MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

ANNUAL REPORT 2021

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 2021

CONTENTS

General 5

New cases and settled cases 6

Rulings of the Maritime Disciplinary Court of the Netherlands in 2021 7

Composition of the Maritime Disciplinary Court of the Netherlands in 2021 28

GENERAL

In terms of figures, 2021 was a notable year. Never before in our history has the Disciplinary Court ruled on 14 cases, four of which were decided by a full tribunal. The large number of rulings is explained by the many petitions filed by the minister in 2020 and the delay in processing caused by the coronavirus. The Human Environment and Transport Inspectorate, Shipping domain (ILT), submitted five new petitions this year.

For the first time in many years, we received a complaint from a seafarer himself. In that case, a preliminary investigation was carried out by one of our members.
Summaries of the settled cases are given further on in this annual report. These summaries give no more than 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.

In June, a successful meeting was held especially for our less experienced members. We held some practice sessions and discussed integrity, objectivity and sentencing and the relationship to other tribunals. The induction procedure for new members has been modified in response to this.

At the end of the year, most of the current members were reappointed for four years. Unfortunately, since they no longer meet the navigation licence requirement, this was not the case for Roel Ballieux, Dirk Willet and Gerard Jansen.

It was also a busy year in terms of meetings. Several meetings were held with the Maritime Affairs Directorate, Shipping Division, of the Ministry of Infrastructure and Water Management and with the ILT. Talks were also held with representatives of the NVKK, OVV, Nautilus and the KVNR.

Amsterdam, 3 May 2022

Peter Santema (Chairman)

NEW CASES AND SETTLED CASES

Year	Petitions of the Minister	Complaints	Preliminary investiga-tions	Number of cases settled by the presid-ing 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
Total	95	2	9	2	92

* In 2011 one case and in 2014 two cases were withdrawn by the minister.

RULINGS OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2021

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.

ZAANBORG

RULING OF 5 FEBRUARY 2021
NO. 1 OF 2021
CASE 2020.V4-ZAANBORG

Person concerned: the first mate

On 15 January 2020, the mv Zaanborg departed in ballast condition from the port of Ravenna, Italy. That was in the evening and the pilot disembarked within the piers. Fairly shortly thereafter, the vessel struck a fixed object (a platform). This resulted in substantial damage above the waterline, mainly to the port side of the foreship.

The Inspector accused the person concerned of acting as follows, despite the fact that he was sailing in or near an area of restricted visibility and there was uncertainty about an echo straight ahead:

1. not reducing the ship's speed to create more time to assess the situation.
2. executing a course change to port. COLREG regulation 19 advises against a change of course to port in respect of a ship more luff than sheer, other than a ship that is being overtaken. When changing course, the person concerned took into account the possibility that the echo was a rain shower or mist bank, but also that it could contain an object.

The person concerned considered all the objections raised by the Inspector to be unfounded. According to him, the weather was acceptable/good and, based on the information available up to the moment of the collision, there was no reason to reduce speed. The echo was ultimately not interpreted as a sailing object and, moreover, a change of course to starboard was not the best option because he saw a drilling platform there on the electronic chart.

After the (online) hearing, the Disciplinary Court ruled the Inspector's first objection well-founded and the second objection unfounded. Upon arrival at Ravenna, the master had already noticed that several obstacles were not correctly shown on the chart. This was one of the reasons why the speed of 13 knots was too high. When uncertainty arose about the echo straight ahead, the vessel's speed should have been reduced in order to have more time to assess the situation better, also because of the limited visibility.

As to the Inspector's second objection, there was little or no evidence that the echo straight ahead was caused by a ship (which was not visible due to rain). In so far as a vessel approaching from ahead had to be taken into account, it was not ill-advised in this case to turn to port because of the platform on the electronic chart on the starboard side. Counsel correctly pointed out that regulation 19 of the COLREGS makes mention of avoiding a change of course to port "as far as possible".
The Disciplinary Court ruled that the person concerned had not acted as befits a responsible officer, thus jeopardising the safety of the ship and the environment. The person concerned is still young and has limited experience as first mate. In connection with this incident he was recently fined in Italy. Although this may have been paid for by the shipping company, it was likely that this procedure has been stressful for him. Furthermore, he appeared to have learned his lesson. Given these circumstances, it was considered sufficient to impose a warning.

Practical recommendations:

1. Radar
The Disciplinary Court advises bridge teams to use both radar systems if the vessel is equipped with an X-band and S-band. Due to the different properties of both systems, objects can come through better on the one system than on the other. This includes Racon signals and objects in a shower. Furthermore, a comparison of the two radar systems can provide a better interpretation of the data obtained from the systems.

2. AIS:
When sailing in areas such as Chinese waters, where every fishing buoy is fitted with AIS, it is tempting to think that every dangerous object is fitted with AIS. The Disciplinary Court wishes to point out that this is not a safe assumption. There are also many objects in the oil industry that have no power supply, are unlit and do not have AIS. There are also many small and even large ships around the world that do not have AIS or have AIS turned off.

3. CATZOC
Category Zones of Confidence indicates the accuracy of the hydrographic data on the chart. The CATZOC table shows the position accuracy, depth accuracy and survey quality of each ZOC value. A misconception is that buoys, drilling rigs and other obstacles are indicated with the same accuracy as the position accuracy in the ZOC table. The accuracy of these objects depends on data provided by third parties to the UK Hydrographic Office. Mistakes regularly creep in. A common inaccuracy is that mistakes are made with degrees, minutes, seconds and degrees, minutes and tenths of minutes.
The Disciplinary Court wishes to point out that any seafarer who observes a position error of a drilling platform or any other object can report this to the UK Hydrographic Office by means of a Hydrographic Note (see NP 100, there is even a separate app developed for this: the Admiralty H-Note; this can be downloaded from the IOS and Android App store).

