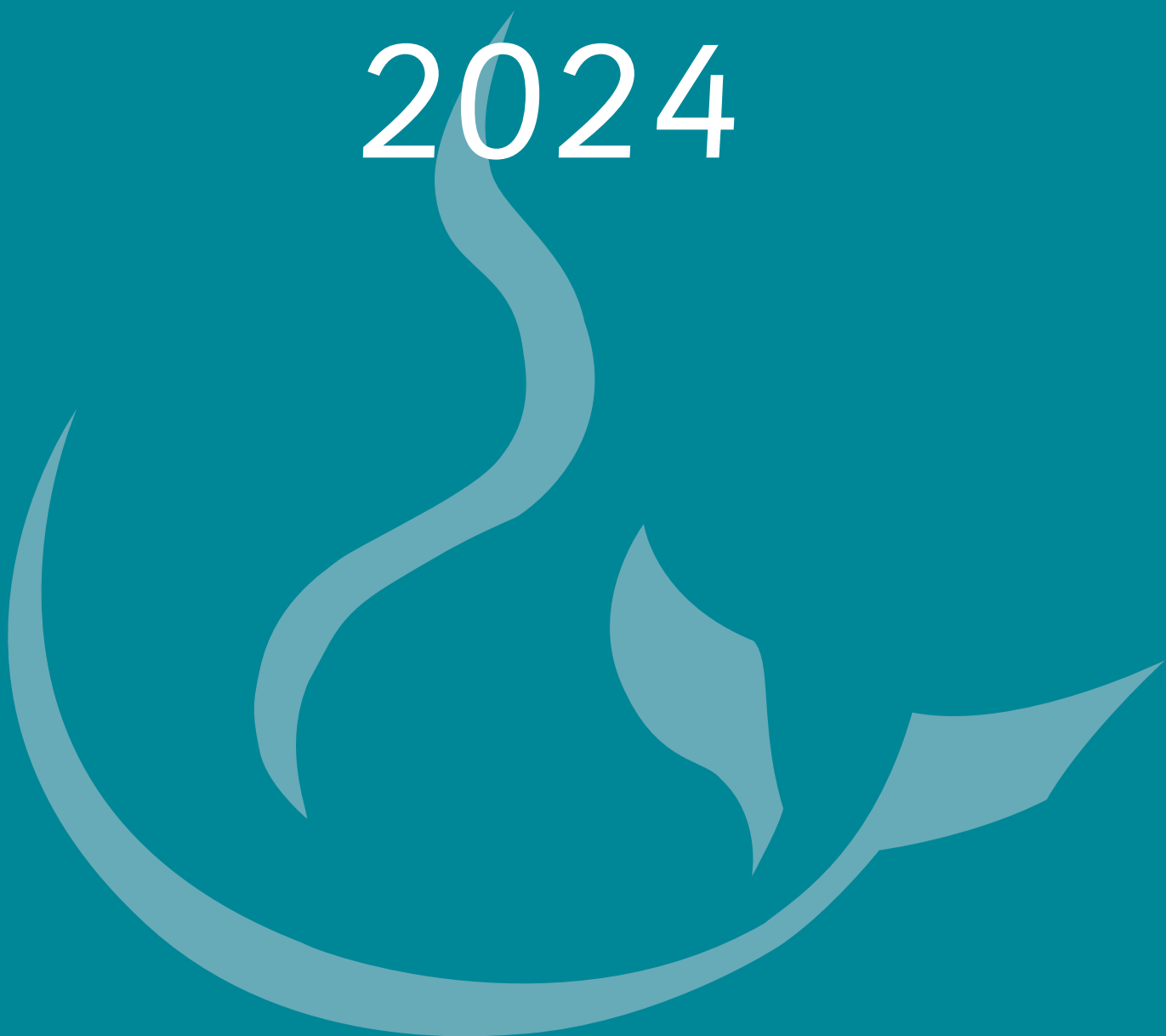


**MARITIME DISCIPLINARY COURT
OF THE NETHERLANDS**

**ANNUAL
REPORT
2024**



MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

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GENERAL

2024 began with hearing the Reggeborg case. Not only the captain but also 4 officers were brought before a large court to justify their involvement in an incident occurring during a barbecue organised on board. Later in the year, a further 7 cases were heard, each one by a small court. Four of the cases concerned a (minor) collision. The Disciplinary Court increasingly opts to impose a fine when foreign individuals are involved.

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.

As of this year, members can log into an internal website of the Disciplinary Court. There, they can find handbooks and presentations of training courses, along with news items, columns and interviews.

Following our previous annual report, I was interviewed by Schuttevaer. Later in the year, after we had placed an advertisement for new (deputy) members, it was Kiki Bouchla and Ellis Doeven's turns.

The presiding judges and secretaries received refresher training in the ECDIS, among other subjects, at the Willem Barentsz Maritime Institute on the island of Terschelling, in April.

Equally successful and educational was our members' day, organised at Marin in Wageningen, in June.

Several meetings were held with the Maritime Affairs Directorate, Shipping Division, of the Ministry of Infrastructure and Water Management, and with the ILT Inspectorate. We consulted with Nautilus International, as a result of a particular case.

In terms of personnel, Fanny Pietersma-Smit has succeeded Karin de Ridder as deputy secretary. Ellis Doeven was temporarily assisted by Patricia Strik.

Amsterdam, May 2025



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
2023	14	0	0	0	14
2024	6	0	0	0	12
Total	127	2	9	2	125

* One case was withdrawn by the minister in 2011, and two cases were withdrawn by the inspector in 2014.

RULINGS OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2024

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 captain or officer concerned, expected of a good seaman in respect of the persons on board, the ship, the cargo, the environment or shipping traffic within the meaning of Section 55a of the Dutch Seafarers Act.

REGGEBORG

RULING OF 22 MARCH 2024
NUMBERS 1 TO 5 OF 2024
2023 CASES. V2 TO V6-REGGEBORG

Persons concerned: captain, first, second and third officers, and second engineer

The cases concerned an incident which occurred on 25 December 2022 on board the Dutch Reggeborg cargo vessel, anchored at anchorage East of Bethany Beach, Delaware, in the United States.

On Christmas Eve, 24 December 2022, the captain, the first officer, the second engineer and the bosun met in the mess room to discuss possible locations for the Filipino Christmas tradition of roasting a suckling pig on a barbecue, the following day. Due to the bad weather forecast, the captain suggested not to hold a barbecue on deck, but rather in the lashing store, starboard on the upper tween deck, where the previous year's Christmas barbecue had also been organised. No risk assessment was conducted.

