 on board the Sydborg, whereby the victim, an apprentice, suffered injury. While loading the ship at the port of Antwerp, using a quayside crane, the victim was instructing the operator of the quayside crane, as assigned by the person concerned, who as chief officer on board was in charge of the loading process. The apprentice did this from the hatches stacked at the rear of the hold, in front of the hatch crane. The hatch crane, which has a railing, was not used because there was insufficient visibility into the hold from there. From that location, however, there was a height of (much) more than 2.5 metres on three sides: to the port and starboard gangways and to the even deeper hold. Only the height aft of the hatches was less than 2.5 metres, i.e. 1.80 metres. The apprentice suffered a fractured fibula, a collapsed lung, head trauma and three bruised fingers in his fall, among other injuries.

The objection offered by the inspector consists of the following elements:

i. The victim was on board as an apprentice and performed his work on the instructions of the person concerned.
ii. Although the distance from the top of the hatches to the gangway was about 5 metres and the distance to the top of the tank in the hold was as much as about 11 metres, the person concerned did not consider this work to be working at heights.
iii. Despite regular safety committee meetings to discuss fall protection, the person concerned did not consider this work as working at heights.
iv. No use was made of the hatch crane to carry out the work from there. This was a much safer workplace because there is a railing (a collective safety measure) around the walkway.
v. It was partly because of these omissions that this workplace accident was able to happen.

The Inspector demanded the imposition of a suspension of the navigation licence for four months, one month conditionally.
According to the person concerned, the starting point should be that the responsibility for safe working on board, including its effective supervision, lies primarily with the shipowner/employer. Pursuant to Article 63(1) of the 2004 Ships Decree, on board a ship, in terms of performance of the task, this is the captain. The person concerned acknowledged that he may have a delegated duty of care but felt that the safety regulations and their practical implementation were not specific enough and unclear; there was no guideline stating what work was considered to be working at heights. It had not been established that the victim fell due to a failure to observe safety regulations. It was even unclear where he fell from and how he ended up in the gangway.

The inspector's objections were ruled to be well founded. It was sufficiently plausible that the victim fell from the stack of hatches. Given the height of more than 2.5 metres on three sides, the

safety rules for working at heights should have been observed. Those rules also require the wearing of a fall protection device.

In his capacity as chief officer in charge of the loading process, the person concerned had a (cf. Article 1 Ships Act under d, and Article 31 paragraph 1 Seafarers Act) duty to ensure that the victim could work safely when he instructed him to carry out that loading process. He should also have ensured compliance with the regulations applicable in that regard. The person concerned should have been extra alert to this, especially since the victim was an apprentice.

The ISM-SMS and Risk Assessment included safety regulations for working at heights. These safety regulations were regularly discussed in the safety meetings at which the person concerned was present. The person concerned failed to comply with these safety regulations and had not ensured compliance by the victim.

By virtue of Article 2 of the Working Conditions Act, this working conditions decree also applies to seafarers performing work wholly or partly outside the Netherlands on board seagoing vessels entitled to fly the Dutch flag under Dutch law. Article 7.23 of this decree imposes an obligation on the shipowner/employer to choose suitable work equipment if temporary work at heights cannot be carried out safely and under suitable ergonomic conditions on a suitable work floor. The shipping company/employer determines how this obligation is incorporated in practical regulations. On board, however, this must be implemented by whoever is responsible for the work being carried out at the time. That is primarily the captain who can also delegate this task and responsibility to, in this case, the chief officer.

In view of the seriousness of this negligence, a suspension of the navigation licence for 6 weeks was appropriate. This duration was shorter than the inspector's demand, as it took account of the measures already imposed in somewhat comparable cases, and with the circumstances that this was only the second deployment of the person concerned as chief officer, and that working at heights was only very generally discussed in the ISM-SMS, the safety meeting and the RI&E. There was no gross negligence by the person concerned. Moreover, he had drawn lessons from the event. He had been greatly affected by the accident suffered by the victim and had sought contact with the victim. For the same reasons, the Disciplinary Court saw good cause to stipulate that the suspension of the navigation licence would the conditional for 4 weeks.

Practical recommendations

It is recommended to explicitly mention in the safety protocols and draw attention to in the safety meetings that working on/from hatches not secured on all sides poses safety risks, and a height of more than 2.5 metres falls under the concept of 'working at heights', which is subject to safety regulations. From a safety point of view, loading supervision is (therefore) best done from the hatch crane. If that is impractical and the space on the (stacked) hatches is used for that reason, a fall protection device is required.