ZAANBORG

VERDICT OF 5 FEBRUARY 2021
NO. 2 OF 2021
CASE 2020.V3-ZAANBORG

Person concerned: the master

Case: see above (Case 2020.V4-Zaanborg)

The inspector accused the person concerned of the following:
1. the person concerned left Ravenna without any proper voyage plan having been made.
2. despite the fact that he was sailing in or near an area with restricted visibility and uncertainty about an echo straight ahead, the person concerned did not reduce the vessel's speed in order to have more time to better assess the situation.
3. despite the fact that he was sailing in or near an area with limited visibility and uncertainty about an echo straight ahead, the person concerned accepted that the OOW changed course to port. COLREG regulation 19 advises against a change of course to port in respect of a ship more luff than sheer, other than a ship that is being overtaken. When changing course, the person concerned took into account the possibility that the echo was a rain shower or mist bank, but also that it could contain an object.

According to the person concerned, he drew up a thorough voyage plan which complied with the IMO Guidelines and the SOLAS Regulations, including the use of nautical charts and publications for the area concerned. He claims that the fact that the incident could still occur was due to errors made by the Italian hydrographic service and the pilot's failure to provide information.
The weather was acceptable/good. Based on the information available up until the moment of the collision, there was no reason to reduce speed.
The echo was ultimately not interpreted as a sailing object and, moreover, a change of course to starboard was not the best option because the first mate saw a drilling platform there on the electronic chart.

The Disciplinary Court considered the first and second objections of the Inspector well-founded. The voyage plan approved by the master was mainly a "paper" voyage plan covering the voyage from the port of Ravenna to the anchorage just off the coast of Ravenna. Just before departure a decision was made ashore to drift. Subsequently, the voyage plan was slightly adapted to the new "destination" while the ship was underway, during which matters were inadequately discussed and the pilot's advice was blindly accepted. Upon arrival at Ravenna, the master had already noticed that several obstacles were not correctly shown on the chart.
This was one of the reasons why the speed of 13 knots was too high. When uncertainty arose about the echo straight ahead, the vessel's speed should have been reduced in order to have more time to assess the situation better, also because of the limited visibility. Contrary to the master's opinion, this does not necessarily mean that the vessel steers less quickly because, when sailing slowly, it is possible to quickly increase the pressure on the rudder by giving rudder and power at the same time. In this case, the additional thrust is almost entirely converted into the rotation. At low speed the turning circle of every ship is smaller, so by definition it is easier to swerve.
The Disciplinary Court considers the Inspector's third objection to be unfounded; see the explanation given for the Inspector's second objection in case 2020.V4-ZAANBORG.
The Disciplinary Court ruled that the person concerned had not acted as befits a responsible officer, thus jeopardising the safety of the ship and the environment. In view of the seriousness of the conduct, the Disciplinary Court considered it right and proper to suspend the navigation licence for four weeks. The person concerned was recently fined in Italy in connection with this incident. Although this may have been paid for by the shipping company, it was likely that this procedure has been stressful for him. Furthermore, he appeared to have learned his lesson. In view of these circumstances the suspension was imposed in its entirety on a conditional basis.

Practical recommendations

In addition to the three recommendations in the case 2020.V4-ZAANBORG mentioned above (Radar, AIS and CATZOC), the Disciplinary Court issues a fourth recommendation concerning the role of the master:
The Disciplinary Court wishes to emphasize the responsibility and "overriding authority" of the master. The Disciplinary Court increasingly sees the pressure of shipowners and/or charterers being exerted on the master. The master is the person who can oversee the situation on board and who takes the decisions and is responsible for them. The master must of course defend his decision with arguments to the interested parties (authorities, pilot, shipowner, etc.). The master must always bear in mind that a shipowner is not setting out to cause an accident, which will usually cost many times more than the savings that the shipowner has in mind if, for example, he presses to depart earlier from a port.

ZEALAND

RULING OF 3 MARCH 2021
NO. 3 OF 2021
CASE 2020.V7-ZEALAND ROTTERDAM

Person concerned: the master

On 23 November 2019, a serious accident took place aboard the freighter Zealand Rotterdam. As a result of that accident, F. Jr. B. C. (the seaman) died. The accident took place when the crew were preparing to unload cargo from the vessel Zealand Rotterdam using their own unloading equipment. During this process, the seaman climbed onto the cargo grab of a loading/unloading crane of the Zealand Rotterdam. He did this in order to attach the hook of that crane to the O-ring at the top of the grab. After he had disconnected the O-ring and/or the grab cable, the crane hook struck him with a swinging motion, probably/possibly due to a rolling movement of the Zealand Rotterdam, which was at that point in time lying at anchor at the roadstead of Mumbai, India. This caused the seaman to lose his balance and he fell a distance of about five metres. He landed on the main deck. The fall left him badly injured. He died of his injuries shortly thereafter.

The Inspector accused the person concerned of the following.

1. The person concerned, as master, attended the toolbox meeting for the day on the morning of 23 November 2019. The unloading of the cargo was not discussed at the time because it was not yet known that unloading would take place that day. When this became clear later in the day, the person concerned failed to hold an additional toolbox meeting.
2. The person concerned did not fill in or issue a work permit for working aloft.
3. The person concerned communicated the order to unload to the first mate verbally and did not attach any further consequences/instructions to this.
4. The person concerned passed on the problem of the pressure of time to make the vessel ready for unloading – imposed by the agent – directly to the first mate. He thus endangered the safety of the crew
5. At an earlier stage, the person concerned had failed to take any measures to make the O-ring secure for sea in a lower position. By doing so, he could easily have created much safer working conditions.

The person concerned did not appear at the (online) hearing, but he did sign an accident report and a master's statement, which were included in the petition as appendices. Leave was granted to proceed in default of appearance by the person concerned. Questions of the Inspector about the circumstances of the accident were answered by the shipping company's agent (compliance manager).

