



DUTCH
SAFETY BOARD

Investigations

The Dutch Safety Board has a legal obligation within the shipping sector to investigate serious and extremely serious incidents involving Dutch seagoing vessels. This obligation also applies to investigating serious and extremely serious incidents involving seagoing vessels in Dutch territorial waters. The Dutch Safety Board carries out such investigations in accordance with the Dutch Safety Board Act and the EU directive 2009/18/EC from the European Parliament and the Council of the European Union, dated 23 April 2009, regarding investigating and preventing maritime transport accidents. In the event of serious incidents, if the Safety Board decrees that there are no structural safety shortcomings after conducting an extensive investigation, a description of the incident is sufficient. The Safety Board's principal goal is to prevent accidents or to limit the consequences of these by drawing lessons and formulating recommendations. Investigations into guilt or liability explicitly do not form part of the Safety Board's remit.

Shipping Occurrences Report

May - October 2016



Being dependant on another person's expertise and at the same time personally responsible for the outcome of a situation is familiar to every captain in shipping. This contradiction in terms applies equally to the piloting of ships. Often it is sensible to hire expertise when one's own knowledge falls short. However, this should not ever lead to situations of total dependence on external expertise. Pursuant to the Belgian report on the collision between the AI Oraiq and the Flinterstar, this issue of the Shipping Occurrences Report takes a detailed look at the role of the pilot and of the crew during piloting.

Investigations do not always yield a clear and demonstrable improvement in safety or a measure for improvement. A case in point is the accident on a Dutch trawler in which a crew member died after becoming trapped. However, as this does not mitigate the severity of the incident in the Safety Board's view, it published an account of the accident to draw attention to the risks.

In the recent period, three new investigations have been launched. The first concerns a fatal accident during container loading activities. The second is an investigation into the breaking off of the mast of a historic sailing ship, which killed three passengers. Finally, the Safety Board has launched an investigation into a fatal accident during painting activities in a ballast tank involving a crew member who was working in a damp space and may have died due to electrocution.

Tjibbe Joustra, *chairman Dutch Safety Board*



Safe pilotage starts with effective cooperation between pilot and crew

This fourth edition of the Shipping Accidents Report addresses the theme of pilotage. This theme has been briefly mentioned in the past, but with the publication of the Belgian Investigation Report into the collision between the AI Oraiq and the Flinterstar, on 6 October 2015, off the coast of Zeebrugge it is now discussed in more detail. A summary of the investigation is provided on page 6 and 7.

Challenging situations

When sailing in shallow waters and manoeuvring in port areas an incorrect estimate of the situation can soon lead to a (near) accident. A split-second decision can sometimes mean the difference between a successful or regrettable outcome. Sailing large ocean-going vessels in close waters and port areas requires specific knowledge of the area, waterways and use by other shipping traffic. The same applies to manoeuvring with the assistance of tugs. One cannot expect every officer on an ocean-going vessel to possess knowledge of all the ports visited. This fact was acknowledged many years ago and this is why compulsory pilotage applies in a large number of ports all over the world. Pilots are the experts in the sailing areas in which they operate. Nevertheless, it was still possible for the LNG tanker AI Oraiq to collide with the cargo vessel Flinterstar near Zeebrugge on 6 October 2015. Both ships were sailing under pilot guidance. The Flinterstar sank very quickly, but the eleven persons on board and the pilot of the Flinterstar all survived.

Accidents under pilot guidance

The Dutch Safety Board notes that, despite proper training and basic agreements related to cooperation, a remarkably high number of accidents still occur under pilot guidance. A pilot boards the ship if the situation requires local expertise or specific skills. One would expect the number of accidents to be limited. The reality reveals that a relatively high number of (near) accidents occurs under pilot guidance. In the previous Shipping Accidents Report, nine of the thirty-four accidents (in six months) described were accidents that occurred under pilot guidance. How is it possible that serious accidents still happen in areas in which those involved are obliged to possess explicit expertise to reduce the risks?

Pilot paradox

Pilot guidance is characterised by a so-called pilot paradox. A paradox is a statement that seemingly contradicts itself. With regard to pilot guidance, on the one hand the crew trust the pilot, because the latter should be the ultimate expert in the sailing area concerned and people faithfully follow the pilot's instructions. On the other hand, the captain is responsible at all times for the ship's safety and navigation and the crew know the specific sailing properties of the ship far better than the pilot does. The only place in the world where the pilot takes over responsibility for navigation from the captain is in the Panama Canal.

When a pilot boards a ship, a brief conversation often takes place with the captain on the bridge, after which the pilot often starts immediately issuing steering orders to the helmsman. As the 'newcomer' on board the pilot must quickly assess the ship's situation, whether the installations work as intended, how the crew operates on the bridge and how they communicate. The crew's lack of explicit knowledge and expertise related to the sailing area means that the crew is dependent on the pilot. Being able to act quickly in unfamiliar, frequently complex situations and the dependence of the crew result in the pilot often being placed on a pedestal. Consequently, the crew, including the captain, will not be inclined to go against a pilot, despite the fact that the captain is still responsible.

