FAIRMONT SHIPPING SINGAPORE
TAMAR SHIP MANAGEMENT

Company Circular no. 03 - 2026

MONTHLY SAFETY CAMPAIGNS - MAR 2026

Dear Captain/CE

Please note as following for your compliance and discussion with all officers and crew members. Lessons Learned to be discussed in the monthly Safety Meeting.

1. MPA advisory on PSC Detention in Paris MOU

There has been spike in PSC detentions in Paris MOU (PMOU). For the first month of 2026, January, three (3) Singapore Registered ships (SRS) have been detained by PMOU PSC i.e. UK MCA (Immingham), France (Dunkirk) and Canada (Quebec). The PSC deficiencies issued covers fire safety, navigation safety, poor structural conditions and non-compliance to maritime labour convention (MLC), etc. The PSC deficiencies issued to SRS are listed in the attached. There were few occasions where ships were detained by PSC while undergoing the change of flag, change of shipowner (Sale & purchase) with multiple serious deficiencies found. These detentions have resulted in delaying of handing over the ships to the new shipowners, prolong stay in port in addition to commercial and associated repair costs implications.

Master/CE to prepare for PSC inspections such as:

a. Ship's planned maintenance system is to be regularly updated and monitored by senior officers/engineers and company.
b. Scheduled inspection and maintenance of emergency and critical equipment carried out onboard by ship crew are to be monitored and to the satisfaction of senior officers/engineers.
c. All ship crew shall be properly trained and competent to perform the emergency and critical equipment operational test.
d. Emergency drills shall be conducted regularly to ensure all crew are familiar with their roles and responsibilities, and implementation of emergency procedures. Master should perform a post drill analysis to identify mistakes/errors, and review lessons learned for improvement.
e. MLC inspection shall be conducted on regular basis, emphasising on MLC documentation, accommodation and workplace cleanliness, and accommodation sanitary facilities in good condition etc.
f. Master and Chief Engineer shall diligently conduct onboard inspection of ship such as the crew accommodation, engine room, various spaces including ballast tanks, on deck and report any non-compliance to the company.
g. Pre-arrival inspection shall be diligently carried out before arrival to a port using flag states inspection checklist as guidance.

Attached PSC deficiencies pointed in Paris MOU, please check each deficiency to ensure that these don't exist on your vessel. Same confirm to you Marine Superintendent/Ship Manager by 15th March 2026.

2. Pilot ladder non-compliance letter and IMPA Safety Campaign Results 2025

Following letter was issued to Master by Port Authority at Port of Tauranga

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Dear Sir/Madam,

Upon arrival to the Port of Tauranga on 23rd February, your vessel was involved in a serious Health and Safety incident. The following was entered into the ports Health and Safety Management System by the Pilot;

///
What Happened: Chocks not visibly loose but allowed steps to rotate significantly underfoot when climbing ladder for boarding.

What Initial Actions / Corrections Were Taken: Informed Master of sub standard ladder and advised it should be taken out of service and replaced immediately. He advised he will take out of service and replace with brand new spare onboard
///

This incident is concerning to the Port of Tauranga. Pilot transfers are a very high risk activity and arrangements must be fully compliant. Non-compliant Pilot Boarding Arrangements can cause a Pilot to fall which would lead to significant injury or death. Pilot boarding arrangements must comply with SOLAS Regulations V/23 and IMO Resolution A 1045 (27) and NZ Maritime Rules Part 53.

This non compliant ladder should be disposed of as soon as possible, as it will not be used again by our Pilots.

We strongly suggest you acquire a high quality ladder such as the ***PTR Holland ladder***, available through Price Providors, Bay Providors, Sea Services and overseas vendors. Thank you very much for your assistance with this issue, please contact me directly if you require further information or clarification.

In view of above complaint to avoid similar incident, please note as following:

- Ensure pilot ladder is maintained as per monthly PMS. Discuss attached PMS Job Description with crew.
- Pilot ladder is inspected before and after deployment
- Any defect is immediately reported to Chief Officer
- Vessel calling New Zealand to use PTR Holland ladder
- Discuss non-compliances with crew as provided in attached **IMPA Safety Campaign Results 2025**

3. Liberia Flag Marine Advisory 03/2026 on Engine Room Fires

On 25 February, Liberia Maritime Authority issued an advisory to reinforce the mandatory compliance requirements that govern engine room fire prevention, same attached.
The advisory includes guidance on fire protection readiness, and safe machinery-space operations on vessels. Salient features of the Marine advisory is being reproduced as following:

Engine room fire trends

Fires aboard Liberian-flagged vessels during 2025–2026 have been reviewed and the number of incidents in the engine room have been identified as follows:

- 46 fires in 2025, of which 21 involved the engine room
- 7 fires in 2026 (YTD), of which 4 involved the engine room

The pattern continues to show that heat sources combined with fuel/oil spray, incomplete ventilation shutdown, improper system readiness, and inadequate training remain core risks, the Authority highlights.

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Marine casualty summaries – background

The Administration has reviewed recent engine room fire incidents with similar root causes and a summary of representative, anonymized cases provided below:

First case – engine room fire during navigation under pilotage
A fire originated in the vicinity of auxiliary diesel generator machinery. Ventilation flaps, particularly upper-level closures, could not be fully secured, allowing continued oxygen supply and enabling rapid fire growth. Crew members assigned to activate the CO_2 system were not fully familiar with the activation sequence, resulting in incomplete cylinder discharge.

Second case – auxiliary engine internal mechanical failure
A sudden mechanical failure caused fuel and lubricating oil to spray onto hot engine surfaces. Heavy smoke forced the evacuation of the engine room. The water mist system did not activate due to a lack of emergency power interconnection, resulting in significant structural and equipment damage.