Based on the statements, findings and documents, viewed in conjunction with the accompanying photographs and drawings, the Disciplinary Court was able to establish the facts in the run-up to and the fatal accident itself. The Disciplinary Court ruled that a fatal accident such as that which occurred here could be prevented by taking appropriate safety measures – by the master or, on his instruction, by other officers. This includes first and foremost a risk analysis before the start of

the work. According to the safety management manual, this risk analysis should have been carried out within the framework of an additional toolbox meeting and/or by using forms and matrices. In this way, potential hazards could have been clearly identified and so could the responsibilities for monitoring compliance with the safety regulations. These safety regulations included the presence of a work permit for the work aloft. As part of the process of issuing this permit, the regulations stipulate that checks should be made on the use of a safety harness and adequate fall protection equipment, among other things. That work permit was not issued in this case.
The victim did not use the prescribed PPE (personal protective equipment); he was not wearing a safety harness and was not equipped with a fall arrest device, and it does not seem that anyone supervised the use of these necessary safety devices. Nor does it seem that the – by no means imaginary – danger of a swinging movement of the crane hook, in combination with the presence of a crew member on top of the grab, or on the steps of the grab, was recognised. To the extent that the swinging motion of the crane hook was a result of the ship rolling, this should also have been taken into account, also considering the fact that the vessel was approximately 6 miles off the coast in the open sea (Indian Ocean), where rolling could be expected, which constituted an additional risk when hitching and unhitching the grab.
In addition, the Inspector rightly pointed out that the person concerned could have achieved safer working conditions at an earlier stage by having the O-ring of the gripper secured for sea at a lower position.

The omissions that the Inspector accused the person concerned of were considered proven by the Disciplinary Court. The Disciplinary Court ruled that the person concerned seriously failed in his duty as master. This includes a duty of care for the safety of the crew members. The duty of care includes preventing exposure to (potentially) unsafe situations, as well as organising supervision of compliance with the safety regulations to be observed, including in this case the wearing of a safety harness and the use of fall protection when working aloft. The breach of this duty of care led to a fatal accident in this case. The fact that the Zealand Rotterdam had to be unloaded unexpectedly and quickly was no excuse. It was his responsibility as master to counterbalance this pressure by stating and ensuring that unloading could only take place once the preparatory work on board had been carried out safely. The person concerned has not shown that he was aware of this responsibility. This counted strongly against him. In view of the seriousness of the negligence a suspension of the navigation licence for a period of 3 (three) months and in addition a fine of € 2,500 were imposed.

Practical recommendations

Reference is made to the report of the Dutch Safety Board published on 3 March 2022.

ZEALAND

RULING OF 3 MARCH 2021
NO. 4 OF 2021
CASE 2020.V6-ZEALAND ROTTERDAM

Person concerned: the first mate

Case: see above (Case 2020.V7-Zealand Rotterdam)

The inspector holds the person concerned – who was on watch as first mate at the time of the accident – accountable for the following:

1. The person concerned was present at the toolbox meeting held for that day in the morning. The unloading of the cargo was not discussed at that time because it was not yet known that the cargo would be unloaded that day. However, the person concerned did not hold an additional toolbox meeting when this became clear later in the day.
2. The person concerned did not fill in or issue a work permit for working aloft.
3. The person concerned left the preparatory work for unloading to the boatswain, without giving clear instructions.
4. The person concerned allowed the time pressure imposed by the agent to outweigh performing the work in accordance with established procedures. He thus endangered the safety of the crew
5. At an earlier stage, the person concerned had failed to take any measures to make the O-ring secure for sea in a lower position. By doing so, he could easily have created much safer working conditions.

The person concerned did not put forward a defence. There was however a signed statement of his as chief officer. In it he wrote, among other things: 'During accident I was in ships office'. Questions of the Inspector about the circumstances of the accident were answered by the shipping company's agent (compliance manager).
The person concerned did not appear at the hearing. Leave was granted to proceed in default of appearance against him.

According to the Disciplinary Court, the accusations made against the first mate and the master coincided to a large extent. The same measure was imposed on the first mate as on the master.

UAL LOBITO

RULING OF 7 MAY 2021
NO. 5 OF 2021
CASE 2020.V1-UAL LOBITO

Person concerned: the master

On the morning of 19 November 2019, aboard the ms UAL Lobito, it was established that the vessel had lost two empty containers (TEUs) in bad weather. It is presumed that this happened on 18 November 2019 at Cape Finisterre while the ship was underway from Dakar (Senegal) to Antwerp (Belgium).

According to the Inspector:

1. The person concerned left Nouadhibou (Mauritania) on 4 November 2019 with a GMfluid which, according to the intact stability and stability in damaged state, was of sufficient magnitude. However, the GM value was much higher than the maximum value calculated in the Cargo Securing Manual. At that time, the person concerned was not convinced whether lashing down the deck cargo containers was sufficient. The deck cargo consisted of 6 containers with cargo in them (total 108.3 T) and 81 empty containers.
2. The person concerned left Dakar, Senegal, on 7 November 2019 with a GMfluid, which was considered of sufficient magnitude according to the intact stability and stability in damaged state. However, that GM value was much higher than the maximum value calculated in the Cargo Securing Manual. At that time, the person concerned was not convinced whether lashing down the deck cargo containers was sufficient. The deck cargo consisted of 85 empty containers.
3. The person concerned did not take into account the expected wind and 'green water'.

The person concerned took part in the hearing by video link from St. Petersburg, assisted by his counsel, who was present in the courtroom.

In reply, the Inspector stated that the use of the Cargo Securing Manual (CSM) is mandatory and that the first and second objections consisted of the fact that the person concerned did not check whether the lashing of the deck cargo, with parameters deviating from the CSM, was adequate. According to the Inspector, this was contrary to good seamanship. He takes the view that the person concerned, by sailing with a high GM value in an area with high waves, accepted that ship and cargo were exposed to excessive acceleration forces and 'green water'.

