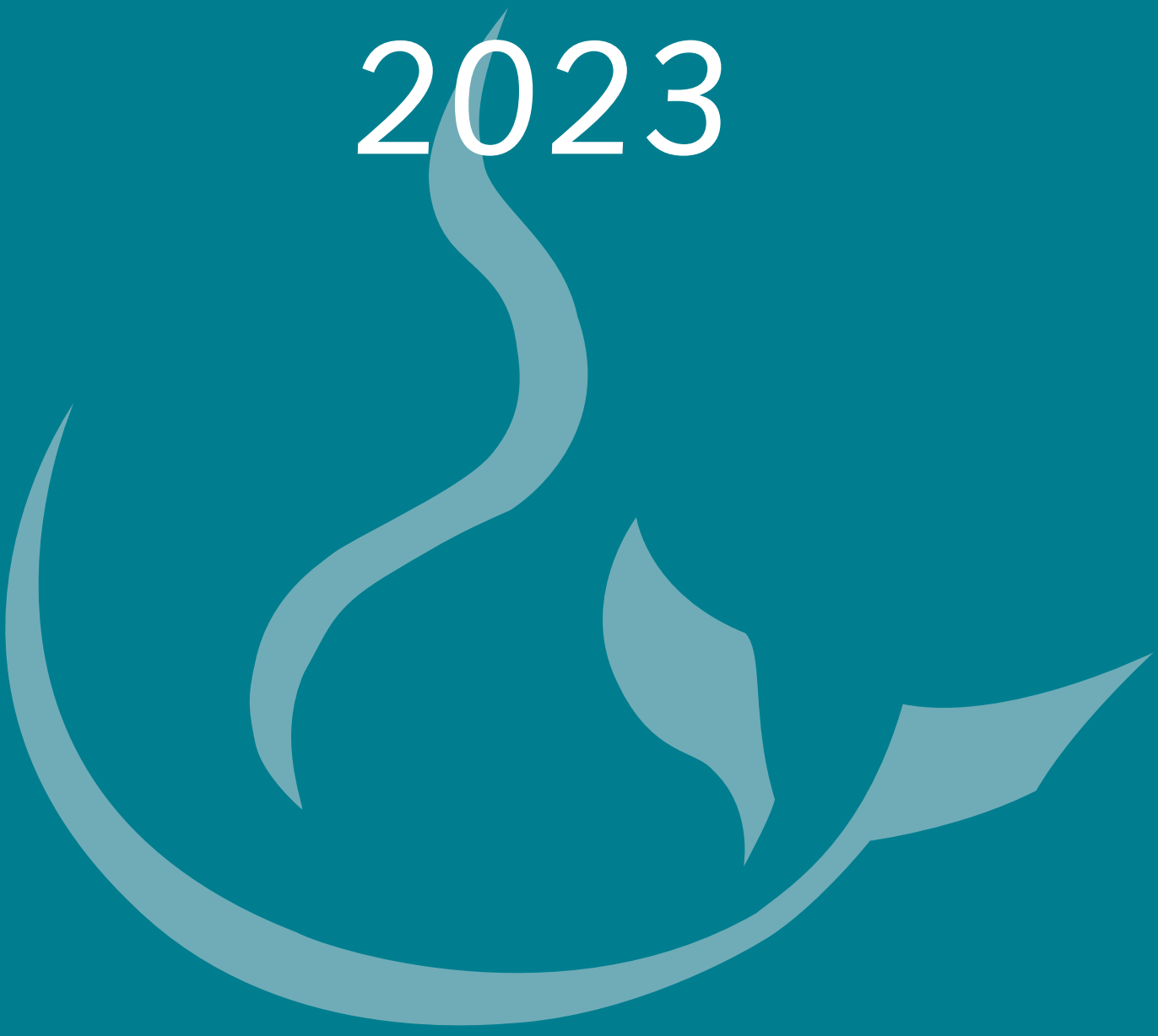
MARITIME DISCIPLINARY COURT
OF THE NETHERLANDS

ANNUAL REPORT 2023



MARITIME DISCIPLINARY COURT OF THE NETHERLANDS

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GENERAL

The Disciplinary court ruled on fourteen cases in 2023. This equals the record of 2021. In five of the incidents, the inspector summoned two persons concerned to justify their actions, resulting in five "double cases" within those fourteen cases. Three of these double cases were heard by a full court; while the other cases were heard by three presiding members. There were no petitions made by private complainants.

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

Several meetings were held with the Maritime Affairs Directorate, Shipping Division, of the Ministry of Infrastructure and Water Management, and with the ILT Inspectorate.
There were also consultations with representatives of the NVKK (Captains' Association), Nautilus International, the OVV (Dutch Safety Board), the KVNR (Royal Association of Netherlands Shipowners) and the North Sea officers of the National public prosecutor's office. There was also written contact with the Dutch Transport Law Association (NVV). In all cases, the agenda included a reflection on our very successful jubilee meeting of 1 July 2022. This has made it apparent that the Disciplinary Court website by now refers to the various options for legal aid available to persons concerned in a case.

We bade farewell to Joris van Vuuren and Tjitte de Groot.
Erik Pannekoek and Rob Ruigrok were appointed as new replacement members. Kiki Bouchla was appointed permanent secretary of the Disciplinary Court, while Karin de Ridder was appointed deputy secretary.

A very useful and fun introduction day was organised for the recently appointed members, in June.

Amsterdam, May 2024

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
Total	121	2	9	2	113

* In 2011 one case and in 2014 two cases were withdrawn by the minister.

RULINGS OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2023

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 ship, the cargo, the environment or shipping traffic within the meaning of Section 55a of the Dutch Seafarers Act.

EN AVANT

RULING OF 27 JANUARY 2023
NO. 1 OF 2023
CASE 2022.V6-EN AVANT

Person concerned: captain

This is concerned an extremely serious accident which took place on board of the En Avant 7 (EA7) in the Centrale Insteekhaven of Moerdijk on 25 August 2021. The EA7 is a traditional Dutch tug (with two fixed propellers). One seaman died and a trainee was injured. The next of kin of the seaman were present in the courtroom. The trainee attended the hearing online.
The EA7 was providing harbour assistance as aft tug. The En Avant 4 was the bow tug. The vessel requiring assistance, the Tia Marta was towed astern out of the Oostelijke Insteekhaven before being turned into the swinging circle of the Centrale Insteekhaven before turning ahead towards Zuid-Hollands Diep. During this manoeuvre, the seaman and the trainee became trapped between the towing line and the accommodation. The seaman died of his injuries almost immediately. The trainee suffered two broken ribs.

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

1. The person concerned, when manoeuvring to come forward with the head, allowed the vessel to swing too far.
2. The person concerned was not sufficiently aware how the EA7 was situated in relation to the Tia Marta, the position of the towing line and the position of the deck crew.
3. The person concerned did not adequately agree with B (the other captain, who was temporarily involved in officer tasks at the time of the behaviour) on who would pay attention to what and how they would communicate about it.
4. The above objections contributed to this accident and partly as a result, one crew member died and one crew member was injured.
5. The person concerned had sailed out with the vessel without complying with all the crew requirements imposed by the applicable inland navigation legislation.
6. The person concerned had sailed out with the vessel without drawing up the crew list.

The Inspector initially demanded imposing a suspension of the navigation licence of the person concerned for six months, whereby three months conditionally. At the hearing however, the inspector stated that imposing a fine would be more relevant, because the person concerned was not navigating at that point in time and the person concerned had indicated that he would not be returning to sea in the near future. The inspector did not include the failure to draw up a crew list and the lack of a crew member on board with a valid inland navigation licence when determining the level of the demand, as these facts did not contribute to the accident.

With regard to the first objection, in combination with the fourth objection, the person concerned stated that he could not remember having swung out (too) far, but that electronic chart data and film images show the vessel swinging out further than he remembered. Also, according to the police who studied the electronic chart data, the ship continued to slowly turn further, but "in the dynamics of sailing, this was not unusual and was possibly to be expected", in the opinion of the police. According to the person concerned, the hawser could not become taut because of the EA7's turn, as the EA7's speed was too low for that. The person concerned argued that it had not been sufficiently substantiated that the accident occurred partly because the EA7 overshot the turn.
With regard to the second objection, in combination with the fourth objection, the person concerned argued that he had reached clear agreements to ensure overview of the complete situation. There was limited visibility standing at the rudder, and the person concerned had therefore asked the shipping company for an experienced officer to take the lookout position on the bridge wing on the port side. The lookout position was the responsibility of B. The person concerned and B were in constant contact through the open door of the wheelhouse. Together, they had a good overview of the situation. Given the EA7's turn, the manoeuvre and the information he had received from B, the person concerned claimed to have acted correctly in indicating to the pilot that it was agreed to turn slowly forward.
With regard to the third objection, in combination with the fourth objection, the person concerned claimed that there were clear agreements and a clear division of tasks, when considering the statements by the person concerned and by B. Moreover, that same manoeuvre had already been made earlier in the day and the person concerned had organised a *toolbox meeting* on both occasions that the manoeuvres were carried out.
With regard to the fifth objection, the person concerned argued that the requirements applicable

under inland navigation legislation were not prescribed and that only seafarer's papers were required in accordance with the Minimum Safe Manning Document in the area the ship was in when the accident took place (the Moerdijk seaport). The person concerned further takes the view that it was primarily the responsibility of the shipping company to man the ship correctly. On the question of whether or not one crew member should have a certificate of competence for inland navigation, the person concerned deferred to the Disciplinary Court's opinion.
With regard to the sixth objection, the person concerned admitted that he had not drawn up a crew list upon coming aboard. He had intended to do so later, which was possible according to the other captains and the shipping company, but he now realised that he should have done so immediately when signing on.

The Disciplinary Court declared objections one through five to be well-founded, and dismissed the sixth objection as unfounded. The Disciplinary Court suspended the navigation licence of the person concerned for a period of six months.
In view of the following circumstances, the Disciplinary Court saw cause to stipulate that the suspension of the navigation licence would be partially conditional (four months):

- the person concerned was a relatively inexperienced captain, who was at the end of his training programme;
- the person concerned was not properly coached by the shipping company (he had apparently not learned from his mentor that when turning, the speed of the ship should be zero);
- the person concerned showed that apart from that fateful day, he took safety on the water very seriously. He sent signals to the shipping company, which signals were ignored by the shipping company until the accident (that he did not think it was a good idea for the EA7 to continue without marine officers; he asked the shipping company if it was possible to install cameras so that there would be a view of the deck and deck work from the wheelhouse; and he did not think it was a good idea to have a trainee on board, because the EA7 would not be a good learning place and because he himself thought this would be an additional burden);
- the shipping company sent an inadequately instructed person (B) to the EA7.