Third Case – Fuel System Component Failure (Filter Cover Failure)
A diesel engine filter cover failed during operation, resulting in lubricating-oil spray onto the lubricating oil and exhaust components. The fire was extinguished, but the surrounding cabling, lights, and machinery sustained heat and smoke damage.

Fourth case – high-pressure fuel pipe failure (main engine)
A high-pressure fuel line ruptured, projecting atomized fuel onto the exhaust manifold and causing immediate ignition. Ventilation was secured, and CO_2 was released, extinguishing the fire. Affected main-engine units and engine room systems require further engineering assessment and root-cause analysis.

Key safety failures identified in four outlined cases

- Fuel/oil spray contacting uninsulated or inadequately shielded hot surfaces.
- Missing, damaged, oil-soaked, or deteriorated thermal insulation.
- Incomplete closing of engine room ventilation flaps and dampers.
- Crew unfamiliarity with CO_2 activation sequence, remote cabinet use, and pilot cylinder initiation.
- Water-mist systems are not fully functional on emergency power.
- Improper torque, workmanship deficiencies, or vibration leading to component failure.
- Emergency response without full PPE and BA sets.
- Inadequate maintenance records or incomplete testing logs.

Required actions to prevent recurrence (Lessons Learned)

These fleet-wide actions are mandatory and align with Liberian regulatory requirements:

#1 Fuel system integrity
- Inspect all high-pressure fuel pipes, clamps, and shielding for wear, corrosion, improper torque, or vibration marks.
- Replace any suspect components immediately.
- Verify proper torqueing and alignment practices.

#2 Hot-surface prevention
- Restore or replace all missing or deteriorated insulation.
- Remove oil-soaked lagging without delay.
- Establish routine inspections for hot-surface exposure risks.

#3 Ventilation & emergency shutdowns
- Test and verify the full closure of all engine room flaps, dampers, skylights, and ventilation stops as per prescribed rules and Company procedures.
- Document closure times and defects for corrective action.

#4 CO_2 system readiness

- Verify all actuating heads are correctly configured for operational readiness.
- Conduct regular CO_2 activation drills, including simulated remote cabinet and pilot cylinder activation.
- Maintain complete testing and maintenance records as required by FIR-001.

#5 Water-mist and foam systems

- Ensure water-mist systems operate in accordance with their approved design and power-supply arrangement.
- Replace any restricted or unapproved firefighting media.
- Perform functional and distribution testing. Following testing of water-mist, a blow through of the spray heads is recommended to clear any potential debris from forming clogs.

#6 PPE and fire party readiness

- Ensure fire suits, BA sets, and radios are fully functional and readily available.
- Require full PPE for all engine room fire responses and drills.

#7 Safety inspections

- Comply fully with the safety inspections as per INS-001, including engine room fire-risk checks.
- Where crew are permitted to perform inspections and maintenance per FIR-001, ensure they have the proper training and are provided with the necessary maker's instructions.

Robust engine room fire prevention is a mandatory requirement and a critical safety obligation. Please be guided accordingly.

4. Fleet Advisory 2024-01

Attached Fleet Advisory 2024-01 which contains all the Fleet Advisories issued in year 2023 containing PSC deficiencies and RightShip findings. All officers are required to familiarize with the Fleet Advisory. Master and CE to ensure that corrective/preventive actions are implemented to avoid recurrence of these deficiencies/findings on board your vessel. Let us know if any support is required from office.
File the signed fleet advisory in the Share point 3.2.3 Training folder by 31st Mar 2026.

5. US-Israel Conflict with Iran

Attached JMIC Advisory Note: 01-04 Mach 2026 on US-Israel Conflict with Iran for your information only. On 28 February 2026, the US and Israel launched coordinated attacks against Iran. This ongoing US-Israel conflict is a massive escalation in longstanding regional tensions in Arabian Gulf, the Strait of Hormuz, the Gulf of Oman, and the Northern Arabian Sea, Spillover events are also expected in the Red Sea, the Bab el-Mandeb Strait, and the Gulf of Aden. At present none of our vessel is in the area.

6. HSE Shares for awareness and good practice sharing (RioTinto)

- **RTM_2026_003 - HSE Share – HSE Share - Mooring Winches & Windlass Condition Checks**

  Refer attached HSE Notification Mooring Winches and Windlasses Condition Checks. Findings include worn brake linings, pitted brake surfaces, incorrect brake support (clearance) bolt, & deficiencies in brake rendering capacity.

  Inadequate brake performance only becomes apparent under peak loads, increasing the risk of mooring line failure, vessel movement alongside, & serious injury. Effective pre-arrival checks, correct brake adjustment, & adherence to recognised mooring equipment guidance are essential safety barriers.