The person concerned considered all the objections raised by the Inspector to be unfounded. The person concerned claims that he took all measures to avoid the loss of containers. According to the person concerned, the loss of the two containers was due to "forces of nature", caused by waves on the underside of the containers.
According to counsel for the person concerned, the Inspector's claim was not formulated with sufficient precision, and there was no causal link between the allegedly breached rules and the loss of the containers. He referred to the report of Van Ameyde enclosed with the defence.

The Disciplinary Court understood that objections referred to as points 1 and 2 were based on the fact that the person concerned had not ascertained whether the lashing of the deck cargo of containers on the journey from Nouadhibou to Dakar and on the journey from Dakar to Antwerp was sufficient in the light of the fact that the GM value was higher than the value calculated in the CSM.

The Disciplinary Court ruled that it is not in itself unseamanlike to sail with a higher GM value than that calculated in the CSM. The standard of good seamanship does however require the person concerned to ensure that the cargo is secured correctly.

The Disciplinary Court did not consider it proven that the party concerned failed to ascertain whether the lashing of the deck cargo of containers on the voyage from Nouadhibou to Dakar and on the voyage from Dakar to Antwerp was adequate. The person concerned could rely on his crew's checks and notifications in this regard.

The ship's CSM requires that containers be secured on deck with bottom twistlocks and twistlocks. The CSM also states that "Additional diagonal lashings are generally required for stacks exposed to wind attack and/or the masses in that stack are to be reduced".

In the given circumstances, securing empty containers on deck in stacks of two with bottom twistlocks and twistlocks and securing containers with dangerous cargo with container chains was not considered by the Disciplinary Court to violate the standard of good seamanship.

The objection mentioned in point 3 was that the person concerned did not take the expected wind and "green water" into account, but the Disciplinary Court did not consider this to be proven.

The person concerned requested a change of course in response to a very rough sea in the Bay of Biscay, but this request was rejected. The Disciplinary Court considered a speed of 6-8 knots and 80% pitch not to violate the standard of good seamanship in the given circumstances and given the need to keep the ship manoeuvrable.

All objections against the person concerned were declared unfounded.

Practical recommendations

1. In a ship design with containers (partly) outside the hull and expected green water, it is recommended to leave the stack outside the hull free;
2. Include stability calculations with higher GM values in the Cargo Securing Manual.

EEMSHOORN

RULING OF 21 MAY 2021
NO. 6 OF 2021
CASE 2020.V8 - EEMSHORN

Person concerned: the master

On 5 November 2018, at approximately 04:50 local time, the Dutch seagoing vessel Eemshorn collided with the inner side of the storm surge barrier Oosterscheldekering. The vessel – of which the person concerned was the master – had left Yerseke and was going to sea via the sea lock Roompotsluis. At the time of the collision, only the mate was on the bridge, without a lookout. The mate has no memory of what happened in the period shortly before the collision.

The person concerned appeared at the online session assisted by his lawyer. At the request of the Inspector, the first mate and the seaman were also heard as witnesses.

The Inspector accused the person concerned of the following:
1. The collision occurred during the hours of darkness. During the hours of darkness there must be a lookout on the bridge. There was no such lookout.
2. The Eemshorn was not manned in accordance with the crew plan. There was only one deck rating onboard instead of the prescribed two. One 'deck rating' cannot (also) serve as a lookout during all hours of darkness without violating the work and rest hours regulations.

It was not clear to the person concerned why the seaman had left the bridge in this case. It is possible that over time adherence to certain instructions had faded.
The person concerned assumed that engineer had a sufficient endorsement on his certificate of competency to (also) serve as a deck rating.
The party concerned asked the Disciplinary Court, when determining a possible disciplinary measure, to take into account the fact that a long period of time elapsed between the accident and the submission of the petition for disciplinary action; almost 1 year and 11 months, which is just short of the maximum submission period of two years stipulated in Section 55h (4) of the Seafarers Act. Until recently, it was also a matter of conjecture as to whether he would be prosecuted. He has since learned that this will not be the case.

The Disciplinary Court ruled that it cannot reasonably be considered that the person concerned, as master of the Eemshorn, sufficiently fulfilled his responsibility to comply with the regulation to keep an adequate lookout during the hours of darkness. This responsibility includes ensuring (i) awareness and familiarity of the crew with the relevant regulation (a clear allocation of duties to each) and (ii) adequate supervision of compliance. This was lacking, which is why the Inspector rightly accused the person concerned of a violation of the relevant regulations from the COLREGs and the STCW Code in combination with Articles 4 and 55a of the Seafarers' Act.
Formally, it was also correct that the Inspector's second accusation was that the requirements as set out in the 'Minimum safe manning document' of the Eemshorn had not been met. Although in the meantime it has been confirmed that, who was signed on as an engineer, also held a cer-

tificate of competency at the time which provided a basis for employment as a seaman (of the watch), the fact remains that the engineer was not signed on in that capacity, as a result of which the Eemshorn was formally undermanned or at least not correctly manned.
In view of the seriousness of the culpability for not having/keeping a proper lookout, the Disciplinary Court considered a measure in the form of an unconditional suspension of the navigation licence for the duration initially proposed by the Inspector to be, in principle, appropriate and proper. On the other hand, the fact that the incident took place a long time ago and, importantly, that lessons were learned weighed in favour of the person concerned. These circumstances give the Disciplinary Court reason to impose – following the Inspector's proposal – a partial conditional disqualification.
Although the failure to comply correctly with the crew regulations applicable to the Eemshorn was also considered proven, in this case that allegation did not justify the imposition of a more severe or different measure because, materially speaking, the prescribed second 'deck rating' was indeed present.
The objections of the Inspector were declared well-founded and the navigation licence of the person concerned was suspended for the duration of 4 weeks, of which 2 weeks were conditionally.