The Disciplinary Court dismissed the sixth objection as unfounded, because violation of section 94 paragraph 2 of the Seafarers Decree and section 33 paragraphs 2 and 59 of the Seafarers Act (that a crew list must be drawn up on every change to the group composition) did not represent a breach of the standard of good seamanship. In this case, this violation of the law did not endanger the persons on board, the ship, the cargo, the environment or shipping traffic.
The content of the evidence led to the following conclusions being drawn in this case (with an adequate measure of certainty).
At the start of the assistance task, the EA7 was stern-to-stern with the Tia Marta. Once the Tia Marta had turned in the Centrale Insteekhaven, the EA7 would come head-to-stern, with the towing line running over the head bollard. The EA7 would thus sail along behind the Tia Marta, heading forward. During the manoeuvre to bring the ship's head forward and put the towing line over the head bollard, the EA7 swung through too far to port and at the same time the towing line became taut. The towing line ran from the bitt to the middle bollard (more or less level with the bitt, but on the port side of the ship). From the port side middle bollard, the port side towing line collided with the front of the accommodation. The seaman and trainee were on the port side in the gangway between the accommodation and the bulwark. They were trapped between the towing line and the accommodation. The seaman was at the forefront and died almost immediately

from his injuries. The trainee was slightly further back and broke two ribs.
The Disciplinary Court declared the first objection to be well-founded, because it transpired that the person concerned approached the stern of the Tia Marta too closely with the EA7 and most probably ran into the Tia Marta's propeller water, as a result of which the person concerned lost control and allowed the tug to swing too far. The wind (according to the pilot, NW - 4 Bft) had also contributed to this. As shown in screenshot 32, the EA7 was incorrectly positioned and could not rectify the situation. The film showed the shock and the abrupt movement the EA7 made. The Tia Marta hardly moved at all, but the EA7 did. The person concerned himself also left open the possibility that he allowed the tug to swing too far.
The Disciplinary Court did not share the police's view that swinging the tug too far (at an angle of almost 90 degrees!) is not unusual and is possibly to be expected in the dynamics of sailing.
The Disciplinary Court declared the second objection to be well-founded, because it transpired that the person concerned was not sufficiently aware how the EA7 was situated in relation to the Tia Marta, the position of the towing line and the position of the deck crew. This was clear from the following.
According to the shipping company's own rules (section 4.9.1 on Safe Speed of the Muller manual), with turning, the ship's speed should be as low as possible. It is normally appropriate and safest to wait to turn until the line is over the head bollard. Therefore, the Tia Marta should not have picked up any speed. Nevertheless, the person concerned agreed with the pilot to turn ahead with the Tia Marta while the line was not yet over the head bollard and he could not see the position of the deck crew. The person concerned had indicated that he could manoeuvre better when sailing forward and building up some speed, as this allowed him to use the propellers for steering. However, this posed an additional risk where alertness was called for. The person concerned was not aware of this. He had not learned this from his mentor.
The position of the towing line was the shared responsibility of the person concerned and B.
An experienced captain has to constantly focus on the hawser to see whether or not it is getting tight. The person concerned could have seen from his position that the hawser was rising and could then have seen that there was tension. The person concerned had stated that he was sailing towards the Tia Marta and he was looking in that direction and that the distance to the Tia Marta determined whether the hawser would be tight. However, he was not certain in his statement that he constantly monitored the towing line. The person concerned was therefore insufficiently aware of the position of the towing line.
The same applies to the position of the deck crew, as B had not informed him about it.
The Disciplinary Court declared the third objection to be well-founded, because the fact that two *toolbox meetings* were held that day and the same manoeuvre was carried out earlier that day did not constitute proof that the person concerned coordinated with B with sufficient precision as to who would pay attention to what and how they would communicate about it. In particular, there was a lack of proper agreements on communication. B had a lookout function and could therefore be expected to keep the person concerned constantly informed about how the manoeuvre was going and to give the person concerned instructions, such as saying "don't steer further to port" or "don't turn too fast". Instead, the person concerned and B barely communicated with each other during the manoeuvre. B only told the person concerned "it's OK" and "there's a problem".
The Disciplinary Court declared the fourth objection to be well-founded, because the accident was contributed to by the fact that the person concerned allowed the EA7 to swing too far during the manoeuvre to come head-on, that the person concerned was insufficiently aware of how the EA7 was situated in relation to the Tia Marta, the position of the towing line and the position of the

deck crew, and that the person concerned did not sufficiently coordinate with B on who would pay attention to what and how they would communicate about it.
The manoeuvre in question was not easy to perform properly with a conventional tug with no bow thruster and a low draft, especially in the dark and windy conditions. It was sufficiently plausible that the captain's lack of experience played a role. The Disciplinary Court had taken into consideration that an accident like this would be virtually impossible using new tugs, as the towing line runs through an eye on the bow to the winch/bitt on the bow and it can be shortened and operated from the wheelhouse.
The Disciplinary Court declared the fifth objection to be well-founded, as there was nobody on board who was holder of a valid Inland navigation licence for the river section to be navigated.
The person concerned – following the shipping company – wrongly assumed that if a vessel sailed in Dutch inland waters on maritime documents (MSMD), in terms of crew requirements, it did not have to comply with Dutch inland navigation legislation. The person concerned was indeed justified to claim that it was primarily the shipping company's responsibility to correctly crew the vessel, but in the opinion of the Disciplinary Court, this did not deter from the captain acting contrary to good seamanship by ignoring conditions in respect of the safety of persons on board, the vessel, the cargo, the environment and shipping traffic.

For focal points for professional practice, the Disciplinary Court referred to the November 2022 report of the Dutch Safety Board ("Crushing by towing wire with a fatal outcome – lessons from the accident aboard the En Avant 7 tug").

EN AVANT

RULING OF 27 JANUARY 2023
NO. 2 OF 2023
CASE 2022.V7-EN AVANT

The person concerned: captain, but temporarily involved in officer tasks at the time of the behaviour

Case: see above (case 2022.V6–EN AVANT)

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned was not sufficiently aware of the situation regarding how the EA7 was placed in relation to the Tia Marta and the position of the towing line.
2. The person concerned did not adequately convey to the captain on who would pay attention to what and how they would communicate about it.
3. The above objections contributed to this accident and partly as a result, one crew member died and one crew member was injured.

The Inspector demanded the amended imposition of a suspension of the navigation licence for four months, two months conditionally.

According to the person concerned, the ILT's petition should be declared inadmissible because he was not part of the crew. The person concerned did argue that this formal defence did not imply that he assumed that he should not have exercised his duty of care as a good seaman.
With regard to the first objection, the person concerned argued that the accident was caused by a steering error made by the captain, which could not have been foreseen by the person concerned. The captain was ultimately responsible for navigation and was at the helm. He could see personally and keep an eye on the towing line from the Tia Marta. The person concerned was outside to keep an eye on the crew members on deck who had to guide the hawser around the bollards, taking care not to snag the hawser behind the straps. His focus was on that, and not on the position of the EA7 relative to the Tia Marta and the position of the towing line between the two vessels. Looking down from the position of the person concerned while the ship was turning, it was not immediately perceivable that the ship is turning too far.
With regard to the second objection, the person concerned stated that during the *toolbox meeting*, there was agreement between the captain and the person concerned regarding who would pay attention to what. Furthermore, a similar manoeuvre had already been done earlier that afternoon with the same crew operating in the same way. The person concerned stood at a distance of approximately 2.5 metres from the captain, allowing direct communication between the two.

The Disciplinary Court declared the inspector's petition to be admissible, declared the objections to be well-founded and suspended the navigation licence of the person concerned for a period of four months.
As the person concerned had been insufficiently instructed by the shipping company, the Disciplinary Court ruled that the suspension of the navigation licence would be partially conditional (two months).

The Disciplinary Court declared the ILT petition to be admissible, because an officer on duty is subject to disciplinary law and must conduct himself in a manner befitting a good seaman, even if he is not on the crew list. In the opinion of the Disciplinary Court, the formal role of the person concerned on board the EA7 remained unanswered, as he was in fact captain of another tug and had been requested to support the captain in training, because of his seniority. The person concerned did argue that his formal defence of inadmissibility did not imply that he assumed that he should not have exercised his duty of care as a good seaman.
The Disciplinary Court had also taken into consideration that based on the content of the means of evidence referred to, the following conclusions could be drawn in this case (with an adequate measure of certainty).
At the start of the assistance task, the EA7 was stern-to-stern with the Tia Marta. Once the Tia Marta had turned in the Centrale Insteekhaven, the EA7 would come head-to-stern, with the towing line running over the head bollard. In this way, the EA7 would sail along behind the Tia Marta, in a forward direction, maintaining the tow connection. During the manoeuvre to bring the ship's head forward and put the towing line over the head bollard, the EA7 swung through too far to port and at the same time the towing line became taut. The towing line ran from the bitt to the middle bollard (more or less level with the bitt, but on the port side of the ship). From the port side middle bollard, the port side towing line collided with the front of the accommodation. The seaman and trainee were on the port side in the gangway between the accommodation and the bulwark. They were trapped between the towing line and the accommodation. The seaman was at the forefront and died almost immediately from his injuries. The trainee was slightly further back and

broke two ribs.
The Disciplinary Court declared the first objection to be well-founded. The person concerned had been asked to support the still-in-training captain because of his seniority. For this reason, he could be expected to go beyond the duties agreed with the captain. The person concerned was therefore partly responsible for the whole manoeuvre and had to keep an eye on whether it was done properly. As such, it was the duty of the person concerned to also pay attention to the position of the towing line and the position of the tug in relation to the Tia Marta. He would then have seen the EA7 turning away from the Tia Marta and would have had to ensure that the line wire relative to the bow of the EA7 would never run to the starboard side of the EA7. He could then have given early warning when the hawser threatened to disappear behind the accommodation. Also noteworthy in the opinion of the Disciplinary Court, was that the trainee stated that he pulled the towing line out from under a tyre, but the person concerned did not see this while his primary duty was to watch the deck crew and guide the towing line. That means that his observations were far from optimal.
The Disciplinary Court declared the second objection to be well-founded, particularly because of the lack of effective agreements regarding communication. The person concerned had a lookout function and could therefore be expected to keep the captain constantly informed about how the manoeuvre was going and to give the captain instructions, for example by saying “don’t steer further to port” or “don’t turn too fast”. The person concerned should have realised based on his experience that there was danger and the ship was running at a dangerously wide angle. The person concerned, as an adviser with seniority, should have filled gaps in the initiatives taken by the captain. However, the person concerned did nothing. The person concerned and the captain barely communicated with each other during the manoeuvre. The person concerned only told the captain: it’s OK” and “there’s a problem”. This course of events showed that the person concerned did not sufficiently agree with the captain on who would pay attention to what and how they would communicate about it.
The Disciplinary Court declared the third objection to be well founded, because the fact that the person concerned was insufficiently aware of how the EA7 was situated in relation to the Tia Marta and the position of the towing line, and that the person concerned did not sufficiently coordinate with the captain on who would pay attention to what and how they would communicate about it, was an indirect contributory factor in the accident. In the opinion of the Disciplinary Court, it was probable that the person concerned could have issued timely instructions to the captain if he had applied his seniority and remained alert.