Language

Communicating in a language mastered by all involved is essential. Pilots speak to the crew in English but, when possible, they often speak in their own language with the VTS, with other pilots or with other shipping. This is not only the case in the Netherlands and Belgium because this problem also crops up in investigation reports from foreign investigation bodies. Even when ships' crews are usually composed of members from many different countries that do not master the local language. This means that not all those involved are able to understand information that is important to them.

Cooperation on the bridge

Safe navigation is a shared responsibility of the pilot and the bridge team, in which the captain bears ultimate responsibility in virtually all cases. This is why the International Maritime Pilots' Association (IMPA) and the Maritime Accident Investigators' International Forum¹ (MAIIF) have joined forces. As a result of diverse studies and investigations a document has been compiled that should make crews and pilots aware that safe navigation in pilot waters is a joint task of the crew and the pilot.

The following basic agreements are of great importance to ensure cooperation between the pilot and the crew is optimal and as safe as possible:

- SHARE navigation information
- RESPECT each other
- COMMUNICATE throughout the voyage
- WORK together
- STAY alert

The accident involving the AI Oraiq and the Flinterstar as well as other accidents with pilotage included in the Shipping Accidents Report make it clear that however basic the aforementioned agreements appear, it is necessary to emphasise their importance. Safe navigation in pilot waters does not begin when the pilot boarding the ship, it starts with effective cooperation between the pilot and the crew.






1 The Dutch Safety Board is a member of MAIIF.

The document compiled by the IMPA and MAIIF is being disseminated in poster form all over the world.

Commit to **Safe** Navigation



SAFE NAVIGATION IN PILOTAGE WATERS IS A SHARED TASK OF THE BRIDGE TEAM AND THE PILOT

-  **SHARE** NAVIGATION INFORMATION
-  **RESPECT** EACH OTHER
-  **COMMUNICATE** THROUGHOUT THE VOYAGE
-  **WORK** TOGETHER
-  **STAY** ALERT



Accident classification

In this Shipping Occurrences Report, the Dutch Safety Board presents incidents on board vessels sailing under the flag of the Netherlands or within Dutch territorial waters, as well as reports published in the period between 1 May and 1 November 2016.

Every accident is classified according to its severity. The categories match those stipulated in EU Directive 2009/EC/18:

Very Serious: accident involving the total loss of a ship, fatalities, or serious environmental damage.

Serious: accident involving a vessel that cannot be classified as 'very serious' and in which, for example, a fire, collision, grounding, etc. has occurred resulting in the ship not being able to sail further or causing environmental damage.

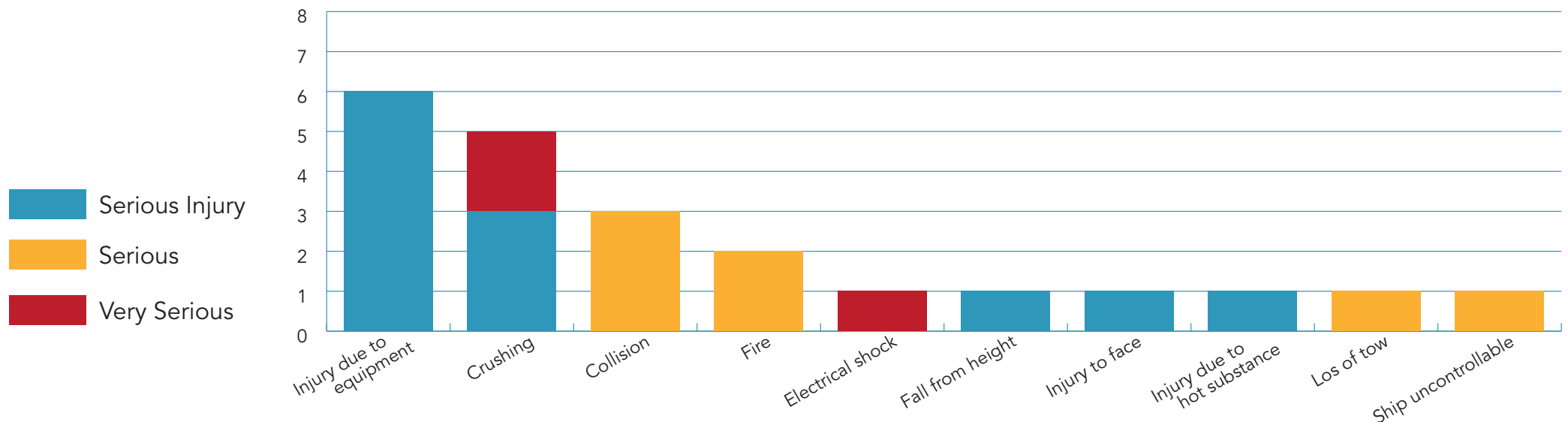
Less serious: accident that cannot be qualified as 'very serious' or 'serious'.