LADY HANNEKE

RULING OF 2 JULY 2021
NO. 7 OF 2021
CASE 2020.V9-LADY HANNEKE

Person concerned: the master

On 24 June 2020, the Dutch vessel Lady Hanneke ran aground in Danish waters on Boels Plade in position 56°37.6N 010°28.3E. The vessel freed itself under its own power after the grounding and was detained by the Danish Maritime Authority. The Danish authorities reported the grounding via SafeSeaNet.

The Inspector accused the person concerned of failing to adequately fulfil his responsibility as the master in the inspection of the voyage planning. It had not been noticed that the planned route ran across the shallow Boels Plade, which resulted in a grounding.

The person concerned stated that the second mate prepared the voyage (from Russia to Randers) and that he checked the voyage plan prior to the voyage together with this second mate. He signed the voyage plan for approval on 15 June 2020. He attributes what went wrong to a stupid mistake. The shallow was overlooked because the electronic charts were not properly set.

The Disciplinary Court found that the voyage preparations had been made by the second mate. The person concerned, when checking this, did not notice that the route had been planned over the Boels Plade shallows. It also went unnoticed that the shallow contour in the Ecdis was set to 2 metres. If, for example, 6 metres had been entered (slightly more than the draught at departure)

the Boels Plade would have been given a different colour, making it clear at a glance that it was unsafe to let the route run over that area. It remains unclear whether, and if so, how the Ecdis settings had been configured for the voyage in question. It is also unclear whether the pilot for the area in question was consulted/interpreted correctly. The first mate, who was on watch at the time of the grounding, also failed to notice that the planned route was not passable in terms of depth. At the time of the grounding, the Lady Hanneke (carrying wood pellets) was sailing at a speed of approximately 7.5 knots. After the grounding, the ship freed itself under its own power. A dive inspection the following day found no holes or cracks in the hull, only some damage to the coating. The Disciplinary Board was of the opinion that the person concerned, in his capacity of master, did not exercise sufficient care when checking, prior to the voyage, whether the planned route, in terms of draught, could be sailed safely. From the data concerning the draught of the Lady Hanneke in combination with the draught on the planned route (over the Boels Plade) it should have been clear to him that, without further provisions, a grounding was inevitable or at least there was a considerable chance of this happening. A grounding is not without risks. Even with a sandy bottom, uncharted hard objects such as stones, anchors, lost cargo can cause holes/cracks in the hull, with all the consequences that entails. It is therefore important to be alert to preventing a grounding before and during the voyage.
The grounding could have been prevented if sufficient attention had been paid to checking the voyage planning. In view of the seriousness of the negligence, a six-week suspension of the navigation licence, two weeks of which conditionally, is appropriate. In determining this measure, account was taken, in the favour of the person concerned, of the fact that the consequences of the negligence had remained limited (to some material damage to the ship) and that the person concerned has been made aware of the fact that and how he failed in his supervisory role and has also learnt from this. This measure was the same as that imposed on the first mate and second mate on watch.

Practical recommendations:

1. There should be an explicit instruction that with every voyage, the Ecdis settings should be (i) adjusted to the new/current voyage and (ii) checked.
2. It is also recommended that awareness be raised by consulting the pilot guides that have been issued worldwide for many areas and explicitly warning of the dangers of entering ports.

LADY HANNEKE

RULING OF 2 JULY 2021
NO. 8 OF 2021
CASE 2020V10-LADY HANNEKE

Person concerned: the first mate

Case: See No 7 of 2021 Case 2020.V9-LADY HANNEKE

The Inspector accused the person concerned of not having checked the route of the journey for passability, which was his responsibility as officer of the watch. For that part of the voyage he was jointly responsible for the course to be followed. He did not check the Ecdis settings, at least for the safety contour, and did not enter the correct values in the Ecdis.
At the meeting of the Disciplinary Court, the person concerned stated that he considered the grounding to be a human error. He knew that there are shallows off Denmark. That is why he constantly monitored the echo sounder. More or less by way of an excuse, he pointed out that the shallows in the vicinity of the grounding had not been clearly pointed out by means of a buoy or some other kind of sign. At the same time he admitted that he also paid insufficient attention to the settings of the Ecdis, with which depths could be observed. The shallow contour was now set to 2 metres, which is a depth that the Lady Hanneke was not allowed to/could not pass.

For the findings of the Disciplinary Court, see No 7 of 2021 CASE 2020.V9-LADY HANNEKE

Practical recommendations: see No 7 of 2021 CASE 2020.V9-LADY HANNEKE

LADY HANNEKE

2 JULY 2021
NO. 9 OF 2021
2020.V11-LADY HANNEKE

Person concerned: the second mate

Case: See No 7 of 2021 Case 2020.V9-LADY HANNEKE

The Inspector accused the person concerned of the following:
1. The person concerned was responsible for drawing up the voyage planning. He did not do this with sufficient precision.
2. The person concerned failed to set the correct values in the Ecdis for the safety contour.
3. The person concerned failed to check the voyage plan with sufficient precision together with the master.

The person concerned stated at the hearing of the Disciplinary Court that he was aware that there are shallow waters off the coast of Denmark. The fact that things went wrong on this occasion – because the route ran over the shallow area of Boels Plade – is, in his opinion, due to the fact that he overlooked certain matters. He was referring to data that had already been entered in the Ecdis. He learned from the incident. Among other things, he needs to zoom in a bit further on the digital charts to be able to observe the depths better. He says he has also consulted the book 'Baltic pilot formula 1' and has seen that it mentions shallows off Randers Harbour. He compared that to what was shown on the charts. These charts indicated a depth of 7 metres or more.
For the findings of the Disciplinary Court, see No 7 of 2021 CASE 2020.V9-LADY HANNEKE

Practical recommendations: see No 7 of 2021 CASE 2020.V9-LADY HANNEKE

TORSTEN

RULING OF 9 JULY 2021
NO. 10 OF 2021
2021.V2 TORSTEN

Person concerned: the master

On 28 May 2020, an accident occurred on the multicat Torsten. The vessel was working on the river Elbe (Germany) for a dredging project (Neufelder sand). A floating pipeline had to be detached from its anchor to be connected to a sand dredger. The wire of the main winch was connected to the coupling wire of the floating pipe. The buoy attached to the anchor wire was pulled on deck with the auxiliary winch. When the buoy was pulled on deck with the bow roller, the buoy, still under tension attached to the wire of the auxiliary winch, moved unexpectedly to starboard. A seaman (referred to below as "the victim") sustained an injury to his lower right leg when he was hit by the wire of the auxiliary winch.