AMADEUS AQUAMARIJN

RULING OF 23 JUNE 2023
NO. 3 OF 2023
CASE 2022.V12-AMADEUS AQUAMARIJN

Person concerned: the second officer

This case concerned the collision between the Amadeus Aquamarijn, a Dutch general cargo vessel, and the Belgian fishing vessel, the Z60 Blue Angel (Blue Angel). Both vessels were sailing in the "Off Texel" traffic separation scheme in the south-southwest bound traffic lane, on 23 December 2021. The speed of the Amadeus Aquamarijn was about 6 knots over ground and the speed of the approaching Blue Angel was about 10 knots over ground. The Blue Angel hit the Amadeus Aquamarijn from behind, resulting in leakage to the wheelhouse of the Amadeus Aquamarijn and subsequently water entering the accommodation. Pumps were switched on and the Amadeus Aquamarijn was later able to reach Harlingen harbour under its own power. The Blue Angel, which had suffered minimal damage to the prow then remained on standby with the Amadeus Aquamarijn until it was no longer needed. Blue Angel then continued her way to the port of IJmuiden.

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned had determined that there was no risk of collision, while there was indeed such a risk.
2. The person concerned had not kept a proper lookout at all times.
3. The person concerned had not complied with the Master Standing Orders.
4. The person concerned failed to take measures to avoid a collision when the Z60 Blue Angel was so close that a collision could not have been avoided by evasive action of the Z60 Blue Angel alone.
5. The above elements had contributed to the collision.

The inspector's demand was to suspend the navigation licence of the person concerned for six weeks, three of which conditionally.

At the hearing, the person concerned admitted the first (partially), fourth and fifth objections, and disputed the second and third objections.
The counsel for the person concerned requested that the Disciplinary Court declares the inspector's petition inadmissible, as both a disciplinary and a criminal investigation of the same facts had been initiated against the person concerned, and the Public prosecution service (OM) did not issue the communication of dismissal until 22 March 2023, i.e. more than a year later (and coincidentally just before the announcement of this hearing date by the Disciplinary Court).

The Disciplinary Court ruled the inspector's petition admissible, and ruled objections one, two, four and five to be well-founded, and the third objection to be unfounded. The Disciplinary Court imposed a suspension of the navigation licence of the person concerned for six weeks.
As the person concerned had also been reprimanded by the shipping company and his promotion temporarily delayed, and had not only been confronted with the investigation by the inspector

but also by that of the maritime police and the Dutch Safety Board, and had learned lessons from this incident, the Disciplinary Court ruled that the suspension of the navigation licence would be partially conditional (four weeks).

With regard to the inadmissibility, the Disciplinary Court had taken into account that the inspector could not be held responsible for the criminal investigation being continued for such a period of time alongside the disciplinary investigation, and that the simple occurrence of a criminal investigation was insufficient cause to not take up a disciplinary petition. The situation would be different if a criminal *conviction* had already taken place regarding the same facts.
The Disciplinary Court had also taken into consideration that based on the content of the means of evidence referred to, the following conclusions could be drawn (with an adequate measure of certainty).
The person concerned had determined that there was no risk of collision, while there was indeed such a risk. He had allowed himself to be overly guided by ECDIS, which could not replace radar when determining the risk of collision.
Furthermore, the person concerned had not kept a good lookout at all times. After all, in his own statement he declared that he had not paid sufficient attention to the fishing vessel closing on the Aquamarijn at a relatively high speed. It was striking that the person concerned could not provide information on the distance between the two vessels. That distance is the first fact established by an officer upon plotting. Once there is an indication of the distance, the degree of urgency can be determined. The lack of response to the radio phone call should also have (further) alarmed him.
The person concerned had been overly focused on the CPA according to ECDIS, and had even started to fill in the logbook. Moreover, he had reassured the lookout rather than instructing him to also check the stern. They did not operate as a team.
The objection that the person concerned had not taken measures to avoid a collision when the Z60 Blue Angel was so close that a collision could not have been avoided by evasive action of the Z60 Blue Angel alone, was also justified. He could have given way to starboard.
The above elements all contributed to the collision occurring, whereby the fishing vessel closing in was actually primarily responsible, due to not having taken any measures to avoid the collision.
The Disciplinary Court dismissed the third objection. After all, the above information showed none of the three described situations to have occurred, *according to the insight of the person concerned*. This did not deter from the fact that his insight was incorrect.

As this case was also under investigation by the Dutch Safety Board, the Disciplinary Court felt no need to make focal points for professional practice.
The inspector had however enquired about the distance to which no change of course is required when another vessel is closing in; it may be necessary to change course because of sailing in the TSS.
The Disciplinary Court replied as follows. There can be no general rule regarding the distance to which a vessel must stand its own course and speed when being closed upon. Too many variable factors play a role in that situation, including the size of the vessels, their speed and the mutual speed difference, the manoeuvrability of the two vessels, the weather conditions, including visibility and the sea state, the settings of the autopilot and many more. When approaching a bend, merging point or division in a TSS, there can be clear communication to the vessel closing in, by altering course slightly in the required direction in good time. In doing so, this more or less invites the vessel closing in to pass the vessel being closed upon, on the favourable side. However the

fact remains: the vessel closing in must give way and if there is no response and the CPA remains alarmingly limited, an alternative method must be found to avoid the occurrence of a close encounter. This can be achieved, for example, by reaching agreements about closing in, via the VHF.

NIEUW AMSTERDAM

RULING OF 23 JUNE 2023
NO. 4 OF 2023
CASE 2022.V8-NIEUW AMSTERDAM

Person concerned: the third officer

This case concerned the occupational accident which occurred on board the Dutch cruise ship, the Nieuw Amsterdam, on 8 March 2021. During transport of steel wire, a seaman's fingers were trapped, which resulted in the amputation of part of his middle finger.

The inspector's objection against the person concerned consisted of the following elements:
1. There were no consequences attached to the crane used being partly defective.
    a. This meant that a very heavy load (180 kg) had to be lifted manually over a coaming.
    b. Partly because of this, a wheel of the trolley ended up in the gap at the hatch's hinge.
2. A home-made wooden trolley had been used for horizontal transport, instead of proper work equipment.
3. The person concerned had accepted the order to carry out this work without sufficiently assessing the risks.
4. During the operations under the responsibility of the person concerned, a seaman's hand had become trapped, resulting in part of his middle finger needing to be amputated.

The inspector's demand was to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally.

The person concerned claimed to have acted in accordance with the tasks and responsibilities delegated to him, according to the applicable protocols and the due care which might be expected from a good seaman.

The Disciplinary Court dismissed the charges against the person concerned. There was no evidence that the person concerned acted contrary to the duty of care that he, as a good seaman, should observe.

The Disciplinary Court's findings were as follows.
The steel wire of a lifeboat needed to be replaced. The new steel wire was hoisted on deck from the boatswain's workshop by means of a crane, after which it was transported horizontally using a trolley. Due to a defect, the crane could only lift and lower the load, and could not move crossways; the trolley was positioned in such a manner that the load could land on the trolley upon pulling the cable sideways. In order to continue on its path, the trolley needed to be lifted over a coaming. The trolley had tilted in doing so. The seaman may have attempted to stop the movement of the steel wire, at which point his finger had become trapped.
A hazard identification & risk assessment form had been drawn up for the replacement of the steel wires of lifeboats on board the Nieuw Amsterdam in August 2019. This form had been drawn

up by the staff captain and the safety officer. It paid attention, among other things, to the correct lifting methods and the risk of hand injury, and the severity of the possible consequences of the identified risks had been estimated with due attention for the prescribed working method. On the day of the accident, a *Permit to Work* had been issued for the replacement of the steel wire. The responsible officer/supervisor (third officer M) had signed the *Permit to Work* to state that he had *"reviewed this permit with the workers(...) and briefed them on work activity and safety precautions"* and that he had *"personally inspected the work site and adjacent spaces and verified the information as per this permit and that safety procedures and equipment are in place"*. The authorising officer (the safety officer) had signed the *Permit to Work* to state that he was convinced *"that all the necessary precautions have been taken and that the Responsible Officer/Supervisor is competent to carry out the work"* and had given his approval to start the work activities. The *Permit to Work* had also been signed in the space reserved for *"Captain's or Staff Captain's approval Signature"*.
From the above, the Disciplinary Court concluded that the consequences of the crane being partly defective and the identification of risks of the work activities, were not the task and responsibility of the person concerned, but rather of the staff captain and/or the safety officer and the responsible officer. The person concerned therefore could not be accused of not having attached consequences to the crane being partly defective. For the same reason, the person concerned could not be accused of accepting the order to carry out this work without sufficiently assessing the risks.
The person concerned was also not present at the *safety meeting* held in the morning prior to the accident. During that meeting, the safety officer had discussed the work activities with the responsible officer (third officer M) and the crew involved. The safety officer had discussed the work activities at a later moment with the person concerned, who had been made responsible for the transport of the steel wire, and indicated that he should contact the electricians regarding the status of the crane, and that a safe distance should be kept from the steel wire. They had not discussed the transport of the steel wire using the trolley at that point, but rather only the lifting process using the crane.
With regard to the trolley, the Disciplinary Court took into account that this device was commonly used on board to transport heavy loads. The trolley had previously been used for transport of steel wire. The person concerned was not present at that time. He had only been on board for three days, and was therefore still establishing his routine. He arrived at the work location slightly later. The seamen had at that point already received instructions to start preparing transport of the steel wire. With this in mind, it was not contrary to the duty of a good seaman that the person concerned did not indicate that the steel wire must be transported in another manner rather than using the trolley.
However, the steel wire did need to be lifted over a coaming. That is when the accident occurred. Once the wire had been positioned on the trolley, the person concerned left the working location momentarily to switch off the crane. At that point, the person concerned did not instruct the seamen to halt further work until he returned. However, the Disciplinary Court did not attach any consequences to this for the person concerned, because the working method was a result of the decision to have the work conducted using a partially defective crane, and the responsibility for this decision did not lie with the person concerned.

In terms of a focal point for professional practice, the Disciplinary Court referred to the fact that the responsible officers/supervisors who will be involved in the actual implementation of work, must be present during the discussion of risks and mitigating measures in the *safety meeting*.

NIEUW AMSTERDAM

RULING OF 23 JUNE 2023
NO. 5 OF 2023
CASE 2022.V9-NIEUW AMSTERDAM

Person concerned: safety officer

Case: see above (2022.V8–NIEUW AMSTERDAM)

The inspector's objection against the person concerned consisted of the following elements:
1. There were no consequences attached to the crane used being partly defective.
    a. This meant that a very heavy load (180 kg) had to be lifted manually over a coaming.
    b. Partly because of this, a wheel of the trolley ended up in the gap at the hatch's hinge.
2. A home-made wooden trolley had been used for horizontal transport, instead of proper work equipment.
3. Despite being a safety officer, the person concerned had instructed the third officer to carry out this work without sufficiently assessing the risks.
4. During the operation, a seaman's hand had become trapped, which resulted in the amputation of part of his middle finger.