Marine incident: an event or series of events, other than an accident, which took place in connection with shipping operations and which endangered the safety of the ship, occupants or the environment, or would have endangered these without correction.

Serious injury: injury sustained by a person, resulting in the person being unfit for work for longer than 72 hours, within seven days of the date on which the accident took place.

This report describes the incidents classified as *Very Serious*, *Serious* and *Serious injury*. It also includes the incidents that relate to the Safety Board's priorities.

Occurrences in this Shipping Occurrences Report



Accidents classified as Very Serious, Serious or Serious Injury between 1 May and 1 November 2016, categorised according to type.

Published reports

Skipper falling overboard, Enterprise (PD-147), North Sea, 9 July 2015

On 9 July, at approximately 04.15 am, the Dutch skipper of the trawler Enterprise (PD-147) sailing under the United Kingdom flag, fell overboard when working on deck. He was not wearing any personal protection equipment. The ship was sailing 16 Nm north of the Dogger Bank. It took the crew 30 to 40 minutes to get the skipper back on board; the subsequent life-saving actions were pointless by then.

The Maritime Accident Investigation Board (MAIB) launched an investigation as a result of this incident. During the course of the investigation, the MAIB identified that:

- The shooting ports did not comply with the minimum bulwark height requirements.

- The onboard risk assessments regarding falling overboard was inadequate.
- Man overboard drills were inadequate and infrequent.
- No contingency plans existed for the loss or incapacitation of the skipper.
- The statutory crew competency requirements were not met, the vessel was carrying more crew members than permitted, and it was also carrying a thirteen-year-old boy.
- The vessel's owner had not reported another man overboard incident that had occurred three weeks earlier.

Classification: Very Serious

The full report is available at <https://www.gov.uk/maib-reports/man-overboard-from-stern-trawler-enterprise-with-loss-of-1-life>

The Enterprise (PD-147).



The shooting ports on the aft of the Enterprise.



Collision between Al Oraiq (IMO: 9360790) and Flinterstar (IMO: 9243758), North Sea near Zeebrugge (Belgium), 6 October 2015

During the night between 5 and 6 October 2015 near Zeebrugge, a collision occurred between the LNG tanker Al Oraiq, sailing under the Marshall Islands flag, and the Flinterstar cargo ship sailing under the Dutch flag. The Flinterstar sank almost immediately as a result of the collision. The captain of the Flinterstar was badly wounded in the incident but the other ten people on board and the pilot were miraculously rescued out of the water unharmed. The Al Oraiq was being piloted by two Belgian coastal pilots at the time of the collision. The Flinterstar was being piloted by a Belgian sea pilot. Traffic guidance was provided by the Zeebrugge VTS Post.

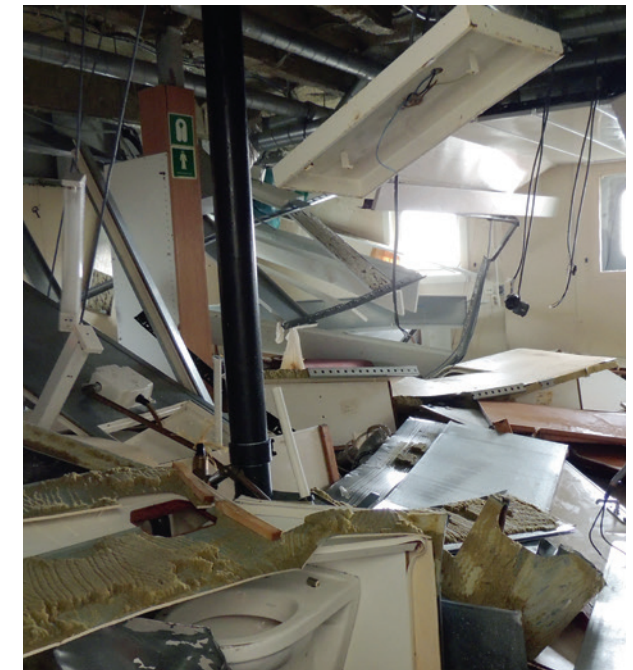
The Al Oraiq was on its way to the port of Zeebrugge, where an LNG terminal is located. This terminal is served by large LNG tankers on a fairly regular basis. Special

LNG management measures apply when sailing in and out of the port of Zeebrugge. These measures incorporate additional safety margins and involve, for example, times of approach or departure, the ship's 'under keel clearance' (that indicates how much space there is between the ship's keel and the ocean bed) and reporting obligations.

One of the two coastal pilots was in charge of the pilotage on board the Al Oraiq. The second pilot was occupied solely with communicating with the VTS post. From the moment the pilots boarded the ship, it was evident from all the pilot's actions that the latter wanted to enter the port of Zeebrugge as quickly as possible. This was apparent, for example, from the deviation from the sailing route specified in the LNG management measures, the increase in speed after boarding the vessel and the initial intention to perform an unusual manoeuvre to overtake another ship. The investigation revealed that these matters were symptomatic of the coastal pilots' attitude. They were sailing an LNG tanker and therefore all other shipping traffic had to give way to them.