  Prevention:

- Inspect brake bands, linings, and drums for wear and contamination
- Check brake band clearance from its support **MEMP Part D / 2. Brake band support**
- Conduct brake rendering tests at annual interval using **company Form 6.5.6**
- Carry out brake rendering test as per instructions provided in **MEMP/5.0 MOORING WINCH BRAKE RENDERING TESTING**
- Ensure brake lining wear down is measured at 6 monthly interval as per **company Form 6.5.7**
- Inspect motors for condition affecting controlled paying/heaving
- Record pre-arrival functional checks and adjustments

- **RTM_2026_004 - HSE Share – HSE Share - Harassment & Bullying in the Maritime Concept**

Harassment and bullying remain serious safety risks in the maritime industry due to isolation at sea, confined living conditions, rigid hierarchies, and multicultural crews. Such behaviour—ranging from verbal abuse and intimidation to discrimination and misuse of authority—often goes unreported due to fear of retaliation, particularly among junior crew. Beyond personal harm, bullying undermines trust, morale, and safety, as intimidated seafarers may hesitate to report hazards or challenge unsafe practices.
To address this, **STCW Code amendments effective 01st January 2026 mandate training for ship staff**, and form part of the Basic Safety Training (PSSR) for seafarers.
Please note the following clarifications:

- Current Certificates of Proficiency remain valid.
- The existing expiry dates of these certificates will be maintained.
- With effect from 1 January 2026, new components will be added to Basic Safety Training, specifically under Personal Safety and Social Responsibilities (Table A-VI/1-4).
- The new topics will also be included in the Basic Training Refresher courses.
- Existing issued certificates do not specify detailed training content but refer to Tables A-VI/1-1 through A-VI/1-4, therefore, no re-issuance or adjustment of existing certificates is required.

In support of this new requirement, training modules titled “Understanding Violence and Harassment at Sea” and “Responding to Violence and Harassment at Sea” have been published under the Well-being Learnings section on the Big Yellow Fish platform. These modules cover the new competence: Contribute to the prevention of and response to violence and harassment, including sexual harassment, bullying and sexual assault.
Refer SMS - Personnel Manual/ Conduct and discipline, Bullying and Harassment

Action Required:

- All Masters and crew on board fleet vessels are required to complete the available module/s at the earliest.
- Upon completion, the Master is to conduct a briefing and record the training and drill in Form 323, with all crew members signatures as acknowledgement.
- The completed Form 323 is to be retained on board and made available for inspection.

7. Safety First: Protecting your eyes while at sea

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Eye injuries happen in a split second, but their consequences can last a lifetime.
Most incidents occur during tasks such as using power or hand tools, welding, handling harmful powders or liquids (Chemicals/Paints/Thinners).
However, risk is not limited to those performing tasks. Personnel nearby – simply observing or passing through a work area – can also be injured.

Common eye hazards on board
Seafarers face multiple eye hazards every day, including:

- Foreign substances from cutting, grinding, drilling, derusting, or anchoring.
- Hazardous chemicals that can burn or irritate the eyes.
- Deflagrations or sudden bursts that may cause burns or trauma.
- UV Radiation from welding arcs or prolonged solar exposure, potentially causing flash burn.

Risk assessment: The first line of defence
Every shipboard task should be subject to a thorough risk assessment. When eliminating the hazard is not possible, PPE becomes essential. Risk assessments should specify the type of protection required for each task:

- **Welding**: Protection against harmful optical radiation.
- **Pressurized liquids/chemicals/paints/thinners/electrolyte**: Safety goggles and/or face shields.
- **General mechanical work:** Safety glasses suitable for flying debris.

Personnel nearby should also be protected through physical barriers, warning signs, or enforced PPE use.

Selecting the right protection
Eye and face protection must guard against mechanical, thermal, optical, and chemical hazards. Key considerations include:

- Match PPE to the specific hazard—not all equipment protects against every risk.
- Task-specific safety glasses or goggles, properly fitted, provide mechanical and splash protection.
- For broader hazards such as UV, IR, or flying particles, a face shield or visor may be required in addition to goggles.
- Only certified PPE with appropriate markings should be used. Use maker's supplied PPE when operating hydroblaster/Denjet.
- Follow company PPE/Activity matrix

Comfort and fit: Compliance matters
Even the highest-quality PPE is ineffective if it is uncomfortable or poorly fitted. Reduced visibility or a poor fit increases the likelihood that protection will be removed during work.

Safety guards and supervision
Safety guards on fixed and portable tools exist to prevent debris from striking operators.
Powered tool like grinder should never be used without guard.

Emergency response
If hazardous substances contact the eye, rinse immediately with clean water or an eye wash solution and seek medical assistance without delay. Prompt action can prevent long-term damage or permanent vision loss.

8. KARCO TRAINING

The ship staff shall conduct the following training modules this month:

- **Slips Trips and Falls**
- **BTM&BRM Failures – Navigational Casualties**
- **Main Engine Turbocharger Failure-Always An Expensive Proposition**

The duration of each title is only about 10-15 minutes.
Training must be carried out in two sessions (based on work/rest hours) to ensure all crew are able to attend. Each session must be opened and concluded by a Senior Officer.
After the training, the Senior Officer should have an interactive session with the crew, discuss questions and the crew can also share their experience (Reflective learning). Once the training is completed, each crew member shall log on individually and an assessment must be completed, and the records must be exported to KARCO system.
The Master can contact IT department and support team (support@karcoservices.com) for any queries regarding KARCO. Records of training to be maintained in form 3.2.3 filed in Share Point.

9. RIGHTSHIP SECTION 10 – Mooring Operations & Section 13 Machinery Space

RIGHTSHIP uses checklist (RISQ) which is uploaded on the landing page of SHEQ.

There are 17 chapters in the RIGHTSHIP questionnaire.

The Company sends guidance for each section as part of the monthly campaign.

For this month, all deck officers shall go through the attached **"SECTION 10 – Mooring Operations & Section 13 Machinery Space"** checklist and ensure that the vessel is in compliance with all the items.

Please reply to the Marine Superintendent / Ship Manager with any queries or sections that your vessel does not fully comply with.
Master/CE to ensure that this section is read and understood by all Deck/Engine officers. Last page of this section to be signed by all deck officers and verified by Master. Please upload the last signed page in the Share Point by end March 2026.