The barbecue was ignited the following morning, 25 December 2022, and the suckling pig was laid on the barbecue at 10:00 hours. The hold ventilation was switched off and the ventilation valves were closed. One door was however open, namely the access door from the raised quarterdeck and possibly also the access door to hold number two. From the entrance to the raised quarterdeck, a vertical ladder of around 6 metres' height, provided access to the upper tween deck. A bucket of water was provided at the barbecue. The second engineer (and the bosun) were constantly present at the barbecue. The first officer came to check it from 09:40 hours to 09:50 hours, while the second officer came to check at 10:45 hours. The third officer was present from 10:00 to 10:15 hours and from 10:35 hours on. The OS became unwell at 11:05 hours. The second and third officers left the lashing store at that point to fetch a stretcher and to warn the captain. The second officer re-entered the lashing store carrying the stretcher. At 11:10 hours, the second engineer became unwell, followed by the AB2 at 11:15 hours. The captain and the first and third officers entered the lashing store at 11:15 hours. The second officer left the lashing store to collect a hoisting harness, and subsequently remained on deck. The third officer left the lashing store to collect blankets, and subsequently also remained on deck. At 11:15 hours, the first officer doused the barbecue using the bucket of water. By now, a portable fan was being operated in the lashing store. The ventilation valves on the boat deck and between holds numbers one and two were opened and the chief engineer started the hold ventilation. A hoisting harness was used to retrieve the second engineer, the OS and the AB2 from the lashing store, at 11:17 hours, 11:20 hours and 11:25 hours, respectively. The captain and the first officer assisted in the process from the lashing store. The chief engineer assisted at the top of the ladder, along with the second and third officers. The captain left the lashing store at 11:30 hours, followed by the chief officer at 11:40 hours. The bosun also began to feel unwell at 11:40 hours, as did the third officer at 12:00 hours. The five crew members were evacuated on board a US Coastguard vessel; oxygen was administered, and they were transferred to a fire department boat for transportation to shore. A US Coastguard helicopter flew above the vessel. Onshore, the crew members were advised by the doctor of the Radio Medical Service, whom the captain had contacted, to spend a few hours in a hospital for medical assessment, treatment and monitoring. They returned to the vessel at around midnight of the same day.

THE CAPTAIN

The inspector's objection against the captain consisted of the following elements:

1. He had suggested organising the barbecue in an enclosed space.
2. He did not conduct a risk assessment with regard to the barbecue in the enclosed space.
3. He decided not to arrange for ventilation of the enclosed space during the barbecue.
4. He did not arrange for the atmosphere to be monitored (for carbon monoxide) during the barbecue in the enclosed space.
5. Partly due to the aforementioned objections, five crew members became unwell due to carbon monoxide poisoning.
6. He entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
7. He also allowed the first officer, second and third officers to enter an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.

8. As a result of the latter two objections, he exposed himself and all other officers to carbon monoxide poisoning even though he was aware that someone had already become unwell in a non-ventilated, enclosed space containing a lit barbecue.

The inspector's demand was to impose an unconditional fine of € 2,000 on the captain.

The captain denied that he had failed to observe the principles of good seamanship. He added the following.

He had felt pressurised by the crew to give permission for the barbecue. Because of the weather conditions, he had suggested organising the barbecue in the lashing store. Although the lashing store is designated an enclosed space by Wagenborg, the legislation in question mainly concerns the possible presence/permeation of any gases from cargo in hold number two. However, the door to hold number two was open and hold number two was empty. This was therefore not officially a "high risk job" in the sense of the SOM. A risk assessment should have been conducted by the first officer, who apparently had failed to do so. The captain assumed that the hatches would be opened and that a carbon monoxide detector would be used, alongside a fire extinguisher (the latter was indeed present). In his opinion, the situation occurred due to the ventilation valves of the hold not being opened, to generate sufficient air circulation. He had been insufficiently aware of the risk of closed ventilation valves due to being extremely busy on the morning of the barbecue, working on repeating stability calculations and the ballast water system, as well as managing the fact that certain crew members were upset that they would not be spending Christmas at home as a result of Covid. He felt responsible that he had not undertaken sufficient checks whether the ventilation valve on the deck had been opened, and was of the opinion that a barbecue should never again be organised in the lashing store. At around 11:10 hours, the captain was informed by the third officer that a crew member had collapsed but was still conscious. The captain admitted that he subsequently entered the lashing store without the use of a respirator, at approximately 11:15 hours. However, at that point in time, he was not yet aware that carbon monoxide was being produced. He was however aware that the atmosphere in the lashing store was not as it should be, and immediately vacated the space. In the meantime, the first officer had doused the barbecue, and a portable fan was being operated. The captain then immediately gave the order to switch on the hold ventilation, to open the ventilation valves and to evacuate the unwell crew members as quickly as possible. This was an instinctive action for the purpose of the safety of the crew during an emergency situation. Without this action, the situation could have had much more serious consequences.

On going below, he immediately suspected the presence of carbon dioxide, and possibly carbon monoxide.

In the event the Disciplinary Court was of the opinion that the Inspector's objections were declared founded (in full or in part), the captain requested that the following was taken into account:

- he was a first offender and was due for retirement on 1 December 2023, following an impeccable record of forty years of service;
- as soon as he became aware of the incident, he acted extremely adequately and took mitigating measures;
- he was still troubled by the incident and the "after effects" (US emergency services out in force including a helicopter and the need to shift the vessel elsewhere, while a number of the crew remained in hospital), on a daily basis;
- the shipowner may still take measures against him;
- he had learned lessons from the incident.

The Disciplinary Court declared all objections to be well-founded.

With a view to objections 1 to 5, the Disciplinary court took into account its advocacy of organising social events on board. Such events can promote the well-being of the crew. A barbecue is an example of a social event. However, due care was essential. The open deck was the designated location for the organisation of a barbecue.

As the weather conditions were not conducive to barbecuing on the deck in this specific case, while barbecuing was extremely important due to the roasting of a suckling pig being an important Christmas tradition for the six Filipino crew members on board, an alternative location was sought on board.

However, the captain did not conduct a risk assessment prior to this charcoal barbecue, whereby the preconditions are clearly ascertained and communicated for the purpose of a safe barbecuing process. A risk assessment also needed to be conducted in the event of risky activities taking place during leisure time. A minimum requirement for safe barbecuing using charcoal was that there was adequate ventilation.

The captain, the first, second and third officers and the second engineer opted for (or agreed to) the lashing store as the location, i.e. a space within the vessel (without having the atmosphere checked). With a view to their position and training, they should have recognised and designated the lashing store to be an enclosed space. After all, there was only one opening for entry and exit via a vertical ladder, and one door giving access to hold number two, this space was in itself inadequately ventilated and “not designed for continuous worker occupancy” in the sense of Resolution A.1050(27) and the “Wagenborg Shipboard Operation Manual”.

On the following day, a barbecue was indeed organised in the lashing store (without the use of a carbon monoxide meter), resulting in five crew members becoming unwell as a result of carbon monoxide poisoning.

Moreover, the captain had not demonstrated the sense of control and leadership that should be expected of a captain. It was his responsibility to organise the barbecue effectively and to prevent accidents from occurring. It was his suggestion to organise the barbecue in the lashing store (there was not any apparent crew pressure) and with this in mind, he should have given instructions for a risk assessment to be conducted whereby, as he himself stated, ventilation valves and the use of a carbon monoxide meter would have been involved. In terms of the ruling, it made no difference whether carbon monoxide or carbon dioxide was involved.