Securing the Voyage Data Recorder of the Flinterstar.



Interior of the Flinterstar after the collision.



The bridge of the Flinterstar after the collision.

Because the coastal pilot on the Al Oraiq was mainly focused on the ultimately abandoned overtaking manoeuvre, he decelerated and changed course too late. At that moment, the pilot was totally unaware of the approaching Flinterstar. As far as he was concerned this was also unnecessary since the Flinterstar would keep its distance from his ship in accordance with LNG measures. However, the pilot on the Flinterstar was insufficiently aware of the approaching LNG tanker. The pilot and the first mate on the Flinterstar were routinely sailing from the Western Scheldt in the direction of the pilot drop-off point past Zeebrugge. Communication between the pilots and with the VTS was in Flemish. The working language on both the Al Oraiq and the Flinterstar was English and nobody could understand Flemish. In addition, the VTS in Zeebrugge failed to issue the prescribed shipping announcement about the approaching LNG tanker, but also other communication between the shipping traffic was also insufficiently monitored on the Flinterstar.

The VTS operator was aware of the imminent collision but, due to the structurally impaired relationship between VTS Zeebrugge and the Flemish coastal pilots, no related communication took place. Consequently, the collision was unavoidable.

With Belgium (Autonomous Unit) as lead investigative state an investigation was performed, with support of investigators from the Netherlands (Dutch Safety Board) and the Marshall Islands. The investigation's main conclusions are:

- The direct cause was an incorrect assessment of the traffic situation by the bridge team (pilot and crew) on board the Al Oraiq. It was established that the bridge team did not perform as expected. The pilot communicated exclusively in Flemish and messages were not translated into English. The sailing plan submitted by the pilot with a deviation from the pre-established route, the relatively high speed and an intentionally planned overtake manoeuvre did not contribute to a safe passage in the direction of the port of Zeebrugge either. It can be established that the interpretation of his duty and the attitude of the Flemish coastal pilot concerned directly contributed to the occurrence of the collision.
- On board the Flinterstar, the pilot and the officer of the watch were insufficiently focused on safe

navigation. As a result, information related to the approaching LNG tanker was not noticed in time, although VTS Zeebrugge also partly failed to provide the right information. The VTS did not issue a warning about the imminent collision.

- Underlying causes mainly relate to the LNG Management Measures that apply off the coast of Zeebrugge. The multitude of rules and regulations have misled the bridge watch teams. Also the different Flemish and Federal interests in these rules and regulations, played a role.

Since the shipping companies involved have largely taken appropriate measures following the accident to prevent it happening again, the recommendations primarily focus on pilots and VTS operators making a better contribution to safe shipping traffic in which attitude, unambiguous language use and communication represent important points for concern.

Moreover, Zeebrugge is located in the busy Scheldtmond. With regard to sailing in the direction of the ports of Antwerp and Ghent in the Scheldtmond and Western Scheldt, the Netherlands and Flanders have established a Common Nautical Authority (GNA) with Common Nautical Management (GNB). The aim is to guarantee safe and efficient shipping on the Scheldt and its seaward approach routes, by means of the common nautical management of traffic flows. Belgian Federal and Flemish authorities are recommended to harmonise the laws and regulations and review the usefulness and the need for measures such as the LNG Management Measures. Improved monitoring of compliance with the rules is a major point. The Common Nautical Authority for the Scheldt area could also play a role herein.

Classification: Very Serious

The full report can be found on <http://www.philippedebacker.be/media/onafhankelijk-onderzoeksrapport-flinterstar-klaar>

Completed investigations

Crewmember killed as a result of being crushed by a beam trawl, Vlissingen (the Netherlands), 20 November 2015

On Thursday 19 November 2015, at around 8 p.m., the beam trawler ARM-7, which was sailing under the Dutch flag, entered the port of Vlissingen after fishing that week. At that time, the weather was good and there was not a lot of wind (wind force Beaufort 3-4 (Bft)). Before the ship could moor in the port, it first had to sail through the lock. In the lock, the crew began preparing to unloading of their catch. The activities on deck also consisted of maintenance of the fishing nets, for which the crew had to place the pulse trawl gear on deck.

After mooring at the fish auction, the crew unloaded the fish on the starboard side. Afterwards they moved to the berth, moored on the port side and continued activities to prepare the ship for its next trip. In the meantime, the wind had increased to wind force 5-6 Bft and gusts of wind force 8 Bft, with intermittent rain.

The beam trawl was positioned on heels on deck, on a wooden panel. The panel was positioned lengthwise in the ship's starboard gangway next to the forecastle. The heels are legs on the beam trawl that ensure the pulse rig

does not lie on deck, preventing it being damaged. The chains that used to suspend the beam trawl from the fish block, were hanging loosely overboard.