Fleet Advisory 2024-01 (Accumulated advisories of last years)

Fleet advisory 2023-02: AMSA PSC deficiencies at Fremantle on 03 Feb

<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>11113</td><td>

Rescue boat unable to be launched using accumulator.

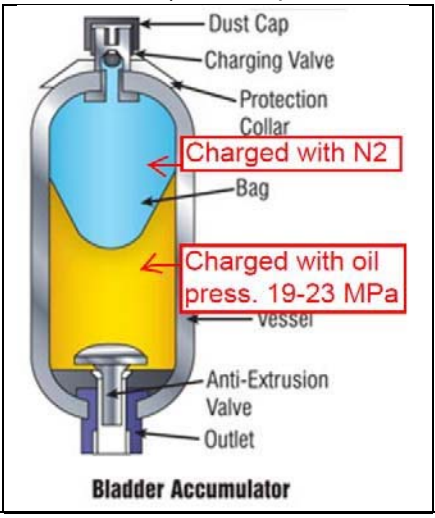
Comments:

- AMSA inspector instructed the crew to swing the rescue boat davit by means of accumulator. The davit only moved to about 30 degrees and the pressure from the accumulator dropped down to zero. The investigations revealed that there was no nitrogen gas in the cylinder as it ruptured the internal bladder.
- New accumulator was ordered and installed in place.
- Test rescue boat davit operation on all modes – electric/accumulator/manual handle during monthly drill and revert with the result to your Ship Manager. Ensure all three modes operating instructions are displayed and crew is trained to operate davit by all three modes.
- Ensure accumulator pressure is maintained as per the manufacturer's manual. Check maker's manual of your vessel in this regard.

- **As per the inspected ship maker's manual:**
  - The charging pressure of accumulator is to be kept 8 MPa (80 bar) and accumulator is to be charged with nitrogen if pressure falls below 8 MPa. There is a bladder (an elastic bag) inside the cylindrical unit which is charged with nitrogen gas.
  - The accumulator pressure is to be kept in the range of 19 – 23 MPa (190-230 bar). This pressure in the accumulator is maintained by automatically controlled electric pump. When accumulator pressure falls below 19 MPa, pump charges the pressure to 23 MPa with the hydraulic oil.

- There is to be always one 230 Bar 50 litre Nitrogen bottle ready for use. Please order if it is not on board. There is a specific fitting with gauge that is needed to fill Nitrogen. Ships are to order this from their manual. Stow this item in the safety locker properly labelled/marked.
- The accumulator shall be serviced/bladder renewed ashore at 5 yearly intervals during dry docking.

Accumulator (General picture for understanding, not ship specific)



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<tr><td>13101</td><td>

Main engine unit #5 noted with jacket cooling water leak.

Comments:

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	• The Main Engine No. 5 unit had a jacket water leak. This was caused due to wear and tear of the O-rings. The ship staff were aware of the leak however they did not plan and complete the repairs in a timely manner. The water jacket was removed and thoroughly cleaned along with the O-ring landing surfaces. All the O-rings were renewed using soft soap on O rings as a lubricant to ensure smooth mating of the O ring between the water jacket and liner. Please note as following: ➢ Ensure that O rings are correctly inserted without 'bruising' them and soft soap is applied for easing them into position. ➢ The water quality shall be in accordance with makers limits and the loading and unloading of the engine shall be done gradually. ➢ Engine is to be kept at constant temperature as much as possible to prevent thermal issues with seals. ➢ Pay attention to detail and look out for leaks, malfunctions, unusual noise and other abnormalities while carrying out any maintenance routine or while taking rounds in the engine room. ➢ When a defective piece of equipment is identified, it is to be relayed to the CEO and brought to the notice of relieving watchkeepers. The equipment is to be isolated, tagged and removed from service until repairs have been affected. A risk assessment as to the compromised system integrity may be required. ➢ Leaks or malfunction on any equipment shall be attended and rectified immediately, or entered into the Defects list (Form 6.1.5) for repair at the earliest opportunity. ➢ The Officers, while doing their watch keeping rounds will ensure that general inspection of Equipment / machineries and housekeeping requirements are being met. Complacency is to be guarded against.
07114	**FO settling tank pneumatic actuating line noted disconnected from remote valve.** **Comments:** • The deficiency was due to improper installation of the copper tube sleeve/nut which got disconnected by vibrations. The sleeve and nut were found lying on the tank top. These were re-connected immediately in the presence of PSCO. • Check the connection of pneumatic actuating line and valve on board your vessel for ensuring that the connections are in good order, tighten if required. • Inspect and test the remote fuel closing valve and fittings as per PMS in timely manner. • Pay attention to detail and look out for leaks, malfunctions, unusual noise, heightened temperatures, smells, defective lighting and other abnormalities while carrying out any maintenance routine or while taking rounds in the engine room.