The Inspector accused the person concerned of the following:

1. The person concerned created a dangerous task by having the victim guide the taut wire of the auxiliary winch with a short boathook;
2. No separate risk analysis was carried out for this task and it was not discussed during a toolbox meeting, partly as a result of which the victim was 'not fully' aware of the risks involved in this task;
3. the communication between the person concerned and the crane operator from the wheelhouse with the victim was not properly set up; it took place with hand signals and there was also a 'blind spot'.

The person concerned acknowledged the facts stated in the application and considered the demand to be reasonable. He expressed regret at what had happened and wants to do better next time.

The Disciplinary Court ruled that the Inspector's objections could be declared proven. The person concerned created a dangerous task by having the victim guide the taut wire of the auxiliary winch with a short boat hook. The use of a boat hook to guide a taut wire from the auxiliary winch was an experiment of the client. Never before had the floating pipeline been linked between two sand dredgers. No separate risk analysis was carried out for this task, and it was not discussed during a toolbox meeting. Given the high-risk nature of the work and the fact that it was an experiment, this should have been done. Partly because of this, the victim was "not fully" aware of the risks involved in this task. The communication between the victim and the crane operator from the wheelhouse was not well established. Communication took place using hand signals while the victim was standing in the wrong place and was out of sight of the crane operator at one point. By acting this way, the person concerned endangered the victim, and the victim was injured as a result. When freeing a floating line from the anchor to be coupled to a sand dredger, the person concerned did not act as befits a responsible master, as a result of which the safety of those on board was endangered. Because the victim was injured in the process, the Disciplinary Court considered an unconditional suspension of the sailing licence for a period of two weeks to be appropriate.

Practical recommendations

1. If measures, procedures and equipment are available on board for a particular activity, they should be used;
2. High-risk activities, such as disconnecting a floating pipe from an anchor to be coupled to a sand dredger, are always subject to a Job Safety Analysis, followed by a Risk Assessment, a possible Last Minute Risk Assessment and a toolbox meeting. The topics covered are the management (overall and at the specific location), division of tasks, communication, visual contact, no-go areas (snap-back zones) and agreements on when an operation will be stopped.
3. If the client and the contractor have different safety cases, the most serious safety case applies to performance of the contract;
4. Familiarization is not just a formality but must have real substance.

OOCL RAUMA

RULING OF 16 JULY 2021
NO. 11 OF 2021
2020.V12-OOCL RAUMA

person concerned: master

On 11 and 12 February 2020, the container ship OOCL Rauma (IMO 9462794, Call sign: PBWS), sailing under the Dutch flag, lost a total of 7 loaded containers at three different times during bad weather. The ship was sailing on the North Sea and was en route from Kotka (Finland) to Rotterdam via the Kieler Channel with 525 containers on board.
During this voyage, the person concerned sailed as master of the OOCL Rauma, which was previously named MV "Elysee".

In particular, the inspector accused the person concerned of accepting, as the party with final responsibility, that the ship in Kotka was not loaded in accordance with Chapter IV of the Cargo Securing Manual (hereinafter: CSM).
Especially during the bad weather en route, the loads on the containers in the higher tiers of the "open top" holds, and the loose lashing materials were therefore bigger than those accounted for in the approval of the container lashing plans.

The person concerned appeared at the hearing, assisted by his counsel. The person concerned disputed the Inspector's objection. He did not know that the vessel was not loaded in accordance with the CSM. The loading plan was drawn up on shore, and the first mate responsible did not establish any errors in it, partly because the software provided by the shipping company had limitations. The person concerned denied that he could be held individually to blame.

The Disciplinary Court found (with a sufficient degree of certainty) as follows. As the party with ultimate responsibility, the person concerned accepted that the vessel in Kotka was not loaded in accordance with Chapter IV of the Cargo Securing Manual (hereinafter: CSM). Especially during the bad weather en route, the loads on the containers in the higher tiers of the "open top" holds and the lashing material were therefore bigger than those accounted for in the approval of the container lashing plans.
Although it is common practice that the first mate supervises the loading and the master has the final responsibility, the person concerned could also be held personally to account in this case. As he stated at the hearing, he had already made this journey several times, and he knew that heavy containers loaded with paper were usually shipped from Kotka. He was aware that the CSM imposes specific requirements on stowing and lashing heavy containers. The person concerned has not been able to make clear to the Disciplinary Court on what basis he relied on the first mate's verification that these specific requirements had been met. In the given circumstances of this case, the person concerned should have actually fulfilled his supervisory role and should not have left it entirely to the discretion of the first mate as to whether or not to inform him.
It could not be determined whether full compliance with the CSM could have actually prevented the containers from going overboard in the very severe weather conditions en route. In any event, unnecessarily heavy loads were placed on containers in the higher tiers of the "open top" holds. The Disciplinary Court found the objection well-founded.
The Disciplinary Court judged that the person concerned had failed in his duty as a ship's master. It should, however, be noted that the master managed to preserve the ship and her crew in very difficult weather conditions.
On the basis of the foregoing considerations, the Disciplinary Board considered it sufficient to impose the measure of a reprimand.