The inspector's demand was to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally.

The person concerned claimed to have acted in accordance with the tasks and responsibilities delegated to him, according to the applicable protocols and the due care which might be expected from a good seaman.

The Disciplinary Court dismissed the charges against the person concerned. There was no evidence that the person concerned acted contrary to the duty of care that he, as a good seaman, should observe.

The Disciplinary Court's findings were as follows.
The steel wire of a lifeboat needed to be replaced. The new steel wire was hoisted on deck from the boatswain's workshop by means of a crane, after which it was transported horizontally using a trolley. Due to a defect, the crane could only lift and lower the load, and could not move crossways; the trolley was positioned in such a manner that the load could land on the trolley upon pulling the cable sideways. In order to continue on its path, the trolley needed to be lifted over a coaming. The trolley had tilted in doing so. The seaman may have attempted to stop the movement of the steel wire, at which point his finger had become trapped.
A hazard identification & risk assessment form had been drawn up for the replacement of the steel wires of lifeboats on board the Nieuw Amsterdam in August 2019. This form had been drawn up by the staff captain and the safety officer. It paid attention, among other things, to the correct lifting methods and the risk of hand injury, and the severity of the possible consequences of the identified risks had been estimated with due attention for the prescribed working method. On the

day of the accident, a *Permit to Work* had been issued for the replacement of the steel wire. The responsible officer/supervisor (third officer M) had signed the *Permit to Work* to state that he had *"reviewed this permit with the workers(...) and briefed them on work activity and safety precautions"* and that he had *"personally inspected the work site and adjacent spaces and verified the information as per this permit and that safety procedures and equipment are in place"*. The authorising officer (the safety officer) had signed the *Permit to Work* to state that he was convinced *"that all the necessary precautions have been taken and that the Responsible Officer/Supervisor is competent to carry out the work"* and had given his approval to start the work activities. The *Permit to Work* had also been signed in the space reserved for *"Captain's or Staff Captain's approval Signature"*.
A *safety meeting* had been held prior to the work activities on 8 March 2021, in which the person concerned had discussed the work with the responsible officer (third officer M) and the crew involved. The other officer who was to be present at the work activities (third officer W) was not present at the *safety meeting*. The person concerned had discussed the work activities with him at a later moment, and indicated that he should contact the electricians regarding the status of the crane, and that a safe distance should be kept from the steel wire.

It was not until the hearing that it became clear that the person concerned had informed the staff captain of his doubts prior to the incident, regarding the work to be carried out using a crane which was partially defective and with a fewer number of people than under normal circumstances. It also became clear that the person concerned had advised the staff captain that it was sensible to postpone the work activities until a special team or extra seamen were on board to conduct the work. The Disciplinary Court appreciated this. It became the task and responsibility of the staff captain to consider the risks of conducting work activities using a crane which was partly defective and with a fewer number of people than under normal circumstances, contrary to the advice of the person concerned. However, the staff captain had overruled the doubts and advice of the person concerned to postpone the work. No cruises were being offered due to COVID-19, and a limited number of crew members were therefore on board. According to company protocol and international guidelines, it was however essential that maintenance work be conducted on the lifeboats. The staff captain therefore believed that the work could not be postponed. The work needed to be done using the crane which was not able to transport the steel wire crossways. With a view to the instructions given by the person concerned to the crew members involved, during and after the *safety meeting*, as well as the doubts which he had expressed to the staff captain, and in the light of the hierarchic structure on board, the person concerned could not be accused of not attaching consequences to the crane being partially defective, nor could he be accused of delegating the task of conducting the work to the third officer without fully identifying the risks.
At the hearing, it also became clear that, prior to the work being conducted, the person concerned had instructed that the steel wire should be pulled crossways using two safety lines, but that this working method had not been followed. On actually conducting the work, the trolley was positioned behind a coaming, over which the trolley containing the steel wire, needed to be lifted. That is when the accident occurred. The person concerned was not present during this actual work. The person concerned therefore could not be reproached with regard to the use of the trolley.

HELGE

RULING OF 14 JULY 2023
NO. 6 OF 2023
CASE 2023.V1-HELGE

Person concerned: the chief officer

This case concerned the collision between the Helge, a Dutch multipurpose dry cargo vessel, and the Wild Cosmos. In the early morning of 9 September 2022, the Helge was en route from Antwerp to Heroya (Norway). The wind was East 7 bft, there was a rough sea and moderate swell, it was dark and raining, but visibility was good. The Helge heading was around 035 degrees, at an SOG of around 8 knots, and the vessel was sailing on the open sea, approximately 20 miles west of the Danish coastline. The Helge was hit starboard aft by the overtaking vessel, Wild Cosmos, which had an SOG of around 17 knots. Two ballast water tanks and the Helge's engine room suffered leaks and flooded. The Helge listed increasingly to starboard and trim by stern, suffered a black-out and was NUC. The crew evacuated the Helge in a life raft. After thirty minutes, a rescue helicopter arrived, hoisted the crew from the life raft and took them to Esbjerg. The Helge was towed to Esbjerg where it arrived on 10 September 2022.

The inspector's objection against the person concerned consisted of a number of elements, which will be given below along with the considerations of the Disciplinary Court.

The inspector's amended demand was to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally.

The person concerned acknowledged the Inspector's objection, but considered the original demand formulated in the petition, to be overly strict and excessive.

The Disciplinary Court declared the objection to be well-founded, and suspended the navigation license of the person concerned for eight weeks, four of which conditionally.
The duration of suspension was shorter than originally demanded by the inspector, due to the person concerned being cooperative throughout the investigation, understanding the error of his behaviour and negligence, and learning from the situation.

The Disciplinary Court's findings were as follows.
Due to the person concerned acknowledging the inspector's objection to his behaviour and negligence, and this acknowledgement being supported by the seaman's statement and the conclusions of the internal investigation report, this meant that (with sufficient degree of certainty), the following facts were ascertained in this case.

1. The person concerned had sent the lookout to his cabin during the hours of darkness and had not replaced him.
2. The person concerned had neglected to at least keep a good lookout himself, in lieu of the dismissed lookout.
3. The person concerned had wrongly assumed on the basis of AIS data from the Wild Cosmos on the ECDIS that there was no danger of collision.
4. The person concerned had not used the radar(s) to determine any danger of collision with the Wild Cosmos.
5. The person concerned had not taken measures to avoid a collision when the Wild Cosmos was so close that a collision could not have been avoided by an action of the Wild Cosmos alone.
6. The person concerned had been distracted by "paperwork" just before the collision.

This negligence and behaviour, which formed the elements of the Inspector's objection, had contributed to the collision.
It went without saying that the Wild Cosmos (not sailing under the Dutch flag), the approaching ship, should have given a wide berth to the Helge. However, as the first officer on duty aboard the Helge, the person concerned had also played a role in the collision occurring. He had for example failed to comply with the COLREG rules 5, 7 and 17. If he had indeed complied with the regulations and the other provisions named by the Inspector, he would have been able to prevent the collision.
Additionally, the Helge was en route from Antwerp to Heroya (Norway), which was a busy navigation area, in which slow vessels were overtaken by faster vessels, sailing the same course. The Helge was sailing relatively slowly: 8 knots. All the more reason therefore to be alert on board the Helge, to any activity behind the vessel. This did not take place adequately.
The person concerned had seen the AIS signal of an overtaking vessel, the Wild Cosmos, on the ECDIS, which at that point was approximately five miles behind the Helge, with an (AIS) CPA of 0.5 – 1.0 mile. The person concerned assumed that the Wild Cosmos would give the Helge a wide berth. He had not contacted the vessel to check this.
The radar was to be used for lookout purposes. Of the radars however, only the x-band radar stood by, at a range of 12 miles, off centre (9 NM forward and 3 NM reverse), true vector and relative trail. Setting the radar to 3 miles reverse (off centre) was not *"long-range scanning"*. This gave insufficient insight into what was happening behind the slow sailing vessel. This would explain why the person concerned had not seen the Wild Cosmos on the radar. *"radar centre"* should have been used instead of *"radar off centre"*, in order to maintain good visibility behind the vessel.
The person concerned was also responsible for effective lookout. Instead, he had dismissed the lookout from the bridge during the hours of darkness, and did not replace him with another lookout, neither had he himself exercised sufficient lookout, but instead had undertaken paperwork.
The circumstances referred to by the person concerned in his defence, which in his opinion rendered the inspector's objection 'overly strict and excessive', did not deter from the well-founded nature of the objection itself.

In terms of a focal point for professional practice, the Disciplinary Court notes that prior attention for shipping vessels approaching from behind is important when sailing at relatively low speed in a busy navigation area, and that the recommended setting for the radar is *"radar centre"* (rather than *"radar off centre"*), in order to maintain good visibility behind the vessel.

ALASKABORG

RULING OF 8 SEPTEMBER 2023
NO. 7 OF 2023
CASE 2022.V10-ALASKABORG

Person concerned: captain

This case concerned oil having been pumped overboard from the Alaskaborg, a Dutch general cargo vessel, which had departed from Baie Comeau, Canada on 7 February 2022, destined for Rotterdam.
The cargo consisted of *crushed carbon anodes* divided between the two holds. It was snowing heavily while loading the Alaskaborg; less heavily when loading hold one than when loading hold two.
On 9 February 2022, the *bilge alarm* (hereinafter: the alarm) of the bilge well port side forward in hold 2 went off. The ship was sailing south of Newfoundland at the time. The person concerned, the chief engineer, and first officer consulted with each other and concluded that the bilge alarm was caused by melting snow in the hold or water ingress. With the ship rolling and pitching, they felt it was too dangerous to allow crew members to go on deck and into the hold for inspection. They agreed to keep the bilge ejector, which had been additionally activated, running on the bilge well in question and to keep that up until the next morning or until the weather improved.
The *bilge ejector* was deactivated the following morning. The first officer went into hold two with deck crew and discovered a hole in a fuel tank, from which VLSFO (*Very Low Sulphur Fuel Oil*, hereinafter: oil) was leaking. That oil mixed with the cargo, and also ran into the bilge well port side fore. This had triggered the alarm earlier.
The hole in the fuel tank had been caused by the lashing rings (d rings) of a between decks hatch having broken loose, and as a result the between decks hatch had fallen into the hold against the wall of a fuel tank.
Part of the leaked oil had been pumped overboard during the more than twelve hours of continuous bilge discharge in the bilge well port side forward in hold two.

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned did not consider any other possible cause of the alarm on only one bilge well, other than that it might have been caused by melting snow or water ingress.
2. The person concerned gave the order to leave the already activated bilge ejector running until the next morning or until the weather improved without knowing what was being pumped overboard.
3. (Amended as followed at the hearing:) Under the command of the person concerned, part of 55 m3 VLSFO (Very Low Sulphur Fuel Oil) had been pumped into the Atlantic Ocean.

The inspector's demand was to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally.