Fleet Advisory 2023-03

PSC deficiencies at Guangzhou on 17 Feb 2023

Code	Description
18418	**The oil level of the Hyd. OTL. Tk for winch was lower than the minimum level marked on the tank.** **Comments:** • The required oil grade was not available at last ports of call which were in Bangladesh and in Indonesia. However, there was a sufficient quantity of the compatible oil on board for using in an emergency. • Plan order in advance when ROB is low in anticipation that vessel may trade at ports which may not be convenient for supply.
13102	**The crank case cover of No.1 G/E found oil leakage.** **Comments:** • During recent maintenance the gaskets were not renewed and deemed fit for further use. • Proper assessment/judgement is to be carried out when re-using the gaskets.
07115	**The operate handle for the fire damper of ventilator duct nearby M/E exhaust pipe seized.** **Comments:** • Carry out the maintenance of the fire dampers diligently as per routine PMS. Operate/exercise fire damper regularly. Senior staff to supervise and conduct the random checks, any defect discovered is to be entered in the defect list for planning and rectifying the defect.
14402	**The dosage pump of sewage treatment plant can not deliver chemical water during inspection.** **Comments:** • The suction line was found above the chemical water level in the container. Watch and monitor equipment operation closely during engine room rounds. • A signage can be marked on the sewage dosing tank.
11117	**The diameter of the lifeline for the lifebuoy nearby the stbd gangway was less than 8mm.** **Comments:** • This deficiency was pointed out due to incorrect judgement by the PSC inspector. The original diameter of the lifeline was already 8mm. The inspector assumed that the diameter was less than 8mm. The ship's request to measure the diameter of the lifeline was declined by PSC inspector and issued this deficiency. • The existing lifeline of the lifebuoy was replaced by new lifeline in presence of the inspector to close the deficiency. • Ensure following LSA Code requirement is mentioned in requisition when ordering the buoyant lifelines. Same requirement is being re-produced as following: === 2.1.4 Buoyant lifelines Buoyant lifelines required by regulation III/7.1.2 shall: .1 be non-kinking;

	.2 have a diameter of not less than 8 mm; and .3 have a breaking strength of not less than 5 kN === • Please check the lifelines attached to lifebuoy on board your vessel for the above requirement (buoyant, non-kinking, diam.), order if lifeline is non-compliant and inform to your Ship Manager.

Fleet Advisory 2023-04

PSC deficiency at Belfast, UK on 01 Mar 2023

S.No./ Code	Description
1/ 04113	**Water Ingress Alarm System – Water level indicator on the Bridge console for which pumproom not correctly indicating and a fault is displayed. Audio and visual alarms are still generated during testing.** **<u>Comments:</u>** • The last monthly PMS was carried out on 19th Jan 2023, the PMS was overdue during PSC inspection. As cargo holds were in loaded condition in the month of Feb, the monthly function test was postponed until after the holds were emptied of cargo. The monthly function test of accessible spaces - Bosun store and hydraulic pumproom was also not carried out as the Crew were planning on doing all the sensors at the same time. • The Zener barrier was found faulty upon investigation. Same was replaced by new Zener barrier available on board to resolve the deficiency. • The PMS of accessible spaces (bosun store, hydraulic pump room) should not be postponed until after the holds are emptied of the cargo. • At least one Zener barrier is to be kept on board as spare. Please order if none on board. • Following is being added in existing monthly PMS: === 3. In the month of Feb and Aug - inspect complete mechanical and electrical installation (Switches, Zener barriers, Sensors, Relays etc) and carry out maintenance as required. 4. Keep at least one Zener barrier unit as spare ===

Fleet Advisory 23-05

PSC at Shanghai on 15 Mar 2023

S.No./ Code	Description
1/ 05104	**Second officer not familiar with the SSB test and operation of MF/HF.** **Comments:** • PSCO asked 2nd Officer to test the MF/HF, 2nd Officer carried out the DSC test with Shanghai Coast Station and showed him the printout of the DSC acknowledgement received from the Shanghai Coast Station. Then PSCO asked 2nd Officer to Call Shanghai for which 2nd Officer replied that he has already shown the result of DSC test. There was no further communication on the subject. 2nd Officer assumed that PSCO was satisfied with the DSC test with shore station. However, it was in the last when PSC report was given to Master, Master inquired PSCO the reason behind this deficiency but no clarification was provided and PSCOs disembarked the vessel in hurry. • We assume that PSCO intended 2nd Officer to carry out the NBDP Test with Shanghai coast station. This deficiency resulted despite 2NO was well familiar with the testing and operation of MF/HF due to lack of communication. • Master to ensure that all deck officers are well familiar with the testing and operation of all GMDSS equipment including NBDP test with shore station which is to be carried out on monthly basis and recorded in GMDSS logbook.
2/ 11124	**The side ropes of the embarkation ladder for bow side craft were rotted.** **Comments:** • Check the condition of all survival craft embarkation ladders on board for external appearance and internal condition by opening the lay for signs of wear/broken fibres/rot and inform your Ship Manager if replacement is required. • Refer HSE Procedures Manual, 4.34 Natural Fibre Ropes and Rope Ladders for stowage and care, inspection and maintenance, and for the replacement criteria. • Company shall replace survival craft embarkation ladders **at five yearly interval** or any degradation of ladder whichever is earlier.

Fleet Advisory 2023-06

RSI Vessel Inspection at Uddevalla, Sweden on 15 Mar 2023

S.No./ Code	Description
7.6.1	Leading lines, parallel index distances **Parallel index (PI) was not properly used during passage planning, no PI available from pilot to berth.** **<u>Comments:</u>** • Use parallel indexing as and where it is required and appropriate to use. Ensure chart is marked accordingly. • Refer attached On Job Training on the benefits of using the Parallel Indexing, all deck officers to familiarize with it. • Refer Nautical manual, 7B-ECDIS, Monitoring Accuracy of GNSS Position in ECDIS requires as following: == 3.2.3 d. In coastal and confined waters, continuous track monitoring by parallel index and frequent position verification by the use of radar overlay. Radar overlay will show instantaneously whether GNSS generated position is correct, or the extent of any error. The position verified and recorded by Radar Overlay at mid interval between the LOP verification where possible, keeping in mind that OOW may be associated with other navigational duties especially in confined waters, which may have priority to recording the verification in ECDIS. ==
8.8	Are enclosed spaces and controls for entry identified onboard? **A list with all enclosed spaces onboard is available onboard, but the enclosed spaces are not properly marked.** **<u>Comments:</u>** • Company SMS – HSEP Manual, 4.10 Enclosed Space Entry requires marking at the entry points as following: == 1.6. Entry points to enclosed spaces shall so far as is reasonably practicable be labelled. == • Company shall provide warning signage “Enclosed Space, No entry without permit” to all vessels for displaying at entry points of the enclosed spaces.
8.11	Is the vessel provided with its own safe means of access? **No gangway was rigged to allow for safe boarding of the vessel.** **<u>Comments:</u>** • The length of the berth was not sufficient to cover the accommodation area from where the fixed accommodation ladder could be rigged and platform could be rested on the berth. • The length of the portable gangway provided on board was not sufficient to be rigged as safe means of access due to high freeboard. Hence, most suitable means of access – Pilot Ladder was rigged for access. • Where a safe access to the vessel cannot be achieved by fixed accommodation ladder, the master should note a protest to the terminal.
9.7	Is there a signage indicating "No visitors" at the gangway? **No signage indication "No Visitors" were present at the gangway/pilot ladder.**