The captain had himself declared that, with hindsight, he should not have assumed that ventilation valves would be opened and that a carbon monoxide meter would be present. He had established incorrect priorities, having been involved in other work on the bridge rather than checking whether the space was adequately ventilated and monitored using a carbon monoxide meter. He had also admitted that he did not have sufficient supervision and had also stated that a barbecue should never again be organised in the lashing store.

Contrary to the arguments of the (counsel for the) captain, there was no reason why the legislation in question should only pertain to the possible presence or permeation of any gases from the cargo in hold number two and not to barbecuing with charcoal in the enclosed space in question, the lashing store.

With regard to objections 6 to 8, the Disciplinary Court took into consideration that if it had been ascertained (in a risk assessment) that there may have been a health risk as a result of entrance to an enclosed space, the precautionary measures of paragraph 5 through 9 of Resolution A.1050(27) needed to be followed. The Disciplinary Court strongly emphasised the importance of taking such precautionary measures to prevent accidents. The captain, the first officer and second and third

officers failed to take such precautionary measures. They entered the lashing store without the use of a respirator.

In this specific case, in which there was an instinctive rescue operation by the captain, the Disciplinary Court did not impose the demanded fine on the captain, but rather a reprimand.

The Disciplinary Court did so because, on arrival in the lashing store, the captain recognised the emergency situation and the need for immediate action. He had assessed the situation correctly, that the ventilation valves needed to be immediately opened and the victims evacuated as quickly as possible, which could not be done alone. In such a hectic situation, it was not reprehensible that the person concerned did not first fetch a respirator (which was located elsewhere), and that he did not withhold the first officer, second and third officers. If he had indeed done so, the consequences of the situation could have been much more severe.

THE FIRST OFFICER

The inspector's objection against the first officer consisted of the following elements:

1. Despite his doubts, he had accepted the captain's proposal that a barbecue be held in an enclosed space.
2. He did not conduct a risk assessment with regard to the barbecue in the enclosed space.
3. He decided not to arrange for ventilation of the enclosed space during the barbecue.
4. He did not arrange for the atmosphere to be monitored (for carbon monoxide) during the barbecue in the enclosed space.
5. Partly due to the aforementioned objections, five crew members became unwell due to carbon monoxide poisoning.
6. He entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
7. He had also allowed the captain, and the second and third officers to enter an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
8. As a result of the latter two objections, he had exposed himself, the captain and the two other officers to carbon monoxide poisoning even though he was aware that someone had already become unwell in a non-ventilated, enclosed space containing a lit barbecue.

The inspector's demand was to impose an unconditional fine of € 1,000 on the first officer.

The first officer denied that he had failed to observe the principles of good seamanship. He added the following.

The idea to organise the barbecue in the lashing store came from the captain, and he had agreed to this, despite his own doubts. The captain was responsible for ensuring safety on board.

The first officer acknowledged that he did not conduct a risk assessment and stated that, with hindsight, he should have done so.

He acknowledged that he had not adequately realised the risks of barbecuing in an enclosed space. He believed there would be sufficient ventilation, because the access door from the raised quarterdeck and (according to him) also the access door to hold number two, was open. He there-

fore did not arrange for the atmosphere to be monitored using a carbon monoxide meter. Another factor was that this was the first voyage for him as an officer and that he was working hard on all kinds of matters on the bridge.

On entering the lashing store, he was unaware that carbon monoxide was being produced. After all, the captain had called in at 11:10 hours, communicating that a crew member had fallen at the entrance to the lashing store, after which he immediately proceeded there and entered without the use of a respirator. When the second engineer and then the AB2 became unwell, he had immediately ordered a portable fan to be operated. The hold ventilation was then also switched on and the ventilation valves opened. He had then exited the lashing store to fetch a gas meter and then re-entered the space, where he extinguished the fire using a bucket of water. This measure stopped the production of carbon monoxide and disposed of any gas present in the space.

In the event the Disciplinary Court was of the opinion that the Inspector's objections were declared founded (in full or in part), the first officer requested that the following was taken into account:

- he was a first offender;
- as soon as he became aware of the incident, he acted extremely adequately and took mitigating measures;
- the shipowner may still take measures against him;
- he had learned lessons from the incident.

The Disciplinary Court declared all objections to be well-founded.

See also the case against the captain, and the general consideration of the Disciplinary Court regarding whether or not the objections were well-founded with regard to the captain, first officer, second and third officers and second engineer.

An additional fact regarding the first officer is that he did not conduct a risk assessment prior to this charcoal barbecue, whereby the preconditions are clearly ascertained and communicated for the purpose of a safe barbecuing process. As first officer, he should have conducted a risk assessment. It was his task, despite his young age, his first voyage as first officer and his trust in the captain. Moreover, he was present in the lashing store from 9:40 hours to 9:50 hours, and should/must have been aware that there was a lack of good ventilation (with an entrance and an exit). He should therefore have made arrangements for ventilation of the space, as the hold ventilation was switched off and the ventilation valves closed. With hindsight, he admitted that he himself should have conducted a risk assessment and that he was insufficiently aware of the risk of barbecuing in an enclosed space.

In this specific case, in which there was a (coordinated) rescue operation, the Disciplinary Court did not impose the demanded fine on the first officer, but rather a reprimand.

The Disciplinary Court did so because on first entering the space, he had been unaware that the crew members had become unwell as the result of carbon monoxide. After all, the captain had only informed him that a crew member had fallen at the entrance to the lashing store. He had however immediately ordered a portable fan to be installed. On the second occasion that he entered the lashing store with a carbon monoxide meter (which was sounding the alarm) and extinguished the fire using a bucket of water, the space ventilation was in operation and the ventilation valves had been opened. The crew members who had become unwell regained consciousness at that point, which was the reason why the respirator was no longer required. In such a hectic situ-

ation, it is not reprehensible that he did not first fetch a respirator (which was located elsewhere) and that he did not withhold the captain, second and third officers. If he had indeed done so, the consequences of the situation could have been much more severe.

THE SECOND OFFICER

The inspector's objection against the second officer consisted of the following elements:

1. He did not recognise the organisation of a barbecue in a non-ventilated enclosed space as being unsafe conduct.
2. He did not apply the stop the job procedure regarding the organisation of a barbecue in a non-ventilated enclosed space.
3. He had (re-)entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
4. He had not applied the stop the job procedure when the captain, the first officer and third officer also entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.

The inspector's demand was to impose an unconditional fine of € 500 on the second officer.

The second officer denied that he had failed to observe the principles of good seamanship. He added the following.