The person concerned denied that he had failed to observe the principles of good seamanship. With regard to the first objection, he argued that it had been snowing heavily while loading the

Alaskaborg (less heavily when loading hold one than when loading hold two), that the daytime temperature of 9 January 2022 was above freezing, therefore allowing the snow to melt, that the snow could also melt due to heating the fuel tanks, and that the vessel's hatches had leaked in the past. The person concerned argued that, following consultation with the chief engineer and first officer, he concluded that the alarm was caused by melting snow or water ingress in hold two. The person concerned had no reason to take account of leaking fuel tanks adjacent to hold two. The person concerned could not have foreseen that the between decks hatch could break loose and eventually cause a hole in fuel tank 7SB, which caused oil to leak in hold two. The between decks hatch had been lashed properly, and inspected. The fact that the SOPEP manual dealt with various causes of oil and other discharges, but not the scenario where the crew pumped leaking fuel from a fuel tank overboard from a hold bilge well, underlined that this was not an everyday scenario the person concerned should have taken into account. Generally speaking, the *bilge ejector* was activated when there was water in the hold.
With regard to the second objection, the person concerned argued that following consultation with the chief engineer and first officer, he concluded that, in the circumstance of a heavily rolling and pitching vessel, with seawater on deck, with swell coming from various directions that were difficult to assess in the dark, it was too dangerous, irresponsible and unsafe to have crew members go on deck or into the hold for an inspection. Therefore, it was decided to wait with inspection until the next morning or until the weather improved. The person concerned was under the impression that water was pumped overboard. The *bilge* system of the Alaskaborg did not have a filter to check what was pumped overboard.
With regard to the third objective, the person concerned acknowledged that oil had indeed been pumped overboard, but that this was unlikely to be a large volume of oil. Much of the oil had probably remained in the hold. The person concerned referred to the expertise report provided by him *("it seems unlikely that much fuel oil was actually pumped by the ejector out of the hold and we would expect that much of the 55 mt remains in the hold")*.
In the event that the Disciplinary Court should rule the petition to be wholly or partially well-founded, the person concerned requested the court take account of him being a *"first offender"*, that he had acted adequately as soon as he became aware of the incident, and had taken mitigating measures, that Transport Canada might also impose a fine on him, and that he had learned from the incident.

The Disciplinary Court declared the second and third objections to be well-founded, and dismissed the first objection as unfounded.
The Disciplinary Court found the inspector's demand to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally, to be in order, in view of the seriousness of the shortcomings. However, the Disciplinary Court imposed a fine of € 2,000 on the person concerned. This was partly because the Disciplinary Court believed it suitable that the same measure was imposed on the person concerned as on the Chief Engineer, while the Chief Engineer would not be affected by a suspension of the navigation licence, because he no longer sailed under the Dutch flag.
As the person concerned had learned lessons from this incident, the Disciplinary Court ruled that the fine would be partially (€ 1,000) imposed.

The Disciplinary Court dismissed the first objection. It had been established that the lashing rings (d rings) of the between deck hatch had broken loose and that as a result the between deck hatch

had fallen against a fuel tank, which caused a hole in that fuel tank from which oil leaked. The person concerned had never experienced this before, and it occurs almost never. On board there was no procedure for dealing with bilge (hold water) from the holds. However, it does happen that sharp cargo causes fuel tanks to leak or that this happens (due to stone fall) during loading with a grab but that was not the case here. Because the person concerned could also rely on the statement from the first officer that lashing had taken place properly, it was logical against this background and not attributable that the person concerned did not think in first instance that the alarm went off because oil was leaking from a fuel tank. At the hearing, the inspector also indicated that such a scenario was not immediately obvious.
In first instance, the person concerned thought that the alarm went off in hold two due to melting water or water ingress. It had snowed harder whilst loading hold two than whilst loading the other holds and the fuel tank was heated. Water ingress had occurred previously. Under these circumstances, with his knowledge at the time of the accident, the person concerned should not have considered another cause.
The Disciplinary Court found the second objection to be well-founded. On the basis of the content of the means of evidence in this case, it was established (with a reasonable degree of certainty) that the person concerned issued the order to keep the already activated *bilge ejector* activated to the next morning or until the weather improved, whilst he did not know what was being pumped overboard. In total, oil had then been pumped overboard for more than twelve hours.
In first instance the person concerned might assume that melt water or water ingress caused the alarm to go off, but when the alarm continued to go off he should have considered that something else was going on, particularly because just one of the bilge wells continued to produce an alarm, and the ejector capacity was 70 m3 per hour, and with the vessel rolling 30/40 degrees, there was a real chance of damage in the holds in that situation. As the heavy weather conditions initially prevented a check of why the alarm was going off, the person concerned should have given an order to pump into the ballast tank instead of overboard, even if there was no official procedure for that. The Chief Engineer had after all stated that there was a ballast tank on board, and that ballast pump-two could have been used to pump bilge water from the holds to that tank. The shipping company had also stated that in the email of 10 March 2022 to the ILT. The person concerned stated that he was not aware of that, but as captain he should have known which systems were present on the vessel he was sailing. In any case he should have asked the Chief Engineer.
Instead, under the responsibility of the person concerned, the alarm was blocked and the *bilge ejector* was stopped the following morning at 08.00 ST. At variance with the inspector, the Disciplinary Court did not deem it proven that it was responsible to have crew members go on deck or into the hold sooner for an inspection.
The Disciplinary Court found the third objection to be well-founded. The person concerned acknowledged that oil had been pumped overboard. Although the survey report he submitted concluded that *"it seems unlikely that much fuel oil was actually pumped by the ejector out of the hold and we would expect that much of the 55m³ remains in the hold"* , it followed from the conclusion that the expert also assumed that oil had been pumped overboard. The Chief Engineer also stated on 11 February 2022: *"found traces of fuel in the bilge system and inform the captain oil spill to the water"*. On the basis of the evidence, it had been established in any case that part of the 55 m3 oil was pumped into the Atlantic Ocean.

The Disciplinary Court made the following two focal points for professional practice:
1. The manuals on board should include how to deal with the bilge alarm from a hold.
2. When it is not clear what is leaking, this liquid should not be pumped overboard, as safety dictates it should be pumped into the ballast tank on board of the vessel if possible.

ALASKABORG

RULING OF 8 SEPTEMBER 2023
NO. 8 OF 2023
CASE 2022.V11-ALASKABORG

The person concerned: Chief Engineer

Case: see above (case 2022.V10–ALASKABORG)

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned did not consider any other possible cause of the alarm on only one bilge well, other than that it might have been caused by melting snow or water ingress.
2. The person concerned left the already activated bilge ejector on until the next morning or until the weather improved without knowing what was being pumped overboard.
3. (Amended as followed at the hearing:) Under the command of the person concerned, part of 55 m3 VLSFO *(Very Low Sulphur Fuel Oil)* was pumped into the Atlantic Ocean by the engine-room personnel.

The inspector's demand was to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally.

The person concerned denied that he had failed to observe the principles of good seamanship. With regard to the first objection, he argued that it had been snowing heavily while loading the Alaskaborg (less heavily when loading hold one than when loading hold two), that the daytime temperature of 9 January 2022 was above freezing, therefore allowing the snow to melt, that the snow could also melt due to heating the fuel tanks, and that the vessel's hatches had leaked in the past. The person concerned argued that, following consultation with the captain and first officer, he therefore concluded that the alarm was caused by melting snow or water ingress in hold two. The person concerned had no reason to take account of leaking fuel tanks adjacent to hold two. The person concerned could not have foreseen that the between decks hatch could break loose and eventually cause a hole in fuel tank 7SB, which caused oil to leak in hold two. The between decks hatch had been lashed properly, and inspected. The fact that the SOPEP manual dealt with various causes of oil and other discharges, but not the scenario where the crew pumped leaking fuel from a fuel tank overboard from a hold bilge well, underlined that this was not an everyday scenario the person concerned should have taken into account. Generally speaking, the *bilge ejector* was activated when there was water in the hold.
With regard to the second objection, the person concerned argued that following consultation

with the captain and first officer, he concluded that, in the circumstance of a heavily rolling and pitching vessel, with seawater on deck, with swell coming from various directions that were difficult to assess in the dark, it was too dangerous, irresponsible and unsafe to have crew members go on deck or into the hold for an inspection. Therefore, it was decided to keep the bilge ejector, which had been additionally activated, running on the bilge well in question and to keep that up until the next morning or until the weather improved. The person concerned was under the impression that water was pumped overboard. The *bilge system* of the Alaskaborg did not have a filter to check what was pumped overboard.
With regard to the third objection, he argued that he believed a much smaller volume of oil to have actually been pumped overboard, rather than the initial rough estimate of 30 m3, and that much of the oil had probably remained in the hold. He thereby referred to the survey report provided by him *("it seems unlikely that much fuel oil was actually pumped by the ejector out of the hold and we would expect that much of the 55 mt remains in the hold")*.
In the event that the Disciplinary Court should rule the petition to be wholly or partially well-founded, the person concerned requested the court take account of him being a "first offender", that he had acted adequately as soon as he became aware of the incident, and had taken mitigating measures, that Transport Canada might also impose a fine on him, and that he had learned from the incident.

The Disciplinary Court declared the second and third objections to be well-founded, and dismissed the first objection as unfounded.
The Disciplinary Court found the inspector's demand to suspend the navigation licence of the person concerned for eight weeks, four of which conditionally, to be in order, in view of the seriousness of the shortcomings. However, the Disciplinary Court imposed a fine of € 2,000 on the person concerned, as he would not be affected by a suspension of the navigation licence, because he no longer sailed under the Dutch flag.
As the person concerned had learned lessons from this incident, the Disciplinary Court ruled that the fine would be partially (€ 1,000) imposed.