	Comments: • The new ISPS desk was prepared recently but company standard gangway poster was not posted on this new desk which was used at the access point during inspection. The company gangway notices were posted on the old desk which was not placed at the access point and resulted in an observation. • Ensure company Gangway Notice is displayed at the access point as attached. The gangway poster was sent to all ships. Let us know if new poster is required.
14.4	Does the company have a lifting equipment management system in place? **1. A lifting equipment management system is in place, but the slings onboard are missing ID-number.** **2. Not all chain blocks onboard included in the lifting equipment management system.** **Comments:** • Our company SMS – Technical Procedure Manual, 12.0 Testing and Examination of Equipment, section 3 requires as following: == 3.2.4. Wire slings are to be marked. This may be on the ferrule, or as a steel washer on the eye, traceable to a certificate. They are to be checked for kinks, broken strands, and flattening in the eyes. Particular attention must be given on either side of the ferrules for damage. 3.2.5. Nylon braided strops must be marked by label. They must be checked for chemical impregnation, chaffing or stitching damage. 3.2.6. Chain blocks are to be traceable to a certificate. They are also to be stencilled with a number for easy identification. Chain elongation, hook opening, housing damage and gear damage must be checked. == • Ensure company Form 6.6.20 is used for the inspection and checking the particulars (e.g. identification tag number, serial number etc) of Chain Blocks, Slings, Shackles and eye bolts. All lifting gears in good working condition are to be captured in this Form. • The lifting gears found defective after inspection are to be discarded and disposed ashore in garbage as operational waste. • Annual examination of the lifting gears is to be carried out as per the PMS job description in the BASSnet, same is attached for your familiarization.

Fleet Advisory 2023-07

PSC deficiencies in Machong, China on 15 June 2023

Code	Description
04103	**Emergency Generator test fail.** Comments: • The batteries of the emergency generator were in use for about 2.5 years and the requisition for new batteries was raised. The new batteries were supplied onboard prior to the PSC inspection and the ship staff had planned to install the new batteries after departure port. Unfortunately, during the PSC inspection, one set of batteries failed and resulted in the deficiency. • The ship staff immediately renewed all the batteries in the presence of the PSC inspector and the emergency generator was tested using both sets of batteries. • The Company has **reduced the renewal interval of the batteries from 2.5 years to 2.0 years for Emergency Generator.** • Ensure that batteries for emergency generator, lifeboats, GMDSS etc are renewed in a timely manner as per SMS. • Raise requisition at least 3 months in advance to avoid any logistic issues. • Also, during routine testing of the batteries, if ship staff observe a significant drop in the voltage or the performance of the battery, then requisition has to be made immediately for new batteries.
14104	**Oily Water Separator 15PPM Alarm simulation test fail.** **Comments:** • OCM simulation mode was working perfectly. PSC inspector required to operate and test the OWS on bilge-to-bilge tank circulation mode. On bilge tank circulation mode, the 3-way manual valve was opened to test pipe and closed to overboard line. However, there was no flow of water from the sample outlet provided on the test pipe. • The test pipe was removed and found clogged with rust and sediment, same was boxed back after cleaning the pipe. OWS was tested and found to be in good working condition with water coming out from sample outlet of the test pipe. • A detailed job description in monthly PMS of OWS 15PPM alarm test is being added consisting of testing the OWS on bilge-to-bilge tank circulation mode and checking the water sample. • **Test the OWS function on bilge-to-bilge tank circulation mode at earliest opportunity or during next monthly PMS if due shortly and confirm the result to your Ship Manager.**
11117	**One Lifebuoy light on the forward unlit.** **Comments:** • During inspection the forward lifebuoy light lit up initially but after few seconds it stopped functioning due to electronic component failure. • The defective light was immediately replaced by new lifebuoy light available on board as spare. • **Ensure a spare self-igniting light for lifebuoy is kept onboard.**

Fleet Advisory 2023-08

PSC deficiencies in Matsuyama, Japan on 19 June 2023

Code	Description
14101	**The solenoid valve for 2nd chamber of oily water separator – not worked because stuck and choked.** Comments: • The 15PPM alarm test and function test of all other solenoid valves was demonstrated to the inspector, unfortunately the 2nd chamber valve would not open during function test. • Valve was dismantled, internals cleaned and performed function test in the presence of the inspector. Inspector closed the deficiency. • Carry out the function test of oil level solenoid valves and report to your Ship Manager if any malfunctioning. • The annual maintenance consisting complete overhauling of the solenoid valves (oil control valves) is being added in the PMS.
11101	**Oar crutches of lifeboats (both side) - not attached to hull lifeboat by lanyards or chains.** **Comments:** • The lifeboats were provided with the oar crutches with chains attached to the boat hull. The ship staff had disconnected the oar crutches and chains as it was creating an obstruction for the crew entering through the lifeboat door and had safely kept them inside the lifeboat equipment locker. • The oar crutches of the lifeboats were immediately attached to the hull by chains. • LSA CODE 4.4.8.1, sufficient buoyant oars shall be provided to make headway in calm seas. Thole pins, crutches or equivalent arrangements shall be provided for each oar provided. **Thole pins or crutches shall be attached to the boat by lanyards or chains;** • Ensure that the lifeboat fittings are maintained as per the LSA code and not altered in any manner or removed from its location. Crutches are kept attached to the boat by lanyard or chain.  