EEMSLIFT HENDRIKA

RULING OF 23 DECEMBER 2022
NO. 6 OF 2022
CASE 2022.V1 - EEMSLIFT HENDRIKA

Person concerned: captain

On Monday, 5 April 2021, the Eemslift Hendrika was en route from Bremerhaven to Kolvereid (Norway) in stormy weather. She was sailing along the Norwegian west coast off Ålesund. On deck there were two catamarans, a yacht, a sailing yacht and a large fishing boat. The bad weather caused the ship to jolt and sway heavily, exerting acceleration forces on the cargo. The sliding cargo eventually caused a couple of filled ballast water tanks to leak from the hold. A large amount of ballast water (120 - 300 m^3) entered the bilge and moved there as a free liquid surface. The free liquid surface and the sliding cargo drastically reduced stability, and the decision was made to abandon ship. The crew had to abandon the ship in stormy weather conditions. Later, the large fishing boat also broke from its lashings and slid off the deck into the sea, severely damaging items, including one of its boarding cranes. The Eemslift Hendrika was taken into tow by salvagers a few days later. This prevented an environmental disaster.

The inspector's objection was that, despite knowing that stormy weather was imminent, the person concerned did not remain in port until the weather en route improved and that, once underway with the project cargo and worsening weather, he had not opted to sail inland through the Norwegian fjords after all or to seek a sheltered place there; this had led to all crew members having to abandon the ship, exposing them to severe risks and causing the ship and cargo to suffer considerable damage.
The demand was to impose a suspension of the navigation licence for a period of 8 weeks, 4 weeks of which conditionally.

The person concerned stated that the weather forecast was reasonable to good for the first couple of days and that there was therefore no reason for him not to depart from Bremerhaven.
Also, he felt the shipping company was pressing him to achieve the ETA.

The Disciplinary Court ruled that it was not illogical to depart from Bremerhaven, as the weather was reasonable during the first days. However, the person concerned should have adjusted his voyage plan and taken a different route or sought shelter, knowing they would enter severe weather in two days. That objection was ruled well founded. The Eemslift Hendrika ran into increasingly bad weather. NAVTEX indicated for the relevant areas: GALE 9 and STORM 10. The person concerned did not use the option to put the route and vessel data into an SPOS programme. He knew that weather conditions close to the Norwegian coast were such that the waves got stronger. Nevertheless, without consulting the chief officer and superintendent, he chose not to sail inland through the fjords. It is important to note that he was en route with project and deck cargo whose lashings he had not sufficiently checked. The Disciplinary Court is at a loss to understand why he still thought he could get to Kolvereid before the storm, despite the Navtex communications. The person concernedhad several opportunities to seek a sheltered place, even at a later date. That

the person concerned felt pressured by the shipping company is incomprehensible. Indeed, he confirmed at the hearing that the co-owner had advised him to go inland because of the severe weather forecast.
All these aspects resulted in considerable material damage as well as exposing the crew members (who had to abandon ship by helicopter in the storm) to considerable risks.
The measure demanded by the inspector did not suffice, due to the person concerned taking unnecessary major risks and also drawing very limited lessons from the event. He failed to recognise that as a captain, he should not rely entirely on his own account but should also actively seek the opinions of other officers. In this case, the shipping company had even advised him to take a safe route.
In view of the seriousness of the conduct, the Disciplinary Court imposed a suspension of his navigation licence for 8 weeks.
Since the person concerned had also suffered personal injury and has been unable to sail for a long time, the Disciplinary Court saw cause to order that the suspension of his navigation licence be partly conditional, for 2 weeks.

Practical recommendations

As the Dutch Safety Board had reported on this incident, the Disciplinary Court referred to this report of 5 April 2021 (" Emergency situation following sliding cargo. Lessons from the Eemslift Hendrika incident").

NJORD

RULING OF 23 DECEMBER 2022
NO. 7 OF 2022
CASE 2022.V4-NJORD

Person concerned: captain

This case concerned the Njord, a Dutch container vessel running aground just outside Brevik, Norway, on 18 November 2021 at around 22:12 LT. The ship had left Brevik shortly before, bound for Bremerhaven, and was piloted by a Norwegian pilot, using the autopilot. It was very foggy (the sector lights could not be seen through the fog). The grounding took place after the pilot initiated a turn to port. The person concerned – who was with the chief officer and the pilot on the bridge – saw that the turn was started too late and that the vessel was turning too slowly. He repeatedly suggested to the pilot to switch to manual steering, but the pilot was not comfortable with that. Eventually, the person concerned added the second steering gear and took over steering from the pilot, switching to manual steering. This was too late. The grounding caused a leak in the ship's forepeak. The only damage was to the ship itself.

The inspector's objection against the person concerned consists of the following elements:

(i) The departure was not postponed to adjust the route that was different from the voyage plan.
(ii) The Parallel Index method was not applied to the radar, even though the sector lights could not be seen through the fog.
(iii) There was only 1 steering gear pump operational in an area where navigation required caution due to major course changes and fog.
(iv) The vessel was not piloted manually in an area where navigation dictated caution due to major course changes and fog.
(v) An ECS was used on board for navigation purposes. However, that was not approved for this purpose and therefore could not serve to substitute an ECDIS.
(vi) The ship ran aground under the command of the person concerned.