One of the crewmembers was busy repairing the pulse rig; he was standing between the beam trawl and the wall of the forecastle. The ship unexpectedly heeled to port. This caused the beam trawl to fall to the starboard side against the wall of the forecastle. The crewmember was trapped between the forecastle's ladder and the beam trawl. This happened around 2 a.m. on Friday 20 November. The skipper on the bridge moved the port rig using the crane from which the fish rig was suspended, causing the starboard beam trawl to roll back and upright itself. This freed the crewmember who slumped to the deck and died later that day from internal injuries.

Initially, as stated in the previous edition of the Shipping Accidents Report, this accident led to an extensive investigation being launched. After gathering information, the Dutch Safety Board came to the conclusion that no sector-wide lessons could be identified. It was subsequently decided to limit the investigation to a preliminary investigation and include it as such in this edition.

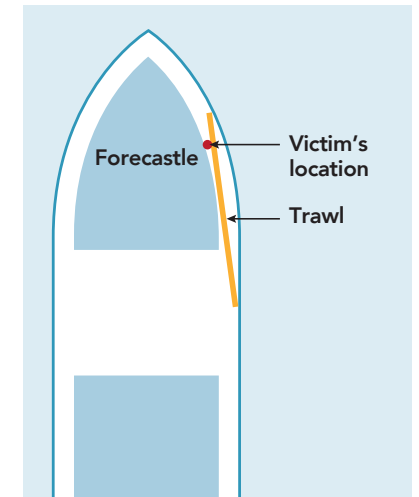
Port side ARM-7 with chains and pulse gear.



Cross-cut end of the pulse trawl on the port side of the deck, right: cross-cut end of the pulse trawl on the port side of the deck.



The victim's location during the accident.



Investigations started

Fatal accident as a result of being trapped between containers, Moerdijk (the Netherlands), 18 May 2016

At around 9 pm Wednesday evening 18 May, on board a ship sailing under the Dutch flag, a fatal accident occurred. During container loading operations, a sailor discovered that a container on the upper second layer had not been properly positioned on the container underneath it. The crane driver had released the container in such a way that two out of the four couplings (twist locks) remained in place. This created space under the upper container that was positioned askew. The sailor proceeded to crawl underneath the upper container. The crane driver eventually replaced the container. This resulted in the sailor's death. At the time of the accident, the ship was in the port of Moerdijk.

The Dutch Safety Board is conducting an investigation into this accident.

Classification: Very Serious

Sailing ship's mast breaks, Harlingen (the Netherlands), 21 August 2016

On 21 August, a Dutch sailing ship was sailing into the port of Harlingen when part of the fore mast suddenly broke off and fell on to the deck. Three German passengers lost their lives as a result. The sailing ship is part of the 'brown fleet'. These are historic ships that can be chartered for (day) trips and journeys with paying passengers.

The Dutch Safety Board is conducting an extensive investigation into this accident.

Classification: Very Serious

Fatal accident while painting a ballast tank, Saudi Arabia, 17 October 2016

On Saturday 17 October, a fatal accident occurred on board the Dutch ship near the port of Gizan, Saudi Arabia. One of the sailors was occupied for the second day in a row painting in the ballast tank. When a colleague no longer received any response from the tank, a 'recovery enclosed space' procedure was carried out. Upon which the victim, a Philippine boatswain, was found unconscious. He was taken from the ship by a rescue boat approximately two hours later, and died in hospital. It is suspected that he had a hand-held lamp with him whose wire had been 'repaired' with duct tape and he was working in a humid environment. Electrocution seems a possible cause. Investigators from the Dutch Safety Board finally conducted an investigation on board the ship in Turkey.

The Dutch Safety Board is conducting an investigation into this accident.

Classification: Very Serious

The sailing ship in the port of Harlingen. (Photo: KLPD- National Police Services Agency)



The boom of the mast overboard. (Photo: KLPD - National Police Services Agency)



Investigation
launched by a
foreign authority
with the
Netherlands as
substantially
interested state

Tugboat loses its towage in bad weather, Scotland, 8 August 2016

On 7 August, a tugboat sailing under the Dutch flag was towing a semi-submersible drilling platform when it encountered bad weather to the west of the Scottish island of St. Lewis. There were gusts with a force of over 60 knots from a west-north-westerly direction. The towing connection broke due to the bad weather and couldn't be re-established. As a result the drilling platform stranded on the Scottish coast near Carloway in the morning of 8 August, at approximately 6.50 a.m.

The British Maritime Accident Investigation Board (MAIB) has launched an investigation into the accident. The Netherlands is a substantially interested state and is assisting with the investigation where necessary.

Classification: *Serious*

Incidents that were not investigated extensively

A jump from a ship to the quay resulting in a fractured ankle, Eems Dollard, Porto Nogaro (Italy), 28 April 2016

On 28 April, the first mate on board the Eems Dollard, a cargo ship sailing under the Dutch flag, broke his ankle in several places. While the ship was moored, he slipped on the first rung while climbing the ladder of the hatch crane. As a result, he lost his balance and tried to jump to the quay to avoid falling in the water. He managed it but the two and a half metre fall broke his heel. He was taken to hospital and will probably be out of action for five months.