	During PSC inspection, crutches were disconnected and kept in the L/B equipment locker	Crutches are to be kept connected to boat by lanyard or chain as above

Fleet Advisory 2023-09

PSC deficiencies in Dunedin, New Zealand on 10 July 2023

S.No./ Code	Description
1/ 09205	**Starboard side accommodation ladder falls inner sheave seized.** **Comments:** • The detailed job description for the maintenance of the accommodation ladder on monthly basis is included in the BASSnet PMS. Last maintenance was carried out on 15th June 2023. The checking on the inner sheave movement was overlooked during last maintenance. • Carry out On Job Training (OJT) to all deck officers and ratings containing monthly PMS Job Description on accommodation ladders, refer attached OJT. Emphasize that all points contained in the job description are to be checked during routine monthly maintenance and moving parts rotation is to be verified on each occasion when rigging the accommodation ladder. • Check and inspect the accommodation ladders on board for all moving parts such as sheaves, hinges, tracks, turntables, bearings and rollers are free to turn, check condition of wire & other fittings as per job description and report the result to your Ship Manager. • Any defect noticed during maintenance and rigging of the accommodation is to be immediately reported to Chief Officer. Any defect not rectified immediately is to be entered in the Defect management Form.
2/ 01315	**Oil record book with incorrect entries on 26 and 30 June 2023.** **Comments:** • The final retained quantity in the bilge tank after transfer operation was incorrect. It was due to an arithmetical error. There was a mistake in subtraction to arrive at retained quantity in bilge tank after transfer from the tank on 26th June 2023 and mistake in addition to arrive at retained quantity in bilge tank after transfer to the tank on 30th June 2023. • The quantity was corrected after deleting the previous entry by drawing a line across the incorrect quantity, signed and dated by person in charge of the operation next to correct entry. • Ensure each entry in the Oil Record Book is cross checked by 2nd person to avoid one man error. • Ensure each completed page is double checked by Chief Engineer before counter signed by Master. • Master to cross check the entries before signing the completed page.
3/14802	**Ballast water record book not kept up to date with ballast water records of recent operations of 8 and 10 July 2023.** **Comments:** • The entries concerning Ballast Operation in port were recorded in the Port Log by OOW but these were not transferred in the Ballast water record book after completion of each ballast operation. • Refer following from the Ballast Water Management Convention 2004: == Regulation B-2 Ballast Water Record Book

	5. **Each operation concerning Ballast Water shall be fully recorded without delay in the Ballast Water record book**. Each entry shall be signed by the officer in charge of the operation concerned and each completed page shall be signed by the master. == • Ensure an entry in Ballast Water Record Book, Oil Record Book and Garbage Record Book is promptly recorded on each occasion after completion of the operation in chronological order as they have been executed on board. • Ensure each completed page of above Record Books is countersigned by Master without delay.

Fleet Advisory 2023-10

AMSA PSC deficiencies at Adelaide / Australia on 25 Oct 2023

Code	Description
11199	**Expired line throwing apparatus and immersion suits stored in unsafe condition** **Preventive action:** • The Third officer shall ensure that expired pyrotechnics are clearly marked as 'out of date and kept segregated in a separate locker for shore disposal. • The Master shall make attempts to dispose expired pyrotechnics or discarded LSA / FFA at each port of call considering the fact that many ports do not have adequate reception facilities. • The Company will appoint vendors / agents at convenient ports for disposal of expired pyrotechnics.
11131	**Port and starboard lifeboat manoeuvring in water overdue** **Preventive action:** • Ship staff shall ensure strict compliance with SOLAS requirements regarding launching and manoeuvring of lifeboats. (Solas III 19 3.4.3 EMERGENCY TRAINING AND DRILLS) • The Master shall plan and try to lower and manoeuvre the lifeboat and rescue boat at every opportunity considering the fact that some ports do not permit the same. Also the weather conditions may not be favourable in some ports. • If weather conditions are not favourable or if the port authorities deny permission to lower or manoeuvre lifeboat/rescue boat in water, same shall be recorded in the log book. The Master shall also maintain the email communication from the port authorities/ agents if permission was denied. • If unable to lower and manoeuvre the lifeboats within 3 months , the Master shall inform the Company with valid reasons. The Company will then apply dispensation from the flag state.
10109	**Aft air horn manual operation defective** **Preventive action:** • The Company has amended the pre arrival and pre departure bridge checklists and have included the requirement to test both the air horns on Manual and Electric mode. (NAV B07 / NAV B06) • The Company has also incorporated maintenance routines for the air horn in the PMS. • Ship staff shall ensure compliance with the checklists and PMS routines.
01306	**Correct working schedule for ships crew not posted** **Preventive action:** • Ship staff shall pay attention in detail and ensure that all documents on board are valid, entries accurate and of latest version at all locations. • Obsolete documents shall be removed promptly from all locations. • The documents shall be cross checked by another officer so as to avoid one man error. • The Master shall also randomly check documents/posters during routine rounds and ensure they are valid.