The inspector's demand is to suspend the navigation licence of the person concerned for 4 weeks, 2 of which conditionally.

Among other things, the person concerned argued that he had been sailing as a captain for 36 years, had not been involved in any incidents, had a pilot exemption in most of the ship's sailing areas and was only actually involved in a grounding precisely where he was obliged to use the services of a pilot. The person concerned believed the policy followed by the pilot to have contributed significantly to what happened. The person concerned also believed that several of the objections raised by the Inspector had no causal link to the grounding.
As another formal aspect, he mentioned that the Inspector did not immediately caution him in the first interrogation.

The Disciplinary Court's most serious finding is that the person concerned – who knew that the vessel turned slowly on the automatic pilot (operated by the pilot) and who was or should have been aware that a sharp change of course was approaching – (i) did not urgently warn the pilot of this slow turn when using the automatic pilot well before approaching/commencing that sharp turn and (ii) did not 'overrule' the pilot, by means of timely and resolute action/intervention in the absence of an adequate response from the pilot. This contributed significantly to the grounding. Furthermore, it can be assumed that an acute need to act could have been avoided if there had been prior discussion of the altered route among the bridge team present (captain, pilot, chief officer). As things stood, the person concerned – who had not sailed in that area before – was unaware of where and how the first sharp turn to port would be taken in the dense fog. He was unfamiliar with the pilot's actions. This should be avoided at all times. Responsibility for this rested primarily with the person concerned as master/captain. In the given circumstances – including the thick fog and the last-minute route change in response to it, which had not been calmly prepared/discussed beforehand – he could not trust that the pilot would know how to guide the ship safely on autopilot through the winding waters of the altered route in thick fog.
The objection concerning the negligence mentioned above was contained in the 6th objection of the Inspector. This negligence contributed significantly to the grounding. This link was less clear in the Inspector's other objections. However, even if such a link exists, it does not give cause for a different measure.

The appeal by the Counsel for the person concerned regarding the lack of caution given by the Inspector was rejected, as the Disciplinary Court had made no use of statements made to the Inspector for the purpose of evidence, not to forget that disciplinary proceedings are also not a "criminal charge" in the sense of article 6 EVRM. For that reason, the Inspector was under no obligation to issue a caution when obtaining information about the grounding reported by the Classification Society. Either way, the omission does not give cause to disregard that information.

The captain as master remains fully responsible when using a pilot, whether compulsory or otherwise. His familiarity with the local situation does not detract from this. However, the pilot can also be expected to do his job properly. That does not appear to have been the case here. The presumed negligence of the pilot weighs in favour of the person concerned, as does the circumstance that the person concerned, as (indirect) owner of the vessel, suffered financial loss as a result of the incident.
Unconditional suspension of the navigation licence was imposed on the person concerned for 1 week due to negligence. It is in favour of the person concerned, in addition to the circumstances mentioned above, that he had shown to have learned from what happened and that no personal injuries occurred and no damage was caused to third parties or the environment.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2022

PRESIDING JUDGE

P.C. Santema
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

W. van der Velde
Lector Maritime Law at Maritiem Instituut Willem Barentsz

MEMBERS

A. Aalewijnse
Chief Engineer

E.R. IJssel de Schepper
Captain

T.W. Kanders
Captain

C. Kuiken
Ship's officer

H. van der Laan
Captain (member until 31 May 2022)

O.F.C. Magel
Captain

R.A. Oppelaar
Captain

R.E. Roozendaal
Captain

C.R. Tromp
Captain

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
Former Chief engineer in marine fishing (deep sea fishing)

DEPUTY MEMBERS

J. Berghuis
Captain

R.M. Boeijen
Chief Engineer (member since 1 September 2022)

V.C. Engel
Ship's officer (member since 1 September 2022)

S.W. Postma
Captain/ North Sea pilot (member since 1 September 2022)

D. Roest
Captain

P.H.G. Schonenberg
Ship's officer

A.W. Taekema
Captain (member since 1 September 2022)

J. van Vuuren
Captain

J.K.J. Bout
Skipper in marine fishing

H.J. IJpma
Formerly skipper in marine fishing

H. Schaap
Formerly skipper in marine fishing

A.J. de Heer
Former Shipowner

C.J.M. Schot
Shipping company

J.J. Spaan
Hydraulic engineer

J.J. Spaan
Hydraulic engineer

E.E. Zijlstra
Hydraulic engineer

T.S. de Groot
Registered pilot

R.J.N. de Haan
Registered pilot

W.A. Barten
Hydrographer

N.P. Kortenoeven-Klasen
Hydrographer

SECRETARY

E.H.G. Kleingeld, LL.M

DEPUTY SECRETARY

V. Bouchla

E.M. Dooting