Classification: Serious Injury



The hatch crane of the Eems Dollard.

Broken wrist while boarding the lifeboat, Zuiderdam, Oslo (Norway), 18 May 2016

On 18 May, a crewmember of the cruise vessel Zuiderdam broke his wrist while embarking the lifeboat. The cause of the accident was a broken proximity switch. The proximity switch should have automatically stopped the winch used to lift the lifeboat. This did not happen and the man's wrist became trapped, and was eventually broken. The accident took place in the port of Oslo. The crewmember was taken to hospital. A new switch was installed on board the ship, and extra attention was paid to boarding procedures for the lifeboat, including checking the proximity switch before use.

Classification: Serious Injury

Eye injury during maintenance work, Amadeus Aquamarijn, Leer (Germany), 21 May 2016

En route up the river to Leer a crewmember on board the Dutch ship Amadeus Aquamarijn was carrying out maintenance work to an external door. During the work, involving a needle hammer and grinder, a metal splinter hit him in the eye. He was wearing his own glasses with safety goggles on top (with an open side). The crewmember suffered a permanent eye injury as a result of this accident.

Classification: Serious injury

Incidents that were not investigated extensively

A ship sails with a wheelhouse into a bridge, pilot was seriously injured, Amadeus Amethyst, Antwerp (Belgium), 31 May 2016

Late in the evening of Tuesday 31 May, the Dutch coaster Amadeus Amethyst collided with a bridge on the IJzerlaan

Left and right the damage to the wheelhouse of the Amadeus Amethyst.



on the Albert Canal in Antwerp (Belgium). As a result, the ship's wheelhouse was completely destroyed. The captain and the river pilot were in the wheelhouse at the time. The captain suffered minor injuries as a result of flying glass caused by the collision. The river pilot was seriously injured as a result of becoming trapped. After being checked over in the hospital, the river pilot appeared to have suffered a fractured pelvis.

The Dutch Safety Board carried out an initial investigation at the site. It found that the height-adjustable wheelhouse on the Amadeus Amethyst was not lowered to its lowest position. If this had been the case, the ship would have been able to sail under the bridge with a margin of one metre. In coaster shipping this is considered to be a safe margin.

The captain stated that the wheelhouse descended to the lowest setting slower than usual. This could indicate a technical malfunction related to the wheelhouse's lifting column.

The shipping company subsequently conducted a further technical investigation of the vessel along with the certification agency. It revealed that there was a defective

hose-rupture security feature. As a result, the height-adjustable wheelhouse lowered slower than usual. As an additional security measure, the shipping company decided to install an emergency lowering feature on this and its sister vessel. This feature is regularly applied in shipping and means that in an emergency the wheelhouse lowers immediately with one push of a button. It is only used in an emergency given the speed with which this happens in such cases.

In the Dutch Safety Board's opinion, the actions undertaken by the shipping company are adequate, which means that a more detailed investigation will not be launched.

Classification: Serious

Ship loses rudder, Slingeberg, North Sea, 4 June 2016

On Saturday 4 June, the Dutch vessel Slingeberg lost its rudder in the North Sea on the way to Gothenburg. At the time, the ship was sailing close to Den Helder (the Netherlands). The coast guard was informed; the ship lowered its anchor and was towed to Zeebrugge (Belgium) later on. As the exact location was known, the rudder was recovered the next day and reinstalled on the Slingeberg.

Classification: Serious

Hydraulic fluid in the face, NDurance, North Sea, 28 June 2016

At approximately 10 am local time in the morning of Tuesday 28 June, a crewmember aboard the Cypriot cable layer NDurance was injured while at work. A hydraulic pipe burst, spraying hydraulic fluid into the victim's eye. After consultation with the Radio Medical Service, it was decided to evacuate the victim by helicopter. The victim was taken to hospital in Rotterdam..

Classification: Serious injury



Sailor loses top of his thumb after getting it caught in a door, Volendam, West coast Canada, 4 July 2016

On 4 July, a sailor lost the top of one of his thumbs on the Dutch cruise vessel Volendam. The sailor was holding the door open with his foot while waiting for a colleague. His hand was resting on the doorframe. After someone else came through the door, he removed his foot, after which the door, fitted with a door closer, closed on his thumb. The door closed faster than expected and what was normal. Following the accident, the speed of the door closer was adjusted and the other doors were also inspected.

Classification: Serious Injury

Engine room fire, Venezia D, Kaliningrad (Russia), 5 July 2016

Late in the evening of Tuesday 5 July, while loading soybeans in the port of Kaliningrad, fire broke out in the engine room of the Dutch chemical tanker Venezia D, because the oil pump caught fire. In the first instance, the fire could not be extinguished by the crew using a foam extinguisher, due to the smoke and heat. The onshore fire brigade were subsequently called and boarded the ship. There were no victims and no environmental contamination. The ship was able to continue its journey on Sunday 17 July after repairs and inspection.