The Disciplinary Court dismissed the first objection. It had been established that the lashing rings (d rings) of the between deck hatch had broken loose and that as a result the between deck hatch had fallen against a fuel tank, which caused a hole in that fuel tank from which oil leaked. The person concerned had never experienced this before, and it occurs almost never. On board there was no procedure for dealing with bilge (hold water) from the holds. However, it does happen that sharp cargo causes fuel tanks to leak or that this happens (due to stone fall) during loading with a grab but that was not the case here. Because the person concerned could also rely on the statement from the first officer that lashing had taken place properly, it was logical against this background and not attributable that the person concerned did not think in first instance that the alarm went off because oil was leaking from a fuel tank. At the hearing, the inspector also indicated that such a scenario was not immediately obvious.
In first instance, the person concerned thought that the alarm went off in hold two due to melting water or water ingress. It had snowed harder whilst loading hold two than whilst loading the other holds and the fuel tank was heated. Water ingress had occurred previously. Under these circumstances, with his knowledge at the time of the accident, the person concerned should not have considered another cause.
The Disciplinary Court found the second objection to be well-founded. On the basis of the content

of the means of evidence in this case, it had been established (with a reasonable degree of certainty) that the person concerned kept the already activated bilge ejector activated to the next morning or until the weather improved, whilst he did not know what was being pumped overboard. In total, oil had then been pumped overboard for more than twelve hours.
In first instance the person concerned might assume that melt water or water ingress caused the alarm to go off, but when the alarm continued to go off he should have considered that something else was going on, particularly because just one of the bilge wells continued to produce an alarm, and the ejector capacity was 70 m3 per hour, and with the vessel rolling 30/40 degrees, there was a real chance of damage in the holds in that situation. As the heavy weather conditions initially prevented a check of why the alarm was going off, the person concerned should have advised the captain to pump into the ballast tank instead of overboard, even if there was no official procedure for that. The person concerned had after all stated that there was a ballast tank on board, and that ballast pump-two could have been used to pump bilge water from the holds to that tank. The shipping company had also stated that in the email of 10 March 2022 to the ILT.
Instead, the alarm was blocked and the *bilge ejector* was stopped the following morning at 08.00 ST. At variance with the inspector, the Disciplinary Court did not deem it proven that it was responsible to have crew members go on deck or into the hold sooner for an inspection.
The Disciplinary Court found the third objection to be well-founded. According to the person concerned, a much smaller quantity than the initial rough estimate of 30 m3 was pumped overboard in reality. On 11 February 2022, he stated: *"found traces of fuel in the bilge system and informed the captain oil spill to the water"*. Although the survey report he submitted concluded that *"it seems unlikely that much fuel oil was actually pumped by the ejector out of the hold and we would expect that much of the 55m³ remains in the hold"*, it followed from the conclusion that the expert also assumed that oil had been pumped overboard. On the basis of the evidence, it had been established in any case that part of the 55 m3 oil was pumped into the Atlantic Ocean.

UK34 KOBUS JR

RULING OF 10 NOVEMBER 2023
NO. 9 OF 2023
CASE 2023.V7-UK34 KOBUS JR

Person concerned: the captain

This case concerned the collision of the Dutch fishing vessel, the UK34 Kobus JR. (UK34), with the platform Q4-A in the Netherlands North Sea on 23 July 2021. The UK34 scraped the platform, causing damage to both the vessel and the platform. The person concerned normally fulfilled the role of engineer, while also keeping watch on the bridge of the UK34. His brother was generally the captain, but he was on holiday. The UK34 was returning from the fishing week. The person concerned was responsible for navigation, in the role of skipper, but was busy working on the administration on the computer in the captain's cabin, located behind the bridge. He was therefore absent from the bridge for an extended period of time, which resulted in him not anticipating the collision with the platform.

The inspector's objection against the person concerned consisted of the following elements:
1. Despite the person concerned being the officer of watch at the time of the collision, he was absent from the wheelhouse for an extended period of time.
2. During his watch, the person concerned was involved in other business for an extended period of time, rather than his navigation tasks.
3. The person concerned had not appointed another crew member as his replacement to conduct the navigation and keep watch.
4. The watch alarm was not switched on.
5. An electronic chart was used as the primary form of navigation, which had not been approved as ECDIS.
6. The deck rating eyes and ears (hereinafter: 'E+E') was lacking, despite being compulsory in accordance with the *Minimum Safe Manning Document* (hereinafter: 'MSMD').
7. The crew list had not been correctly completed. The various functions were not correctly stated and the engineer was missing on the crew list.

Due to the economic police courts involved in this collision already having imposed a fine, the inspector's demand was to reprimand the person concerned.
The person concerned acknowledged the correctness of the first four objections. The person concerned stated that he was unaware of the conditions of the final three objections.

The Disciplinary Court declared objections one through four to be well-founded, and dismissed the other objections. As the person concerned had already been imposed a considerable fine by the economic police courts (€ 4,100, of which € 2,050 conditionally) and the person concerned recognised the error of his actions, the Disciplinary Court simply imposed a reprimand.

The Disciplinary Court had taken into consideration that the person concerned was the officer of watch at the time of the collision, he was absent from the bridge for an extended period of time,

he was involved in other business for an extended period of time, rather than his navigation tasks, he had not appointed another crew member as his replacement to conduct the navigation and keep watch, and that the watch alarm was not switched on.
Although the Disciplinary Court felt empathy considering the complicated nature of the fishing log book administration, the person concerned should have ensured that the watch took place (by another person). If he had switched on the watch alarm, it would have needed to be reset in the wheelhouse, or otherwise the general alarm would have sounded and the collision could probably have been avoided.
The Disciplinary Court dismissed the fifth objection as unfounded. Although the Disciplinary Court agreed that *Quodfish* and *TimeZero* were not qualified as ECDIS, the Disciplinary Court was of the opinion that *TimeZero* was an extremely reliable and current electronic charting and navigation system for sea fishery, so that its use as a primary means of navigation within sea fishery was not contrary to good seamanship. *TimeZero* was updated weekly after all, and any changes observed by fishing vessels at sea were communicated by them to *TimeZero* via *WhatsApp*.
The Disciplinary Court dismissed the sixth objection as unfounded, as too much doubt had arisen regarding whether the person concerned acted contrary to good seamanship within the scope of this objection. The person concerned was inadequately aware of the crew requirements to be able to make a statement on this. The email message of 5 August 2021 at 14:44 hours, from the Shipping Kiwa Register NL to the inspector, did however show only three of the six crew members to have a navigation licence. As the MSMD required four crew members to hold a navigation licence rather than three crew members, the aforementioned email message might indicate that the UK34 was at that time lacking one crew member with an "E+E" navigation licence, and therefore did not comply with the MSMD. However, the aforementioned email message did not show which annexes were actually provided by the inspector to the Shipping Kiwa Register NL, so that it remained unclear whether the correct names were provided for assessment. Moreover, the maritime police report stated that a crew check conducted on 23 July 2021 showed the UK34 to be manned in accordance with the requirements of the Shipping crewing act.
The Disciplinary Court ruled the seventh objection to be unfounded, due to the mere fact that the crew list was incorrect did not automatically imply a serious failure in the duty of care that should be observed by a competent seaman in relation to the people on board, the ship, its cargo, the environment and shipping traffic. According to the Disciplinary Court, good seamanship referred to actually sailing with an adequate and proficient crew, and there was insufficient evidence that this was not the case.

In terms of a focal point for professional practice, the Disciplinary Court advised adoption of the Belgian policy with regard to the crew list (possibly automated) in the Netherlands, in order to prevent more accidents.
The digital system in Belgium works as follows: The Belgian government digitally links any diplomas and certificates required in sea fishery, to the fisher in question who has attained the diploma or certificate. The skipper adds the names of his crew members to the crew list, and submits this list digitally. The appropriate documents are also required to be kept on board. If the documents are incorrect or any persons on the list are missing on board, mustering is not allowed and/or the vessel may not leave the harbour. Last but not least, the Belgian government actively monitors compliance with these rules.

The inspector has appealed against the ruling in this case. This appeal is ongoing.

RUYTER

RULING OF 1 DECEMBER 2023
NO. 10 OF 2023
CASE 2023.V8 - RUYTER

Person concerned: maritime officer

This case concerned the collision between de Ruyter, a Dutch trailing suction hopper dredger, and the Celestine, a Maltese vessel, on exiting the Westerschelde on 11 April 2022.
Once de Ruyter had discharged her cargo into other vessels in the fairway close to the Hoofdplaat, the vessel departed again to sea. The person concerned was officer of the watch. The captain was also on the bridge. The person concerned reported the departure from the transshipment point to the vessel traffic service. They agreed that the vessel would sail out behind the other shipping traffic. This concerned the incoming Sunny Horizon and the outgoing Celestine. The captain agreed with this decision. Once de Ruyter had passed behind the Sunny Horizon, the captain became seated at a table on the bridge, with his back to starboard. He was therefore unable to see the Celestine approaching. The first officer also joined them on the bridge with food. The collision took place shortly afterwards.

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned had kept much too small a CPA from the Celestine.
2. The person concerned had not altered course sufficiently after passing the Sunny Horizon.
3. Besides altering course, the person concerned should have reduced the speed sooner in order to keep a safe distance from the Celestine.
4. The person concerned did not adequately anticipate the slowing of the Celestine.
5. The collision had occurred partly because of the aforementioned objections.

The inspector's demand was to suspend the navigation licence of the person concerned for eight weeks, two of which conditionally.

The person concerned believed that the inspector's petition should be declared inadmissible, as it contained a fundamental shortcoming. The inspector had omitted essential aspects which served as the basis of the petition. The inspector had based the petition on the COLREG, but this should have been primarily the SRW 1990.
With regard to the objection concerning keeping too small a CPA, the person concerned disputed whether a CPA of approximately 180 metres would have been insufficient in this case. The person concerned also disputed that he should have anticipated the Celestine slowing down.
The person concerned believed the accusations regarding the change of course and speed reduction (elements two and three of the objection) to be understandable, but to be based on an excusable error. He had realised too late that the necessary change of direction to starboard should have been made earlier by activating and switching to the river pilot system, setting the sea pilot system to standby and changing the selector switch. In the opinion of the person concerned, this all constituted a human, one-off error, in a total of approximately seventy trips made on de Ruyter, of which thirty responsible for navigation on the bridge. This was not a decision of bad seaman-

ship; accusations of a disciplinary nature could therefore not be made against the person concerned, in his opinion.
The person concerned requested that, in the event of the Disciplinary Court ruling to suspend the navigational licence, that this suspension would only apply to his authority as maritime officer and therefore not to his authority as engineer.

The Disciplinary Court declared the inspector's petition to be admissible, declared the objections to be well-founded and suspended the navigation licence of the person concerned for a period of eight weeks.
As the person concerned was a relatively inexperienced and young maritime officer, who had received little to no support from the captain, and whose statement at the hearing showed him to be certainly aware of his failure and lack of practical know-how and skills, the Disciplinary Court stipulated that the suspension of the navigation licence be imposed for four weeks conditionally, rather than the two weeks conditionally demanded by the inspector.
Given the information received, the Disciplinary Court saw no reason to have this suspension only apply to the authority of the person concerned as maritime officer. Aside from that, the Disciplinary Court believed that suspension of part of the authority of the person concerned would also not be feasible in practice. The person concerned is a Mar. Off. and his *certificate of competence* as such covered both the authority to navigate a vessel as maritime officer and the authority to work on board as an engineer. Upon suspension of the navigation licence, the *certificate of competence* must be surrendered. Suspension of the navigation licence therefore applies to both the authority as maritime officer and the authority as engineer.