The captain and the first officer had decided that the barbecue would be organised in the lashing store. There was therefore no reason for him to assume that this was unsafe. As a Filipino subordinate officer, who had only been on board for one month, he could not challenge such a decision. He kept the suckling pig rotating on the spit, after he had ascertained that – in his opinion – there was sufficient ventilation and that there were fire extinguishers and two buckets of water in place. When he discovered there was a problem, he had taken immediate action to remedy the situation. He was unaware of the carbon monoxide, but was aware that this was an emergency situation whereby the OS and the second engineer became unwell. He had immediately fetched a stretcher. He could not withhold the captain and the first officer from entering the lashing store. He was assigned to fetch a portable fan, and also fetched the hoisting harness. He could not issue a stop the job.

In the event the Disciplinary Court was of the opinion that the Inspector's objections were declared founded (in full or in part), the second officer requested that the following was taken into account:

- he was a first offender;
- he believed to have acted correctly in an emergency situation by immediately offering assistance to his fellow crew members in order to prevent escalation

The Disciplinary Court declared all objections to be well-founded.

See also the case against the captain, and the general consideration of the Disciplinary Court regarding whether or not the objections were well-founded with regard to the captain, first officer, second and third officers and second engineer.

In the case of the second officer, although he himself was not party to the decision to organise the barbecue in the lashing store, on the evening prior to the barbecue, he was however responsible

for checking for himself whether there was adequate ventilation (unlike the captain and first officer who bear that responsibility on behalf of the rest of the crew members). Moreover, he was himself present in the lashing store and was operating the barbecue. He could and should have ascertained that the ventilation was not in order. After all, the ventilation valves were closed. A stop the job might have been expected from him at that point, and therefore also as a Filipino subordinate officer.

In this specific case in which there was a (coordinated) rescue operation, the Disciplinary Court did not impose the demanded fine on the second officer, but rather a caution. As the second officer has less responsibility than the captain and the first officer in estimating safety aspects, the Disciplinary Court did not impose a reprimand, but rather an official warning.

In the opinion of the Disciplinary Court, the second officer was unaware of the presence of carbon dioxide. When he saw that the OS and the second engineer had become unwell, he had fetched a stretcher and warned the captain. On his return, he became aware that this was an emergency situation which required immediate action. Upon the captain and first officer entering the lashing store, he was assigned to fetch a portable fan, which he did, while also fetching the hoisting harness. He then assisted in hoisting the OS and the second engineer up onto deck. In such a hectic situation, it is not reprehensible that he did not first fetch a respirator (which was located elsewhere), and that he did not withhold the captain, the first officer and third officer. If he had indeed done so, the consequences of the situation could have been much more severe.

THE THIRD OFFICER

The inspector's objection against the third officer consisted of the following elements:

1. He did not recognise the organisation of a barbecue in a non-ventilated enclosed space as being unsafe conduct.
2. He did not apply the stop the job procedure regarding the organisation of a barbecue in a non-ventilated enclosed space.
3. He had (re-)entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.
4. He had not applied the stop the job procedure when the captain, the first officer and second officer also entered an enclosed space where carbon monoxide gas was being produced and where someone had already become unwell, without the use of a respirator.

The inspector's demand was to impose an unconditional fine of € 500 on the third officer.

The third officer denied that he had failed to observe the principles of good seamanship. He added the following.

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

He was not aware that carbon monoxide was being produced. He had followed the first officer

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

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

The Disciplinary Court declared all objections to be well-founded.

See also the case against the captain, and the general consideration of the Disciplinary Court regarding whether or not the objections were well-founded with regard to the captain, first officer, second and third officers and second engineer.

In the case of the third officer, although he himself was not party to the decision to organise the barbecue in the lashing store, on the evening prior to the barbecue, he was however responsible for checking for himself whether there was adequate ventilation (unlike the captain and first officer who bear that responsibility on behalf of the rest of the crew members). Moreover, he himself was present in the lashing store. He could and should have ascertained that the ventilation was not in order. After all, the ventilation valves were closed. A stop the job might have been expected from him at that point, and therefore also from a third officer.

In this specific case in which there was a (coordinated) rescue operation, the Disciplinary Court did not impose the demanded fine on the third officer, but rather a caution. As the third officer has less responsibility than the captain and the first officer in estimating safety aspects, the Disciplinary Court did not impose a reprimand, but rather an official warning.

In the opinion of the Disciplinary Court, the third officer was unaware of the presence of carbon dioxide. When he saw that the OS and the second engineer had become unwell, he had fetched a

stretcher and warned the captain. He then re-entered the lashing store and immediately returned above deck to fetch blankets and to throw them into the lashing store. He subsequently stayed above deck. When the bosun and the seaman came upstairs and communicated that the air was not in order, he was ordered by the captain to open the ventilation valve, before helping hoist the OS and the second engineer out of the hold. In such a hectic situation, it is not reprehensible that he did not first fetch a respirator (which was located elsewhere) and that he did not withhold the captain, first and second officers. If he had indeed done so, the consequences of the situation could have been much more severe.

THE SECOND ENGINEER

The inspector's objection against the second engineer consisted of the following elements:

1. He did not recognise the organisation of a barbecue in a non-ventilated enclosed space as being unsafe conduct.
2. He had lit the barbecue in an enclosed space.
3. He decided not to arrange for ventilation of the enclosed space during the barbecue.
4. He did not arrange for the atmosphere to be monitored (for carbon monoxide) during the barbecue in the enclosed space.
5. Partly due to the aforementioned objections, five crew members became unwell due to carbon monoxide poisoning.
6. He did not apply the stop the job procedure regarding the organisation of a barbecue in a non-ventilated enclosed space.

The inspector's demand was to impose an unconditional fine of € 1,000 on the second engineer.

According to the second engineer, the lashing store would have been suitable for barbecuing purposes, as in the previous year, as long as the ventilation had been in order. The second engineer blamed himself for not having checked this.

As mitigating circumstances, he stated that he had never before been subject to disciplinary measures, and that he had learned his lessons from the incident and the aftermath.

If disciplinary measures were to be imposed, this should at most be an official warning, though he had actually received sufficient warning in the form of carbon monoxide poisoning and his visit to the hospital following the rescue operation.

Should the Disciplinary Court be of the opinion that a fine was justified, he requested that such fine be made provisional for a period of two years following the incident.

He stated that he was now fully familiar with the Marine Guidance Note MGN 406 (M+F) of the British Maritime and Coastguard Agency (MCA). He believed that the advice – which was apparently known to the inspector – should also have been announced on vessels sailing under the Dutch flag, so that the incident in question could possibly have been prevented. It would have been better for everyone involved if they had been warned of the hazards of carbon monoxide poisoning during non-work related activities, such as this barbecue, instead of fines now being demanded without this advice of the MCA having been communicated on vessels sailing under the Dutch flag.

The Disciplinary Court declared all objections to be well-founded.

See also the case against the captain, and the general consideration of the Disciplinary Court regarding whether or not the objections were well-founded with regard to the captain, first officer, second and third officers and second engineer.