Classification: Serious

Collision with the quay, Northsea Sense, Sluiskil (the Netherlands), 9 July 2016

On Saturday 9 July, the ship the Northsea Sense, sailing under the Maltese flag, collided with the quay at Sluiskil, where it planned to unload its cargo. This caused a leak in the fuel tank, which resulted in fuel oil entering the water. The crew were able to temporarily repair the leak. Zeeland Seaports (port authority) organised for the oil to be cleaned up. When mooring, the instructions issued by the pilot on board were followed, but the ship responded less efficiently than expected, which meant that the

planned manoeuvre was not effective and resulted in a collision with the quay. The pilot then tried to sail against the quay's fenders, but this manoeuvre was unsuccessful, after which the stern hit the quay under the bridge at Sluiskil.

Classification: Serious

Engineer suffered serious burns when working on a boiler, Samskip Skaftafell, Orkney Islands (United Kingdom), 22 July 2016

On 22 July, the Dutch cargo ship Samskip Skaftafell was sailing near the Orkney Islands, on the way from Rotterdam to Iceland, when the second engineer was injured by boiling water. The engineer was working on the boiler at the time. The crewmember suffered serious

burns as a result and was evacuated off the ship by helicopter and taken to hospital.

Classification: Serious Injury

Collision in the port, Hanze Gendt and Dicle Deniz, Algeciras, (Spain), 25 July 2016

On Monday 25 July, at approximately 4.24 pm, a collision occurred in Algeciras Bay between the manoeuvring Turkish chemical tanker Dicle Deniz and the moored Dutch flagged ship Hanze Gendt. This caused damage to the Hanze Gendt's ballast water tank. It is suspected that the Dicle Deniz experienced engine problems. The shipping company Hanzevast Shipping dispatched a technical specialist; the Hanze Gendt will be out of action for a week for repairs to be carried out.

Classification: Serious

Left and right: Damage to the Hanze Gendt.



Damage to the Dicle Deniz.



Incidents that were not investigated extensively

Forklift truck drives over the foot of a crewmember, Zuiderdam, Copenhagen (Denmark), 9 August 2016

When loading the Dutch cruise vessel Zuiderdam, a forklift truck reversed over the foot of a crewmember. The crewmember was walking behind the forklift truck when it suddenly began reversing. He suffered several bone fractures to his foot and was taken to hospital..

Classification: *Serious Injury*

Broken fuel line.



Occupational accident, Multratug 4, Zeebrugge (Belgium), 16 August 2016

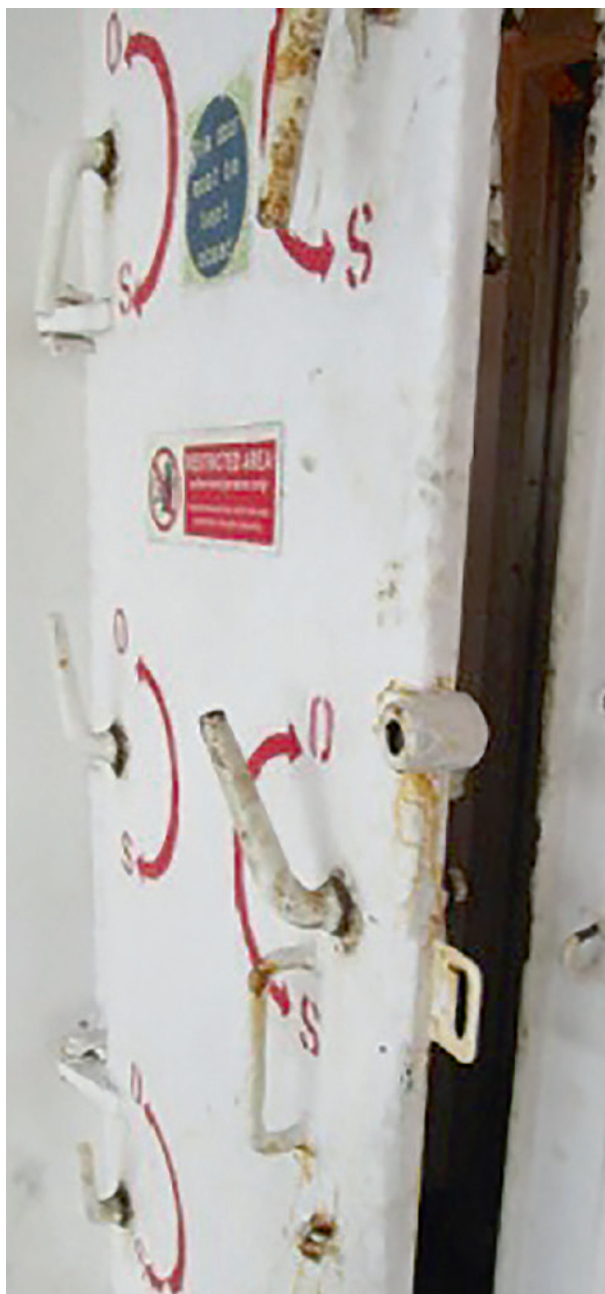
In the early morning of Tuesday 16 August, an accident occurred aboard the Multratug 4. The ship was working at the 'Flinterstar' wreck location off the coast of Zeebrugge, Belgium, on the wreck clean-up operation of the Flinterstar shipwreck. At around 6.15 am, a sailor was hit in the face by a tugger cable when removing a 34 mm cable on the aft deck. The sailor was transported to hospital by helicopter.