The Disciplinary Court therefore rejected the appeal for inadmissibility by the person concerned.
Pursuant to section 55a of the Seafarers Act (Wet Zeevarenden) in connection with section 4, paragraph 4 of the Seafarers Act, the Disciplinary Court assesses whether the acts or omissions of the person concerned are contrary to the care that he, as a good seafarer, should observe towards the persons on board, the ship, the cargo, the environment or shipping traffic. Based on section 55h of the Seafarers Act, the petition must give reasons and must at least include the personal information and position of the person concerned, information regarding the vessel, a description of the behaviour and the objections which have arisen against the challenged behaviour. The petition complied with these requirements, even though the inspector had not referred to the conditions from the applicable Westerschelde Shipping Regulations (SRW 1990), in the petition. The standard of good seamanship as described in section 4, paragraph 4 and section 55a of the Seafarers Act, is an open standard for which guidance can be found in treaties, laws and decrees for shipping. The inspector had stated this open standard of section 55a of the Seafarer Act in the petition, while also referring to various COLREG conditions.
The Disciplinary Court also considered that the following facts had been ascertained. The person concerned was Mar. Off. and officer of the watch of de Ruyter when leaving the Westerschelde on 11 April 2022. The person concerned consulted with the vessel traffic service to navigate behind the incoming Sunny Horizon and the outgoing Celestine. Once de Ruyter had passed the Sunny Horizon (at a good distance), the captain who was also present on the bridge, had become seated at a table to eat, with his back to starboard. The collision with the Celestine took place shortly afterwards.
It had been established that the person concerned maintained a CPA of 0.1 mile from the Celestine. In the given circumstances, namely on the Westerschelde with crossing vessels and the local

current, the Disciplinary Court believed a CPA of 0.1 mile to be greatly insufficient. At such a CPA, the person concerned had not planned sufficient margin to take account of the realistic possibility that other vessels could change course and/or speed. When questioned at the hearing, the person concerned informed the court that he would plan a larger CPA should such a situation occur again. The above information meant that the first and the fourth elements of the objection were declared to be well-founded.

The person concerned had stated that after passing the Sunny Horizon, he had headed up twice and reduced his speed by 10 percent, and that he could not steer to starboard any earlier due to the Sunny Horizon. In heading up, the person concerned had used his plot data and looked outside. In his statement to the police, the captain had confirmed that the person concerned had given two ticks backwards and that he had heard the blower revs being reduced. The captain had also declared that he saw they would pass 'well behind the Sunny Horizon'. The film images also showed de Ruyter navigating at a good distance behind the Sunny Horizon. In the opinion of the Disciplinary Court, the person concerned should have changed his course much more strongly after passing the Sunny Horizon, for which there was space, and should have reduced his speed earlier. The fact that the person concerned had forgotten to change the selector switch between the sea pilot and river pilot directly prior to the collision, as a result of the stress, did not deter from accusations of a disciplinary nature being made with regard to the change of course. Operating the equipment is a basic skill required of any maritime officer, despite the relatively young age and inexperience in this case. A maritime officer may always be expected to have the required knowledge and skills. Moreover, the person concerned had already undertaken various trips as maritime officer on board de Ruyter. Although the level of supervision by the captain – who was also aware that the person concerned was relatively inexperienced – was certainly not entirely adequate, this did not deter from the individual responsibility of the person concerned.

The Disciplinary Court noted hereby that it was indeed the first officer who cautioned the person concerned regarding the emergency situation. The person concerned did not seem to have realised at all that this was a hazardous situation. He seemed surprised by the circumstances. The above considerations resulted in the court also declaring the second and third elements of the objection to be well-founded.

The above elements had contributed to the collision occurring.

NOORDERLICHT

RULING OF 29 DECEMBER 2023
NO. 11 OF 2023
CASE 2023.V10-NOORDERLICHT

Person concerned: captain

This case concerned the grounding of the Noorderlicht, a Dutch passenger/sailing vessel, built in 1910, on the rocky ground on the northern side of the small village of Auken, in Norway, on 23 March 2023. There were 26 persons on board, including 9 crew and 17 passengers aged 14 to 18 years (trainees in the Masterskip educational programme). The Noorderlicht sailing vessel was underway from Trondheim to the more northerly located Rørvik. The vessel was motorised. The route passed close to fjords and islands, as well as between the islands. This occurred due to the Noorderlicht correcting its course close to a narrow strait at the island, and sailing too far south. The first officer was the ship's OOW at the time. There was a lookout, but he was below deck at that point. All persons on board were evacuated following the grounding, with the exception of the person concerned and the engineer. They used the dinghy to access the dry part of the island. There, they were picked up by a cargo vessel. They were then transferred by the local lifeboat from the cargo vessel to a passenger vessel, which transported them to Lauvsnes. There were no personal injuries and only limited damage. The vessel did not make water.

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned had not ensured effective and comprehensive voyage preparation for the Trondheim – Rørvik voyage.
2. The person concerned had not effectively communicated with the first officer regarding preparation of the voyage from Trondheim – Rørvik.
3. An ECS, not compliant with the IMO Performance Standards for ECDIS, had been used as the primary navigation tool.

The inspector demanded a reprimand and a conditional suspension of the navigation licence of the person concerned for a period of two weeks.

At the hearing, the person concerned had acknowledged the first two points of the inspector's objection. However, the person concerned had disputed the correctness of the accusation that an ECS had been used as the primary navigation tool. According to the person concerned, navigation took place by sight, the radar and the paper chart (which was located below deck). The ECS was an additional navigation tool, the use of which the person concerned did not consider to be contrary to the duty of a good seaman.

The Disciplinary Court declared the inspector's objections to be well-founded and suspended the navigation licence of the person concerned for a period of three weeks.
The inadequate voyage preparation and communication, in combination with the final responsibility of the person concerned as captain, resulted in the Disciplinary Court imposing a more serious measure than demanded. As the person concerned and the first officer had been mutually

involved in the voyage to be undertaken and the (inadequate) preparation/communication thereof, the Disciplinary Court imposed the same measure on the person concerned as that imposed on the first officer.
Given that the person concerned had learned from the incident and was willing to make every effort to prevent repetition, the Disciplinary Court ruled that the suspension of the navigation licence would be imposed partially conditionally (two weeks).

The Disciplinary Court had taken into consideration beforehand that the captain and the ship's officers of the Noorderlicht were subject to disciplinary rules, because the Dutch nationality vessel, the Noorderlicht, was described by the owner as a "tall ship", governed by the scope of the Dutch Seafarers Act (see sections 1 and 2 of that act).
The Disciplinary Court had also taken into consideration that the voyage preparation and communication had been inadequate. It had been established that the grounding of the Noorderlicht was the direct consequence of the steering error by the first officer. In this case however, this steering error could not be seen separately from the inadequate voyage preparation and lack of communication between the first officer and captain. These points also related to the acts or omissions of the person concerned as master of the Noorderlicht.
Although this was not his responsibility, the person concerned had not ensured/supervised the effective and comprehensive voyage preparation for the Trondheim – Rørvik voyage. This is contrary to good seamanship. Good seamanship assumes a good preparation of the voyage to be undertaken. Voyage preparation concerns not only the charting/plotting of a route, but also a comprehensive risk analysis, whereby the best possible inventory is made of possible hazards and therefore also potentially tricky navigation sections. This must take into account the specific characteristics of the vessel and the expected weather conditions. The legislation cited by the inspector defined the obligation to work in this manner, though such obligation always exists even without legislation.
It needed to be determined that this obligation to undertake good voyage preparation by the person concerned (who had plotted the courses in the digital ECS chart) and by the first officer (who had drawn up the voyage plan) had not been met in the correct manner. The voyage plan was limited and was not mutually discussed. This (also) particularly applied to the narrow strait/passage at the small island of Auken, where the incident occurred. It was only with hindsight that both persons concluded that they should have conferred on the navigation at that point. Partly due to the layout of the ship – with the engine/rudder controls above deck and the navigation room below deck, resulting in the steering position needing to be abandoned to note and check the position and course of the vessel – it was contrary to good seamanship to sail through narrow straits between islands close to the coast of Norway during night hours, with only the first officer acting as officer of the watch. This should have been recognised during the voyage preparation, all the more with a view to the (forecast) weather conditions and the fact that this was the first voyage on the Noorderlicht for the person concerned, and that the first officer was inexperienced in sailing under such circumstances and also unfamiliar with this route.
The person concerned, who should have monitored the voyage preparation, should have reached clear agreements with the first officer regarding the distribution of tasks. All the more because the person concerned was aware, or at least should have been aware at the beginning of the voyage and at the change of watch, that the vessel would need to navigate a narrow strait in the darkness of the night hours, with 17 children on board. The standard watch orders were inadequate under such circumstances. The person concerned should have explicitly agreed with the first officer that

he wished to be present when navigating the narrow strait in question.
Incidentally, the Disciplinary Court also noted on this point that following the grounding, it was agreed with the shipowner that sailing close to the Norwegian coast would only be allowed in daytime, supervised by two officers alternating between the steering position above deck and the navigation room below deck.
With regard to the opinion of the person concerned that this was a well-lit fairway, in which a vessel such as the Noorderlicht could easily navigate by sight with only one officer of the watch, without the need for further, more accurate determination of the position, it should be noted that the first officer had stated otherwise; he had indicated that he had no land recognition points for a large stretch of the voyage and that he had found it difficult and time-consuming to recognise the (position of the) beacons at the island of Auken when they came into sight.
With regard to the third object, that an ECS, not compliant with the IMO Performance Standards for ECDIS, had been used as the primary navigation tool, the Disciplinary Court took into account that based on the current legislation (SOLAS Chapter V Regulations 19 under 2.1.4) all vessels, regardless of their size, must be equipped with seagoing charts and seagoing publications required to plan and display the route of the vessel's proposed voyage, and to plot and track positions during the voyage. An Electronic Chart Display and Information System for sea charts (ECDIS) used for the same purpose is also acceptable. An ECS, as used on board of the Noorderlicht, is not a legally accepted alternative for the presence and use of the seagoing charts and publications.
In this case, the route had only been planned beforehand in the ECS. This track in the electronic chart, which was visible from the steering position, was used by the first officer en route to determine the vessel's position. The positions and times of course changes and when passing recognisable points had not been accurately recorded on the paper sea chart, or at least no more than once per hour (and equally inadequately recorded in the ship's journal).
In this case the ECS was the primary navigation tool for the first officer. He did not deny that. Shortly before running aground, he dispatched the lookout down to the navigation room in order to be able to change the scale of the ECS image if necessary.
Even if the Noorderlicht was unsuitable for the installation of an ECDIS and/or the owner of the Noorderlicht objected to this for some other reason, this did not justify simply using an ECS system as the primary navigation tool. Some other form of accepted method of navigation then needed be applied. Any passengers enjoying the travel programmes offered on board the Noorderlicht must be able to rest assured that navigation takes place in a safe and legal manner. Although in this sense the duty of care for the required equipment/crew of the vessel lay primarily with the owner, the person concerned had a responsibility in his position as captain.
For the record, the Disciplinary Court added that the use of the ECS was not the cause of the grounding. Although the inspector's objection to the use of the ECS was indeed justified in itself, it did not result in a more serious measure being imposed in this case, than if it were not involved.