Practical recommendations

1. As the Inspector and counsel also pointed out, the on-board computer program does not contain a module that tests the strength of the lashing system in cases where the individual weights in the stacks differ from the container lashing plans. Equipping container ships with this would make it easier to monitor compliance with CSM.
2. The first mate should not have to keep watch on deck in port but should concentrate fully on the loading. Shipowners must facilitate this.
3. It is recommended that officers on deck share information with each other, in this case about

the specific requirements of the CSM regarding the manner of stowage and lashing.
4. Important requirements should be stated in a CSM more clearly than as a “Note” in a small box on 2 of the 3 container lashing plans.

EEBORG

RULING OF 30 JULY 2021
NO. 12 OF 2021
2021.V1-EEBORG

Person concerned: the second mate

On 6 October 2020, at around 03.50 LT (=UTC+2), an incident took place on board the Eeborg. The person concerned was officer of the watch. The ship was sailing in the Vessel Traffic Service (VTS) area Storebelt at that time. They had just crossed the bridge Storebeltbrug. The person concerned went to the toilet. By taking this action he left the lookout alone on the bridge, who had no command of the English language and therefore could not understand what was being said over the VHF radio.
A collision almost occurred with the ship Flag Mette (Maltese flag).
At the time of the incident, the person concerned was sailing as second mate the seagoing vessel Eeborg, sailing under the Dutch flag (IMO number 9568328, call sign PCNL). The Eeborg is a general cargo ship with a length of 144.56 m, width 15.87 m and a gross tonnage of 7680.

The Inspector accused the person concerned of the following:
1. that he left the bridge as OOW to visit the toilet for approx. 10 minutes
2. that he left the bridge 15 to 20 minutes before the end of his watch
3. that he did not call a replacement on the bridge
4. that he only looked at the radar a few minutes ahead. As a result, he did not notice the Flag Mette.
5. that he remained in the toilet much longer than he had thought he would beforehand. Even then he did not inform and/or instruct the lookout on the bridge.
6. due to his absence from the bridge, the ship passed the next waypoint and deviated from the planned route.
7. that in view of the above, the person concerned seriously neglected his duties as an OOW and the near-accident situation arose as a result.

The person concerned took part in the hearing by video link from China, assisted by his counsel, who was present in the courtroom. The person concerned denied that he seriously neglected his duties as OOW. It is not always possible to give an AB or replacement detailed instructions in such circumstances. Moreover, the person concerned said that he did not leave the bridge because the toilet was adjacent to the bridge.

Based on the contents of the evidence, the Disciplinary Court declared all the objections of the Inspector well-founded. The Disciplinary Board found it incomprehensible that the person concerned did not see Flag Mette before leaving the bridge for the toilet. Both visually and by radar, that ship had to have been visible. It was certainly a busy and winding waterway. It was therefore irresponsible to go to the toilet at that moment. It is equally incomprehensible that the person concerned did not arrange for a replacement when it became apparent that he would be unable to keep watch for a longer period. Of course it can happen that the officer of the watch urgently needs to go to the toilet, but personal inconvenience should not be at the expense of safety at sea. In this case, a shipping disaster came very close.
The Disciplinary Court judged that the person concerned had failed in his duty as second mate. The person concerned did not act as befits a responsible officer, resulting in a life-threatening situation. It was in the favour of the person concerned that he accepted responsibility at the hearing and learned from this incident. All things considered, the Disciplinary Board deemed the measure demanded by the Inspector appropriate.
The Disciplinary Court suspended the navigation licence of the person concerned for a period of 8 weeks, 4 weeks of which conditionally.

Practical recommendations

1. If an officer on watch absolutely must go to the toilet he must ensure in advance that it is safe to do so and that an adequate watch is maintained during his absence.
2. If an officer of the watch is unable to carry out his duties (temporarily) due to illness, he must immediately arrange for a replacement.

BERGFJORD

RULING OF 19 NOVEMBER 2021
NO. 13 OF 2021
2021.V3-BERGFJORD

Person concerned: the master

On 7 January 2021, the vessel Bergfjord ran aground near the Norwegian island of Ytstegeita, a few dozen miles north of Bergen. As a result of this grounding, the forepeak and the port and starboard deep tanks were pierced and took in water. At the time of the accident, the crew consisted of six people in total. The cargo consisted of steel products.

The inspector accused the person concerned of:
1. Failing to conduct proper navigation.
2. Sending the lookout off the bridge to clean the windows, while he himself did not keep a lookout either.
3. After the ship came outside the set cross-track error of the Ecdis, he accepted the alarm, changed course, but did not check whether the vessel had actually returned to the set course.
4. The above errors eventually led to the vessel running aground.

The person concerned attended the hearing via a video link from Russia and admitted at the hearing that the accident was due to his negligence and that he had made a number of serious mistakes.
Based on the contents of the evidence, the Disciplinary Court considered all four objections by the inspector to be well-founded. The Disciplinary Court found it incomprehensible that the person concerned did not correctly enter the settings in ECDIS, while being charged with the navigational watch and having sent the lookout off the bridge to clean the windows, turned his attention to working on the computer with his back to the window without looking back. The person concerned thus failed to keep a proper lookout at all times. It was also incomprehensible that after the ship missed waypoint 137 and the alarm sounded, the person concerned did not sufficiently alter course or check the drift, as a result of which the vessel collided with the island of Ytstegeita and the forepeak and the port and starboard deep tanks of the ship let in water.
In view of the seriousness of the proven behaviour, the requested measure (a suspension of the navigation licence for a period of 4 weeks, of which 2 weeks conditionally) was not sufficient, given the extent to which the attitude and behaviour of the person concerned played a role in the breach of the standard. On several occasions, the person concerned behaved indolently before and during the trip and did not focus sufficiently on his job.
In the circumstances that the employment contract between the shipping company and the person concerned has been terminated as a result of the incident and that the person concerned admitted his liability during the hearing, the Disciplinary Court saw good reason to rule that the suspension of the navigation licence should be imposed partially conditionally.
The Disciplinary Court suspended the navigation licence of person concerned for a period of 6 weeks, 2 weeks of which conditionally.