Classification: *Serious Injury*

Fire in the engine room, Alizee (IMO: 9574303), Kattegat (Denmark), 25 August 2016

On 25 August, the Dutch ship Alizee was sailing approximately four miles south of Drogden lighthouse (Denmark) when fire was discovered in the engine room. The crew began fighting the fire as soon as possible; they cooled the environment in the engine room (hatch and surrounding decks), sealed the emergency valves and first activated the water mist system followed by the CO2 extinguishing installation. Meanwhile the crew lowered the anchor. After approximately half an hour a drop in the temperature was observed, measured on the engine room hatch. After another half hour, the crew ventilated the engine room and went in to inspect whether there were any remaining sources of fire. The fire appeared to have been extinguished. They discovered the cause of the fire must have been a broken fuel line connection (near the pressure gauge). The ship was taken to Landskrona (Sweden) for further inspection.

Classification: *Serious*



Door to accommodation.
(Photo: crew of the Chemical Distributor)

Sailor loses three fingers during crane operations, Phoenix J., Port of Rotterdam (the Netherlands), 15 September 2016

The under the flag of Antigua and Barbuda sailing container ship Phoenix J., was in Rotterdam on 15 September. While unloading in the morning several crewmembers collected the lashing materials in a steel container on the quayside. The ship's crew then asked for the container to be lifted back on board using the quay crane. The quay crane operator had no problem with this on the condition that a crewmember issued crane instructions. The container was subsequently lifted on board by the crane. When positioning it on board a sailor tried to guide the container with his hand. The crane operator proceeded to set the container down. As a result, three of the sailor's fingers became jammed between the steel container and another container. The sailor was rushed to hospital. However, his fingers could not be saved.

Classification: Serious

Finger trapped in watertight door, Chemical Distributor, Rotterdam (the Netherlands), 26 September 2016

On 26 September, a crewmember on board the chemical tanker Chemical Distributor, sailing under the Maltese flag, trapped his fingers in a watertight door. The crewmember had his hand between the door and the doorframe and intended to open the door wider. However, the accommodation's changing air pressure resulted in the door being sucked closed, trapping his fingers. The ship was preparing to dock in the port of Rotterdam. The crewmember was transported to the nearby hospital for medical treatment.

Classification: Serious Injury

Sailor lost the top of his finger when cleaning in the engine room, Norrfury, North Sea, 5 October 2016

On board the Dutch cargo ship Norrfury, a sailor was evacuated on 5 October by the English coastguard, after seriously injuring his middle finger. The crewmember was cleaning in the engine room when his cleaning rag became caught in the rotating coupling of the water pressure system pump. The sailor was unable to move his hand out of the way in time and lost the top of his right middle finger. The crewmember was repatriated following treatment in hospital.

Classification: Serious Injury

Broken hand, Eems Chrystal, Gothenburg area (Sweden), 28 October 2016

On 28 October, an engineer broke his hand when moving a pump on board the Eems Chrystal, a cargo ship sailing under the Dutch flag. The crewmember was taken off the ship to receive medical treatment.

Classification: Serious Injury

The Dutch Safety Board in four questions

1

What does the Dutch Safety Board do?

When accidents or disasters happen, the Dutch Safety Board investigates how it was possible for them to occur, with the aim of learning lessons for the future and, ultimately, improving safety in the Netherlands. The Safety Board is independent and is free to decide which incidents to investigate. In particular, it focuses on situations in which people's personal safety is dependent on third parties, such as the government or companies. In certain cases the Board is under an obligation to carry out an investigation. Its investigations do not address issues of blame or liability.

Recently the Dutch Safety Board reported about the investigation into the causes of the crash of flight MH17, about an investigation of a diving accident and the provision of medical assistance on the North Sea and the collision between a passenger train and a man lift at Dalfsen.

2

What is the Dutch Safety Board?

The Safety Board is an 'independent administrative body' and is authorised by law to investigate incidents in all areas imaginable. In practice the Safety Board currently works in the following areas: aviation, shipping, railways, roads, defence, human and animal health, industry, pipes, cables and networks, construction and

services, water and crisis management & emergency services.

3

Who works at the Dutch Safety Board?

The Safety Board consists of three permanent board members. The chairman is Tjibbe Joustra. The board members are the face of the Safety Board with respect to society. They have extensive knowledge of safety issues. They also have wide-ranging managerial and social experience in various roles. The Safety Board's office has around 70 staff, of whom around two-thirds are investigators.

4

How do I contact the Dutch Safety Board?

For more information see the website at www.safetyboard.nl
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