NOORDERLICHT

RULING OF 29 DECEMBER 2023
NO. 12 OF 2023
CASE 2023.V9-NOORDERLICHT

Person concerned: the first officer

Case: see above (CASE 2023.V10–NOORDERLICHT)

The inspector's objection against the person concerned consisted of the following elements:
1. The Noorderlicht had run aground as the result of actions by the person concerned.
2. The person concerned had failed to effectively and comprehensively prepare for the voyage from Trondheim – Rørvik.
3. The person concerned had not effectively communicated with the captain regarding preparation of the voyage from Trondheim – Rørvik.
4. The primary navigation tool used by the person concerned was an ECS which did not comply with the 'IMO performance standards' for ECDIS.

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

The person concerned acknowledged the Inspector's objection.

The Disciplinary Court declared the inspector's objections to be well-founded and suspended the navigation licence of the person concerned for a period of three weeks.
Given that the person concerned had learned from the incident, the Disciplinary Court ruled that the suspension of the navigation licence would be imposed partially conditionally (two weeks).
The fact that no personal injuries occurred and that the damage was only limited was one of the factors taken into account by the Disciplinary Court in favour of the person concerned, when determining the duration of the suspension. The decision was thereby in accordance with the Inspector's demand.

The Disciplinary Court had taken into consideration beforehand that the captain and the ship's officers of the Noorderlicht were subject to disciplinary rules, because the Dutch nationality vessel, the Noorderlicht, was described by the owner as a "tall ship", governed by the scope of the Dutch Seafarers Act (see sections 1 and 2 of that act).
The Disciplinary Court had also taken into consideration that the grounding of the Noorderlicht was the direct consequence of a steering error by the person concerned, contrary to good seamanship. On approaching the island of Auken too northerly, the person concerned, who as first officer was the OOW, had corrected his course to starboard for a more southerly approach. However, he had oversteered and was unable to correct this in time, which had resulted in the ship sailing too southerly, to the south of the fairway, and running aground on the north side of the island.

The Disciplinary Court had also taken into consideration that the voyage preparation and communication had been inadequate. Voyage preparation concerns not only the charting/plotting of a route, but also a comprehensive risk analysis, whereby the best possible inventory is made of possible hazards and therefore also potentially tricky navigation sections. This must take into account the specific characteristics of the vessel and the expected weather conditions. The legislation cited by the inspector defined the obligation to work in this manner, though such obligation always exists even without legislation.
It must be determined that this obligation to undertake good voyage preparation by the person concerned (who drew up the voyage plan) and by the captain (who plotted the courses in the digital ECS chart) was not met in the correct manner. The voyage plan was limited and was not mutually discussed. This (also) particularly applied to the narrow strait/passage at the small island of Auken, where the incident occurred. It was only with hindsight that both persons concluded that they should have conferred on the navigation at that point. Partly due to the layout of the ship – with the engine/rudder controls above deck and the navigation room below deck, resulting in the steering position needing to be abandoned to note and check the position and course of the vessel – it was contrary to good seamanship to sail through narrow straits between islands close to the coast of Norway during night hours, with only the person concerned acting as officer of the watch. This should have been recognised during the voyage preparation, all the more with a view to the (forecast) weather conditions and the fact that the person concerned was inexperienced in sailing under such circumstances and also unfamiliar with this route, while it was also the captain's first voyage on the Noorderlicht.
Incidentally, the Disciplinary Court also noted on this point that following the grounding, it was agreed with the shipowner that sailing close to the Norwegian coast would only be allowed in daytime, supervised by two officers alternating between the steering position above deck and the navigation room below deck.
With regard to the opinion of the captain that this was a well-lit fairway, in which a vessel such as the Noorderlicht could easily navigate by sight with only one officer of the watch, without the need for further, more accurate determination of the position, it should be noted that the person concerned had stated otherwise; he had indicated that he had no land recognition points for a large stretch of the voyage and that he had found it difficult and time-consuming to recognise the (position of the) beacons at the island of Auken when they came into sight.
With regard to the third object, that an ECS, not compliant with the IMO Performance Standards for ECDIS, had been used as the primary navigation tool, the Disciplinary Court took into account that based on the current legislation (SOLAS Chapter V Regulations 19 under 2.1.4) all vessels, regardless of their size, must be equipped with seagoing charts and seagoing publications required to plan and display the route of the vessel's proposed voyage, and to plot and track positions during the voyage. An Electronic Chart Display and Information System for sea charts (ECDIS) used for the same purpose is also acceptable. An ECS, as used on board of the Noorderlicht, is not a legally accepted alternative for the presence and use of the seagoing charts and publications.
In this case, the route had only been planned beforehand in the ECS. This track in the electronic chart, which was visible from the steering position, was used by the first officer en route to determine the vessel's position. The positions and times of course changes and when passing recognisable points had not been accurately recorded on the paper sea chart, or at least no more than once per hour (and equally inadequately recorded in the ship's journal).
In this case the ECS was the primary navigation tool. The person concerned did not deny that. Shortly before running aground, he dispatched the lookout down to the navigation room in order

to be able to change the scale of the ECS image if necessary.
Even if the Noorderlicht was unsuitable for the installation of an ECDIS and/or the owner of the Noorderlicht objected to this for some other reason, this did not justify simply using an ECS system as the primary navigation tool. Some other form of accepted method of navigation then needed be applied. Any passengers enjoying the travel programmes offered on board the Noorderlicht must be able to rest assured that navigation takes place in a safe and legal manner. Although in this sense the duty of care for the required equipment/crew of the vessel lay primarily with the owner, the person concerned had a responsibility in his position as officer.
For the record, the Disciplinary Court added that the use of the ECS was not the cause of the grounding. Although the inspector's objection to the use of the ECS was indeed justified in itself, it did not result in a more serious measure being imposed in this case, than if it were not involved.

BARNEY

RULING OF 29 DECEMBER 2023
NO. 13 OF 2023
CASE 2023.V11-BARNEY

Person concerned: captain

This case concerned the Barney, a Dutch SHOALBUSTER, which collided with the top of its wheelhouse against the underside of the Schellingwouderbrug bridge in Amsterdam, on Friday, 3 March 2023. The satellite domes were damaged among other things, a life raft was activated and the cradles of the life rafts were damaged.
At the time of the accident, the crew consisted of six people in total. The navigation was in the hands of the Mar. Off. The person concerned, as captain, was also on the ship's bridge. There had been no (effective) assessment of the air draft, in relation to the clearance height of the Schellingwouderbrug bridge. At the very last moment, the person concerned realised that the vessel could not fit under this bridge, but this occurred too late and resulted in the collision. There had been no personal injuries.

The inspector's objection against the person concerned consisted of the following elements:
1. The person concerned had not checked the voyage plan accurately enough.
2. The person concerned had taken account of an *air draft* of 2 metres less than it was in reality.
3. The person concerned therefore also had not recognised the consequences of the noted clearance height of the Schellingwouderbrug bridge in relation to the actual *air draft* of the Barney.
4. The person concerned had sailed out with the vessel without complying with all the crew requirements imposed by the applicable inland navigation legislation.

The demand was to impose a suspension of the navigation licence for a period of six weeks, two weeks of which conditionally.

The person concerned acknowledged the Inspector's objections. Unlike earlier statements, the person concerned stated at the hearing that the intention was to sail through the lift section of the Schellingwouderbrug, passing under the bridge after leaving the locks.

The Disciplinary Court declared the inspector's objections to be well-founded and suspended the navigation licence of the person concerned for a period of four weeks.
Given that the person concerned had learned from the incident, the Disciplinary Court ruled that the suspension of the navigation licence would be imposed partially conditionally (two weeks).

The Disciplinary Court had taken into consideration that the person concerned was extremely inattentive, and that for unexplainable reasons, the vessel had hit the bridge, despite the knowledge that the *air draft* was too high for the clearance opening.
The Disciplinary Court considered it unlikely that the intention was to pass through the lift section of the Schellingwouderbrug bridge. This could not be read either in the *statements* drawn up a day after the incident, or in the written replies from the person concerned and the Mar. Off., approxi-

mately one month later. The report of 23 August 2021 drawn up by the shipowner, also did not refer to the plan to sail through the lift section. It was the responsibility of the person concerned to produce any deviating *track record* of the ECDIS.
Even if sailing through the lift section was the original intention, the Disciplinary Court felt that this did not deter from the basis of the objections.
The Disciplinary Court noted, for the sake of completeness, that it is generally recommended that ILT also go on board to undertake investigation and to safeguard authentic documents.

In terms of focal points for professional practice, the Disciplinary Court named:
1. It is recommendable that the standard forms used by shipowners for voyage preparation include a separate box with questions regarding the minimum clearance height of bridges, etc., the actual *air draft* of the vessel and clearance, in order to be able to safely sail under such objects.
2. Effective *Bridge Resource Management* entails everyone sharing the same navigation information, thus making the intention clear to everyone involved. Furthermore, crew working on the bridge should not be distracted by visitors.

BARNEY

RULING OF 29 DECEMBER 2023
NO. 14 OF 2023
CASE 2023.V12-BARNEY

Person concerned: maritime officer

Case: see above (case 2023.V10– BARNEY)

The inspector's objection against the person concerned consists of the following elements:
1. The person concerned had not made any note of the *air draft* in the voyage plan.
2. The person concerned therefore also had not recognised the consequences of the noted clearance height of the Schellingwouderbrug bridge in relation to the actual *air draft* of the Barney.
3. The person concerned had not exercised own initiative to take action to prevent collision with the Schellingwouderbrug bridge.

The demand was to impose a suspension of the navigation licence of the person concerned for a period of six weeks, two weeks of which conditionally.

The person concerned acknowledged the Inspector's objections. Unlike earlier statements, the person concerned stated at the hearing that the intention had been to sail through the lift section of the Schellingwouderbrug, and that he had only chosen to pass under the bridge after leaving the locks.

The Disciplinary Court declared the inspector's objections to be well-founded and suspended the navigation licence of the person concerned for a period of four weeks.
Given that the person concerned had learned from the incident, the Disciplinary Court ruled that the suspension of the navigation licence would be imposed partially conditionally (two weeks).

The Disciplinary Court had taken into consideration that the person concerned was extremely inattentive, and that for unexplainable reasons, the vessel had hit the bridge, despite the knowledge that the *air draft* was too high for the clearance opening.
The Disciplinary Court considered it unlikely that the intention was to pass through the lift section of the Schellingwouderbrug bridge. This could not be read either in the statements drawn up a day after the incident, or in the written replies from the person concerned and the captain, approximately one month later. The report of 23 August 2021 drawn up by the shipowner, also did not refer to the plan to sail through the lift section. It was the responsibility of the person concerned to produce any deviating *track record* of the ECDIS.
Even if sailing through the lift section was the original intention, the Disciplinary Court felt that this did not deter from the basis of the objections.
The Disciplinary Court noted, for the sake of completeness, that it is generally recommended that ILT also go on board to undertake investigation and to safeguard authentic documents.

COMPOSITION OF THE MARITIME DISCIPLINARY COURT OF THE NETHERLANDS IN 2023

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

SECRETARIAT

E. Doeven