In the case of the second engineer, although he himself was not party to the decision to organise the barbecue in the lashing store, on the evening prior to the barbecue, he was however responsible for checking for himself whether there was adequate ventilation (unlike the captain and first officer who bear that responsibility on behalf of the rest of the crew members). He admitted this and blamed himself for not having checked this. He had lit the barbecue, had failed to have the atmosphere monitored while doing so, had not noticed that the ventilation was not in order, had not ensured that the lashing store was adequately ventilated and had not applied a stop the job, while this could have been expected from him.

As the second engineer had himself become unwell, the Disciplinary Court did not impose the demanded fine, but rather a reprimand. Due to him being much more closely involved in the barbecue than the second and third officers, the Disciplinary Court did not impose an official warning, as for said officers, but rather a reprimand.

As a focal point for professional practice in all cases pertaining to the Reggeborg, the Disciplinary Court named the following, taking into account the request by Counsel for the third officer and the suggestions of the second engineer:

Generally speaking, any risky activities, such as barbecuing with the use of charcoal, must be preceded by a risk assessment, whereby the preconditions for safety must be ascertained and communicated. When conducting any risky activities, there must be monitoring of compliance with the preconditions.

Furthermore, the Disciplinary Court advised that the Marine Guidance Note MGN 406 (M+F) of the British Maritime and Coastguard Agency be followed specifically when organising a barbecue, not only “on the job” but also a barbecue as a social event. This includes the following:

- 2.1 The use of barbecues/pig roasts on board vessels presents additional dangers. This guidance sets out practical steps to minimize the risk of fire or explosion. An appropriate risk assessment should be made when using this type of equipment.
- 2.2 All ships intending to use barbecues should have a safety procedure in place and this guidance will help (...)
- 3.1.2 The appliance should be sited on an open deck in a well-ventilated position (...)
- 4.1 Due to the production of carbon monoxide when charcoal is burned, charcoal barbecues should not be used inside enclosed spaces, even if ventilation is provided (...)

DOUWE-S

RULING OF 19 APRIL 2024
NO. 6 OF 2024
CASE 2023.V13-DOUWE-S

Person concerned: the second officer

This case concerned the motor vessel Douwe-S travelling north in the Celtic Sea on 31 July 2022, which collided with the port side boom of the British fishing trawler PZ115 Steph of Ladram, whereby the Douwe-S suffered minor damage to the starboard side of the bow, while the Steph of Ladram suffered a damaged boom.

The inspector's objection was that the second officer as OOW of the Douwe-S, collided with the fishing vessel PZ115 Steph of Ladram, as he did not apply the COLREGS correctly by not moving out far enough and by moving out too late.

The inspector's demand was to impose a suspension of the navigation licence of the second officer for a period of four weeks, two weeks of which conditionally.

The second officer admitted that he had not applied the COLREGS correctly, and offered his apologies to all involved.

The Disciplinary Court declared the objection to be well-founded. As it had become apparent that there was little chance of the second officer being allowed to sail again as officer in the short term, the sanction of suspending his navigation licence would not affect him. The Disciplinary Court therefore imposed a fine of € 500. In a situation where he had been punished already because he had been reduced in rank (not officially) and received lower wages, the Disciplinary Court saw cause to provide that the fine was imposed conditionally in full.

According to the Disciplinary Court, the second officer should have made better use of the radar and should have plotted the Steph of Ladram. Also, as the OOW of the power-driven vessel Douwe-S, he should have moved out adequately and on time for the Steph of Ladram, which according to the second officer, was fishing and was displaying fishing lights. As demonstrated by the screenshot of the ECDIS, he would still have had enough room if he would have maintained his course, but he made a minor adjustment to his course to port side. He had assessed incorrectly that he would cross the bow of the Steph of Ladram. In reality he would have passed aft. The fact that the Steph of Ladram came from starboard, as described in the petition, was not relevant in this matter, as acknowledged by the Inspector at the hearing. COLREG rule 15, which provides for the situation when two power-driven vessels are crossing so as to involve risk of collision, the vessel which has the other on her own starboard side shall keep out of the way and shall, if the circumstances of the case admit, avoid crossing ahead of the other vessel, did not apply here. This incident did not concern two power-driven vessels, as the Steph of Ladram was fishing and the vessel is not considered to be a power-driven vessel at that point due to its limited manoeuvrability.

Insofar as the second officer (in his statement at the hearing) wished to argue that the disciplinary measure should be less severe, because he was not yet sufficiently familiarised, and consequently unable to activate the alarm, the Disciplinary Court held that this was also the responsibility of the second officer. The ship management and the shipping company did have a role to play here, but he himself should have taken action to be sufficiently familiarised when he was on watch.

In terms of focal points for professional practice, the Disciplinary Court named the following: In the OOW's assessment as to whether two vessels safely pass each other, the CPA should be considered as a numerical value, whilst the position of the vessels in relation to each other before, during and after reaching this point should also be taken into consideration.

The ship management, the shipping company, and the officer in question should be aware that novice officers of the watch still require good guidance and instruction due to a lack of experience, even if they have completed the familiarisation "successfully".

EEMS CARRIER

RULING OF 19 JULY 2024

NO. 7 OF 2024

CASE 2024.V2- EEMS CARRIER

Person concerned: the third officer

This case concerned a collision on 20 September 2023. The cargo vessel Eems Carrier was en route, in ballast, from Lysekil in Sweden to Faxe Ladeplads in Denmark. As the Eems Carrier was heading south to the north of the small island of Ven, she suddenly failed to answer the wheel. She veered to port, on which side she was at that time being overtaken by another vessel, the Rix Explorer, a few points abaft the beam. The distance between the two vessels was approximately 0.2 NM at that time and the Rix Explorer was travelling more than 1 knot faster. Approximately three minutes after failing to answer the wheel, the port bow of the Eems Carrier collided with the starboard quarter of the Rix Explorer. The third officer was officer of the watch (OOW) prior to and during the collision.

The inspector's objection against the third officer consisted of the following elements:

1. When the Eems Carrier failed to answer the wheel, he had not attempted to avoid a collision by steering manually.
2. When the Eems Carrier failed to answer the wheel, he had not attempted to avoid a collision by reducing speed.
3. The collision between the Eems Carrier and the Rix Explorer had occurred partly because of the above.

The inspector's demand was to impose a fine on the third officer, possibly (partially) conditionally.

To summarise, the third officer argued that he had attempted to avoid a collision by steering manually, but that this was ineffective because he had not learned how to do so on board. He claimed that his familiarisation had only lasted thirty minutes and that he had been left with no choice but to sign it, due to being new to the shipping world. Furthermore, the third officer stated that the captain had forbidden him to reduce speed, and that he had therefore attempted to call the captain. However, the captain did not reply to his call. Finally, the third officer argued that he had communicated via the VTS that the vessel could not change course, because the steering did not react. He believed that the Rex Explorer would overtake the Eems Carrier and would avoid it because of the VTS message.