Practical recommendations

There should be an explicit instruction that with every voyage, the ECDIS settings should be (1) adjusted to the new/current voyage and (2) checked.

THUN LIFFEY

RULING OF 29 NOVEMBER 2021
NO. 14 OF 2021
2021.V4-THUN LIFFEY

Person concerned: the master

On 29 December 2020, the Thun Liffey ran aground after departing from Londonderry. This happened just after the pilot had been disembarked with the pilot boat. The vessel was aground for several hours before being released by the rising water and the help of two tugboats.

The Inspector made the following accusations against the person concerned:

1. by heeding to the pilot boat's skipper to give even more leeway to starboard, he effectively surrendered his vessel's safe navigation to the pilot boat's skipper. That was certainly the case

when the person concerned could not monitor his position, course and speed over ground because he was looking out over the starboard side. He did that because it took so long to disembark the pilot.

2. he did not switch on the ECDIS screen on the starboard bridge console or have it switched on.
3. he did not instruct the first mate to monitor the vessel's position, course, and speed from the starboard console when he left the centre console to look out to starboard.
4. he took insufficient account of the influence of the strong ebb tide and rising NNW wind on the vessel when disembarking the pilot.
5. the ship was grounded for several hours.

In summary, the person concerned argued that the accusations against him were based on incorrect facts and assumptions. It followed from what he regarded as the correct facts that the person concerned turned to a safe course too late because the pilot remained on board far too long. The pilot and the pilot boat skipper could and should have stopped the operation when it took too long and warned the person concerned, which they failed to do. The first mate and third mate should also have provided the person concerned with information, which they failed to do.

The Disciplinary Court states first and foremost that the person concerned, as master, is ultimately responsible for the safe navigation of his ship. This means that – even if he receives insufficient information from his crew or the pilot – he must make active enquiries to find out what is going on if the vessel is in danger. Against this background, on the basis of the evidence in this case, the following emerged (with a sufficient degree of certainty).
The third objection was well-founded, in the sense that the person concerned should have instructed the first mate to keep an eye on the position, course and speed of the vessel when it was decided that the pilot would disembark earlier and it became clear that the pilot would leave the bridge with the third mate, a member of the Bridge Resource Management (BRM) team. The third mate's task should have been taken over. The disembarkation of the pilot took a total of five minutes from the time the pilot left the bridge to the time the pilot left the vessel. There may have been something wrong with the manropes, but this did not become clear at the hearing.
The fourth objection was well-founded. In response to written questions from the Inspector, the person concerned acknowledged that he failed to take sufficient account of the influence of the strong ebb tide and the increasing NNW wind on the vessel during the disembarkation of the pilot. Had he taken these circumstances sufficiently into account, he would not have agreed to the pilot's wish to disembark earlier, in accordance with good seamanship. However, the person concerned could have agreed to the pilot's wish and, in accordance with good seamanship and taking into account the ebb current and the wind, should have cleared more space on the starboard side by positioning the vessel more on the port side of the fairway before starting the manoeuvres in connection with disembarking the pilot. Another possibility if he had realised the influence of the strong ebb tide and increasing wind is that he could have aborted the operation when he felt that the disembarkation of the pilot was taking too long.
The fifth objection was well-founded. It was an established fact that the vessel was grounded for several hours.
The first objection was unfounded. The person concerned did not transfer the safe navigation of his vessel to the skipper of the pilot boat. He himself took over navigation from the pilot when the pilot left the bridge with the third mate. The person concerned was in control and fully engaged

in his task of navigating. The second objection was unfounded. It was true that the ECDIS on the starboard bridge console was not switched on. However, it was understandable that this ECDIS was not switched on, because it was of no use when disembarking the pilot.
The Disciplinary Court judged that the person concerned seriously neglected his responsibilities as master, which resulted in the vessel's grounding.
The Disciplinary Court took the following into account: – two of the five objections were unfounded; – the behaviour shown in respect of the three remaining objections was serious enough to warrant the measure of suspension of his navigation licence for a period of two weeks; – the person concerned received an official warning from the office and was told that, if it happened again, other measures would follow; – there was no damage to the ship or the environment; – the person concerned has learned from the incident.

Practical recommendations

1. The pilot ladder should be made ready and checked by a competent mate well before the pilot disembarks. This preparation is even more important when using manropes. "2.2. The rigging of the pilot transfer arrangements and the embarkation of a pilot shall be supervised by a responsible officer having means of communication with the navigation bridge and who shall also arrange for the escort of the pilot by a safe route to and from the navigation bridge. Personnel engaged in rigging and operating any mechanical equipment shall be instructed in the safe procedures to be adopted and the equipment shall be tested prior to use."
   - SOLAS CH V, Reg 23
2. A BRM team has a verifying task and should identify and correct individual errors made by team members. All members of the BRM Team must therefore be aware of their responsibilities and job descriptions within the team. This means that if one or more members of the BRM team leave the bridge for a short or long period of time, the master (or another team member) will ensure that their tasks are fulfilled or taken over.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2021

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

E.R. Ballieux
Master

E.R. IJssel de Schepper
Master

C. Kuiken
Ship's mate

H. van der Laan
Master

R.A. Oppelaar
Master

R.E. Roozendaal
Master

C.R. Tromp
Master

D. Willet
Chief Engineer

S. Kramer
Skipper in marine fishing

J.L. Schot
Skipper in marine fishing

P.L. van Slooten
Skipper in marine fishing

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

DEPUTY MEMBERS

A. Aalewijnse
Chief Engineer

J. Berghuis
Master

G. Jansen
Chief Engineer

T.W. Kanders
Master

O.F.C. Magel
Master

D. Roest
Master

P.H.G. Schonenberg
Ship's mate

J. van Vuuren
Master

J.K.J. Bout
Skipper in marine fishing

H. Hakvoort
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

J.J. Spaan
Hydraulic engineer

E.E. Zijlstra
Hydraulic engineer

C.J.M. Schot
Shipping company

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