The Disciplinary Court declared the objections to be well-founded. As the third officer did not have his Dutch navigation licence and subsequently sailed under a different flag after the collision, the Disciplinary Court believed a fine of € 1,500 to be an appropriate measure. In the circumstances that he had already suffered the consequences of his failure, in the sense that he had spent a number of months unemployed at home, he subsequently had a lower salary and had expressed regret for the incident, the Disciplinary Court saw cause to impose a partially conditional fine (of € 750).

According to the Disciplinary Court, when the Eems Carrier failed to answer the wheel, the third officer may have attempted to avoid a collision by steering manually, but without result because he completely failed to undertake the attempt properly. As a third officer whose (full) chief mate licence makes him the replacement for the captain, he should have known how to manually steer the vessel, and must not be allowed to hide behind the captain or other officers. If he was unaware of how to steer manually, he should himself have taken action to learn such a skill. An officer must be capable of steering a vessel, and should even be able to warn the captain if the latter should make a mistake.

The third officer had also not attempted to avoid a collision by reducing speed. With a view to his rank, he should have done so. Even if the captain had indeed forbidden this, the person concerned should not have interpreted such an order as stopping him from reducing speed in an emergency situation.

Regardless of whether this played a role in this case, the Disciplinary Court named a focal point for professional practice, that there must be a procedure (or the work on board must be arranged in such a manner by the captain), so that differences in rank cannot result in officers on board not daring to take action in emergency situations due to fear of their superiors.

In this case, the Disciplinary Court had not used an audio tape as evidence, as it concerned “communication, using a technical instrument, between persons involved in the functioning of a means of transport”, in the sense of article 69b of the Dutch Safety Board Act. According to the Disciplinary Court, this article (preamble) does not allow the use of such an audio tape as evidence in a disciplinary procedure, except for exculpatory purposes.

CORA JO

RULING OF 19 JULY 2024
NO. 8 OF 2024
CASE 2024.V1- CORA JO

Person concerned: captain

This case concerned the Dutch multi-purpose dry cargo vessel Cora Jo which was navigating the opposite traffic lane of the traffic separation scheme of Norra Kvarken, in Swedish waters on 19 October 2023, with restricted visibility due to heavy snowfall. This was a conscious choice by the captain, who was also the officer of the watch.

Together with the Maritime Police, the inspector had opted to bring this violation before the Disciplinary Court rather than the criminal court. In the opinion of the inspector, this violation not only concerned a lack of good seamanship, but also that there was little chance of the Cora Jo returning to the Netherlands within the foreseeable future, nor was there any opportunity to interview the captain by telephone and to correctly ascertain his identity (no Dutch officers were involved).

The inspector's objection against the captain consisted of the following elements:

1. Despite restricted visibility due to heavy snowfall, the captain opted to navigate in the incorrect traffic lane of the Norra Kvarken traffic separation scheme. In doing so, he did not take (sufficient) account of the limited visibility due to snowfall, nor of the possibility of radar interference caused by that heavy snowfall, which might impede radar observations. By navigating in this way, he not only increased the distance to the CEMSEA III but at the same time took a serious risk. After all, he could not preclude that other shipping traffic might be navigating in the south-westerly direction, not being visible on the radar, and not being timely visually detected as a result of the restricted visibility.
2. Despite restricted visibility due to heavy snowfall and navigating in an opposite traffic lane of a TSS, there was no lookout on the bridge.

The inspector's demand was to impose an unconditional fine of € 1,750 on the captain.

In doing so, the inspector was in agreement with the transaction which the Public Prosecutor (OM) would offer.

The captain admitted that he entered the incorrect traffic lane. He had done so because according to him, there was no traffic entering the other traffic lane, enabling him to keep a minimum distance of 0.5 nm versus another vessel, the CEMSEA III. With hindsight, he believed that it would have been more sensible if he had decided to slacken his speed to keep a safe distance or to turn round to port before entering the TSS, which would have increased the distance. The captain believed that he had incorrectly concentrated on simply maintaining a safe CPA. He disputed that there was no lookout on the bridge. He stated that the lookout was indeed present, though this had not been recorded in the logbook. He also stated that this had also been a lesson to him, that he must work more accurately on inputting data in the logbook.

The Disciplinary Court declared the first element of the objection to be well-founded and the second to be unfounded (as not proven).

It had been proven that the experienced captain consciously chose to sail in the incorrect traffic lane, and while doing so did not take sufficient account of the restricted visibility and the possible interference on the radar due to heavy snowfall. The captain himself had admitted and acknowledged with hindsight that he could and should have avoided the CEMSEA III in another manner. He could have slackened his speed to allow the CEMSEA III to overtake.

As the inspector had indicated that the second element of the objection had not contributed to determining the amount of the fine, the lack of proof of the second objection did not result in a reduction of the fine demanded by the inspector. The Disciplinary Court imposed an unconditional fine of € 1,750 on the captain. The captain agreed.

MUNTGRACHT

RULING OF 09 AUGUST 2024

NO. 9 OF 2024

CASE 2023.V14-MUNTGRACHT

Person concerned: the first officer

This case concerned the Muntgracht cargo vessel which had collided with a buoy on entering Darwin Harbour in Australia on 10 October 2022. The buoy had become stuck between the vessel's hull and the rudder, so that the vessel had dragged the buoy, including chain and concrete block, to the mooring location in the harbour. During this period of more than two hours between the collision and mooring, the captain had only noticed that the vessel sailed 1 to 1.5 knots slower than usual. The crew only detected the buoy when they used a monkey ladder to inspect the outside of the stern.

The inspector's objection against the first officer consisted of the following elements:

1. The voyage plan referred to a strong current. He had taken insufficient account of the actual current.
2. He had not noticed on time that there was a considerable discrepancy between the course over the ground and the compass course (heading) of the vessel.
3. There was no lookout on the bridge, despite the fact that it was dark.
4. After the collision, he had not noticed that the red buoy had 'disappeared'.

The inspector's demand was to suspend the navigation licence of the first officer for six weeks, two of which conditionally.

The first officer admitted having made a navigation error, resulting in collision with the buoy. He also admitted all elements of the objection.

The Disciplinary Court declared the objection to be well-founded and imposed a suspension of the navigation licence of the first officer for six weeks. As the first officer had relatively little experience and indicated that he had learned from the incident, the Disciplinary Court saw cause to impose a partially conditional suspension, so that the sanction was in accordance with the inspector's demand.

In the opinion of the Disciplinary Court, it should be concluded that the first officer did not take sufficient account of the current at that time and did not notice on time that there was a considerable discrepancy between the course over the ground and the compass course (heading) of the vessel. He had also failed to arrange for a lookout on the bridge, even though this was essential for the navigation situation. Finally, he had not ascertained the consequences of the collision, so that he did not notice that the red buoy had "disappeared" and had been dragged by the vessel along with its chain and concrete block.

The fact that another vessel was incoming could not serve as an excuse. With a view to the mutual distance between the two vessels, there was no risk of a collision and the Muntgracht could have steered to starboard earlier in order to anticipate any discrepancy between the course over

the ground and the compass course (heading). The first officer had only navigated on sight (and intuition). This was inadequate and resulted in a lack of situational awareness. With the adequate use of the available nautical instruments, there were sufficient opportunities – taking into account the current at that time – to navigate the entrance to the port while avoiding the buoy, even in the presence of other incoming vessels. The buoy could have been plotted, and furthermore he could have used the radar overlay, the parallel index line and the radar ground–stabilized mode (instead of sea–stabilized mode). He had made no use or inadequate use of the ECDIS. He could have set a safety frame around the vessel, and could have ensured that the buoys were located outside the route corridor (x track error) – the green and red lines, so that he could have seen where and where not to navigate, whereby the ECDIS alarm would have sounded in case of a navigation error. In the opinion of the Disciplinary Court, the effective use of nautical equipment is part of the basic skills expected of an officer. The route corridor of the Muntgracht was directly between buoy berths 1 and 2. In order to avoid a collision, the first officer could have steered to the track given in the voyage plan well before the buoy berth, which would have given him better sight of the current pushing the vessel to port side.

Moreover, he did not arrange for a lookout on the bridge, even though entering a port is the perfect example of a potentially hazardous situation whereby the bridge must be adequately manned. The vessel collided with the buoy as a result of the acts/omissions of the first officer. He had stated that he could hear the collision occurring and that it was clear to him that this concerned the buoy. He should have ascertained the consequences of the collision, thereby checking whether the buoy was still in place. Instead, he hoped that nothing serious had occurred and continued to sail for two hours with the buoy between the vessel's hull and the rudder. Failing to stop after a collision was not only reprehensible but also a criminal offence.

The Disciplinary Court named as a focal point for professional practice, that a comprehensive voyage plan is of eminent importance at all times, therefore also when deviating from a preplanned route, such as the return from an actual anchorage to that route, in this case. In this sense, the Disciplinary Court compared this to the use of a voyage plan for movements within a port (from port basin to port basin). According to the Disciplinary Court, the ECDIS is ideal for this purpose, as it can automatically carry out a route check, allowing for anticipation when off-track.

JORIS SENIOR ARM18

RULING OF 30 OCTOBER 2024

NO. 10 OF 2024

CASE 2024. V5-JORIS SENIOR ARM18

Person concerned: the officer

This case concerned the collision in the night of Wednesday 28 to Thursday, 29 September 2022, between the Dutch fishing vessel Joris Senior, registered ARM 18, with the anchored tanker, Golden Daisy (hereinafter the tanker). This occurred in anchorage area 8, to the north of the approach to IJmuiden. The ARM 18 was under steam to IJmuiden after a week of fishing the North Sea. The tanker suffered a hole in the sludge tank during the collision. Approximately 2 m³ of sludge was discharged into the sea. The ARM 18 itself suffered damage to the prow. All the damage was well above the waterline. There were no personal injuries.

The officer was signed on as deputy skipper and was the officer of the watch at the time of the collision.

The inspector's objection against the officer consisted of the following elements:

1. he had left the bridge for approximately five minutes, while nobody else was present on the bridge;
2. he had misjudged the risk of collision before leaving the bridge to go to the toilet;
3. he had not woken the skipper, despite it nearly being time to do so;
4. the collision occurred partly because of the above-mentioned objections.

The inspector's demand was to impose a fine of € 3,000 on the officer, € 1,000 of which conditionally.

The officer acknowledged all the Inspector's objections.

The Disciplinary Court declared the objection to be well-founded and imposed a fine of € 3,000 on the officer. As the officer had received a fine of € 1,500 from the Public prosecutor (due to him not being authorised to act as deputy skipper on the vessel), due to him not being able to work for health reasons and requiring an impending operation (partly because of injuries sustained during the incident), as well as being sole earner and having children at home, the Disciplinary Court saw cause to determine that part of the fine (€ 1,500) would be conditionally imposed.

In the opinion of the Disciplinary Court, he demonstrated a severe lack of good seamanship, which could have had much more serious consequences. The officer was the officer of the watch at the time of collision. He was alone on the bridge. There was no lookout. The skipper had retired to his accommodation, as had the remaining crew members. The skipper had prepared the voyage plan following the fishing activities. According to the plotted route, the vessel would navigate north of the anchorage area to IJmuiden. The officer had opted to deviate from the plotted route and to navigate through the anchorage area. There, he collided with the anchored tanker. He had stated that he left the bridge to go to the toilet shortly before the collision. He had previously

observed the tanker. It should have been clear to him that constant alertness was essential on the bridge when navigating through the anchorage area. He should therefore have called the skipper to the bridge prior to his planned visit to the toilet. In this case, this is even more obvious as the vessel had (approximately) approached the position at which the skipper should have been called anyway, as agreed. The person concerned should not have assumed that no risk of collision could develop at a CPA set to 0.3 miles. He should have taken account of the influence of the wind and current.

The Disciplinary Court named a focal point for professional practice that collisions during the return journey, following a demanding week of fishing, were unfortunately common practice and that it was therefore advisable that extra attention be paid to good/alert bridge manning, with a view to returning home safely.

STAVFJORD

RULING OF 20 DECEMBER 2024
NUMBERS 11 AND 12 OF 2024
CASES 2024.V3 AND 2024.V4-STAVFJORD

Persons concerned: captain and first officer

These cases concerned the following incident.

On 18 February 2024, the Stavfjord cargo vessel was travelling from Hekkelstrand near Narvik, to Holmestrand in the vicinity of Oslo. The vessel was sailing in the Norwegian fjords with a draft of Tmean. 6.18 metres. Midway through the afternoon, the route took it past Bergen Flesland airport. There, the (new) first officer had landed at 13:55 hours, following a flight from Manila lasting nearly 26 hours in total, including two transfers. At approximately 15:30 hours, this first officer was transported by MOB boat to board the Stavfjord, which was kept running. Once on board, he quickly assumed the sea watch following brief transfer instructions. He was replaced for a meal between 17:15 and 17:25 hours. At approximately 18:58 hours, the vessel grounded at position 59 53 50.4N, long 005 31 43.2E (Norway), whereby the Stavfjord bow collided with the rocky shoreline on a course of 143 degrees and a speed of around 10.5 knots. The first officer was asleep at that time; his estimation was that he possibly fell asleep around 20 minutes before the grounding. He was alone on the bridge and the watch alarm was switched off. Following grounding of the bow, the vessel moved to aft, resulting in the stern colliding with the rocks. As a result of the collision, the forepeak ballast water tank of the Stavfjord flooded. The vessel also suffered damage to its steering gear and thruster. On that same evening, the Stavfjord was towed to nearby Eldoyane (Stord).

THE CAPTAIN

The inspector's objection against the captain consisted of the following elements.

1. He had not ensured that the (new) first officer was adequately rested and was otherwise capable of assuming duty upon commencement of the watch.
2. The first officer fell asleep due to not being adequately rested. This had partly caused the grounding.

The inspector's demand was suspension of the navigation licence for four weeks or (only) imposing a fine.

The captain stated that

- he was not on the bridge when the incident occurred;
- he did not have the watch (except in an advisory sense);
- the first officer probably had more experience in this specific region than he did.
- the first officer was fully rested, according to the vessel's resting hours.
- he was not required to question everyone arriving on board regarding their movements during their free time, and that the vessel did not keep registration of resting hours for the crew before they were on the crew list;

- he had spoken with the first officer for 45 to 60 minutes when he arrived on board, and had assessed that he was suitable for watch duty;
- if the first officer had been feeling too tired to take over the watch, he should have immediately informed him of this;
- this incident did not result in any injury or damage to other vessels, installations or infrastructure.

The Disciplinary Court declared the objection to be well-founded. As the Disciplinary Court agreed with the captain that there should also have been a sense of own responsibility by the first officer, who himself should have realised that he was insufficiently rested to be able to conduct the watch in a responsible manner under these circumstances, and that he should therefore have clearly communicated this, and because the consequences of the incident remained relatively limited and the captain no longer worked under the Dutch flag, the Disciplinary Court imposed a fine of € 2,500 on the captain.

In the opinion of the Disciplinary Court, this case did not concern whether the captain should question each crew member arriving on board regarding their movements in their leisure time, nor whether the resting hours needed to be registered for crew members not yet on board. In this case after all, one must assume that the captain was aware that the first officer had undertaken a lengthy journey from another continent before starting his watch: a flight from Manila to Bergen, including two transfers, lasting nearly 26 hours, excluding local travel before and after. The captain should have been aware that fatigue could (suddenly) strike during the subsequent watch duty. With this in mind, the Disciplinary Court also referred to the reaction from the ship's management to the inspector's question regarding how rested the first officer had been when boarding the vessel and quickly starting his watch: "He travelled from Manila to Bergen, so I wouldn't imagine he'd be completely fit" and to the question regarding the procedures on board to ensure that anyone joining the vessel is rested before his/her watch starts: "No procedure for this situation, is currently under improvement". The Disciplinary Court therefore believed it improper to require the first officer to undertake the watch shortly after such a lengthy journey, without further adequate bridge crewing, in the dark, navigating the fjords, while the watch alarm and the ECDIS warning system were also deactivated. Even if the first officer had not (yet) appeared tired to the captain, when the captain spoke to him upon coming on board, that offers insufficient guarantee that fatigue will not become an issue during subsequent work. Apart from that, the captain's perception was contrary to the first officer's own description of his well-being, namely that he was only slightly rested upon starting his watch.

The Disciplinary Court also took into consideration that fatigue was a known cause of incidents at sea and that it should be assumed that a lengthy journey from another continent to the vessel might result in fatigue and resultant sleepiness during subsequent, routine-based working activities. The Disciplinary Court referred to the Guidelines on Fatigue of the Maritime Safety Committee (MSC) of the International Maritime Organization (IMO), MSC.1/Circ. 1598 and the previous versions. This should have been taken into account when organising duties. This did not take place in this case and was a serious offence also by the captain. Any further statements by the captain did not deter from this.

THE FIRST OFFICER

The inspector's objection against the first officer consisted of the following elements.

1. He was inadequately rested to be capable of assuming duty upon commencement of the watch, and had not informed the captain of this.
2. He had not activated the BNWAS upon commencement of his sea watch.
3. He had dismissed the lookout from the bridge to conduct another task.
4. Despite the audible alerts of the ECDIS not forming a replacement for the BNWAS, the inspector held the first officer responsible that he had maintained the audible alerts switched off (silent mode).
5. He had fallen asleep due to (the combination of) these circumstances, was not alerted and the grounding could take place.

The inspector demanded suspension of the navigation licence for a period of four weeks.

With the exception of the first part of the objection, the first officer acknowledged the correctness of the inspector's objection.

The Disciplinary Court declared the objection to be well-founded and imposed a suspension of the navigation licence of the first officer for four weeks.

According to the Disciplinary Court, the experienced first officer should have been aware of the possibility of being overwhelmed by fatigue, during such a long watch, so soon after a lengthy journey, possibly as a result of sleep deprivation. In the case against the first officer, the Disciplinary Court once again referred to the circular MSC.1/Circ. 1598 – Guidelines on Fatigue, and specifically to the point of jet lag.

There should have been even more awareness – also by the first officer – that constant vigilance was required while navigating in the dark through a tricky navigation area (the fjord), while he was actually in an unfit state in which, objectively speaking, (travel) fatigue could trouble him. For that reason, among others, he should not have fulfilled this watch as sole officer on the bridge. The Disciplinary Court did not believe the fact that the captain was aware of the lengthy journey made by the person concerned prior to his watch to be a sufficient excuse. In the opinion of the Disciplinary Court, this would imply a failure by the first officer to recognise the personal responsibility of a duty officer of the watch. The Disciplinary Court also found it to be particularly harmful that he did not activate the BNWAS, which he knew to be switched off, and that he left the ECDIS in silent mode, while the functioning of such alarms carried extra importance in the given circumstances (which included: a sole officer on the bridge, who had also just completed an extremely long journey; sending the lookout below, navigating the fjords in the dark).

In both cases, the Disciplinary Court named a focal point for professional practice: the importance of recognition of fatigue factors when appointing and fulfilling watch duties. Such factors also include lengthy travel time prior to joining the vessel. Moreover, the (prescribed) use of alarm systems and a lookout remains essential.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2024

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
Deputy justice at the Court of Appeal in the Hague
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

S. Kramer
Skipper in marine fishing

O.F.C. Magel
Captain

R.A. Oppelaar
Captain

R.E. Roozendaal
Captain

C.R. Tromp
Captain

J.L. Schot
Skipper in marine fishing

P.L. van Slooten
Skipper in marine fishing

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

DEPUTY MEMBERS

W.A. Barten
Hydrographer

J. Berghuis
Captain

R.M. Boeijen
Chief Engineer

J.K.J. Bout
Skipper in marine fishing

V.C. Engel
Captain

R.J.N. de Haan
Registered pilot

A.J. de Heer
Former Shipowner

H.J. Ijpma
Formerly skipper in marine fishing

N.P. Kortenoeven-Klasen
Hydrographer

H.H. Pannekoek
Captain

S.W. Postma
Captain/North Sea pilot

D. Roest
Captain

R.H.P. Ruigrok
Registered pilot

H. Schaap
Formerly skipper in marine fishing

C.J.M. Schot
Shipping company

P.H.G. Schonenberg
Ship's officer

J.J. Spaan
Hydraulic engineer

A.W. Taekema
Captain

E. E. Zijlstra
Hydraulic engineer

SECRETARY

V. Bouchla

DEPUTY SECRETARIES

E.M. Dooting

K. de Ridder until 1 July 2024

Fanny Pietersma-Smit since 1 July 2024

SECRETARIAT

E. Doeven