04101	**Port and starboard bridge wing talk back system defective** **Preventive action:** • The ship staff shall ensure that the maintenance routines of the talk back system as per the Company PMS are strictly complied with. • The talk back systems on bridge and all other locations shall be tested for proper operation and the ship staff shall ensure that messages are audible and broadcasted into all spaces where crew members are present and to muster stations. • The drawing indicating the number and location of all speakers onboard shall be carried by the officer while testing to ensure that no speaker is missed out.
10105	**Compass error not checked as per STCW requirements** **Preventive action:** • The navigating officers shall strictly comply with the SMS / STCW requirements and ensure that Compass error is calculated and recorded every watch at sea and at anchor and after every major alteration of course. • Where an error cannot be taken (example overcast skies) an entry in the compass error book shall be made giving the reason. • **Not calculating the compass error due to sheer laziness OR just making an entry " ERROR UNOBTAINABLE " without a valid reason will not be tolerated and strict disciplinary action will be taken against offenders**. • The Master shall also cross check the compass error log on daily basis and ensure compliance.

Fleet Advisory 2023-11

RIGHTSHIP INSPECTION FINDINGS, 28 Nov 2023

One of our vessel had undergone RIGHTSHIP inspection recently and following findings were issued. Kindly discuss these findings along with the preventive action with all crew onboard and take necessary measures to prevent recurrence.

<table>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>3.10</td><td>Is navigation equipment in good order? (V)

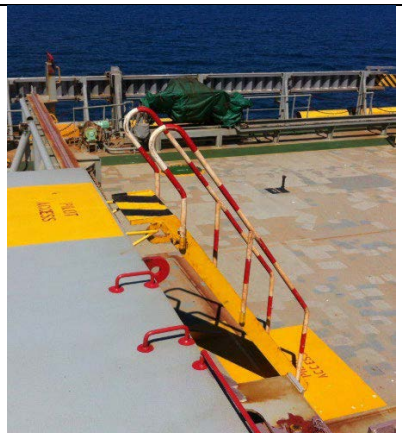
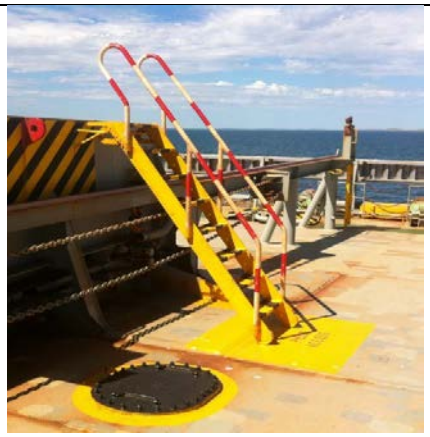
Finding description
The illumination for the bridge wing tachometers and rudder angle indicators was not functional at the time of inspection. Rectified during inspection. The dimmer controls on all of these units were seized.

Root cause:
• Inadequate inspection and maintenance of dimmer controls
• Lack of compliance with Company SMS requirements – The Company’s “NAVB22 - DAILY CHECKS” form clearly specifies that buzzer / lamp tests / dimmer lights on each equipment shall be tested which was not complied with in true spirit by the OOW

Preventive action:
• Ensure strict compliance with all the bridge checklists paying attention in detail to each item.
• Ensure that each bridge equipment including indicators ,dimmers and associated controls are operational. Any defect identified shall be promptly reported through the defect list and rectified at the earliest opportunity.
• The Master shall also make random checks on the operational status of the bridge equipment and its controls during daily bridge rounds and during navigational audit.
 
Starboard Rudder Angle Indicator and Propeller Shaft revolution Indicator DIMMER ON
 
Starboard Rudder Angle Indicator and Propeller Shaft revolution Indicator DIMMER OFF</td></tr>
<tr><td>4.15</td><td>Has a smoking policy been implemented; is it being followed and are designated smoking areas adequately identified? (V)

Findings: The Company Smoking Procedure - Revision01/03 July 2023 did not list the Crew Mess as an approved smoke room, however this space was listed in the posted adjacent list of designated smoking areas. There were soiled ashtrays in the Crew Mess at the time of inspection. The Officer's recreation room was listed as an approved smoking area, but this space was being utilised as a gym at the time of inspection - rendering it unsuitable for this purpose.</td></tr>
</table>

	Root cause: • Inadequate design • Lack of compliance with SMS - The ship staff did not implement the revised designated smoking areas as per Company SMS. • Inadequate record keeping – The obsolete poster was not removed from the location **Preventive action:** • Revised smoking posters shall be posted onboard and the obsolete posters shall be removed. • The designated smoking areas as per Company SMS requirements shall be clearly marked on board. • The Master shall implement the smoking policy and ensure that the crew smoke only in the designated smoking areas. • Crew shall not smoke in the crew mess room and ash trays (if any) shall be removed from the location. • If there are any concerns regarding the smoking areas , the Master shall consult the Ship Manager and clarify his concerns.
4.39	If the vessel is provided with a helicopter operating area, does the area comply with the requirements of ICS guidelines, and is there a safe access from the hatch cover to deck? (V) **Findings:** The helicopter operating area was said to be "winch only" but was not marked accordingly. The access ladder was not fitted with a front platform with operational load for two persons 150 kg. There was only one access / egress route provided for embarking / disembarking passengers. **Root cause:** • Inadequate record keeping – The Class approved helicopter landing certificate was not filed onboard in BASSNET system as per Company requirements • Lack of familiarization – The Master was not aware that the vessel hatch No 5 was certified for helicopter landing • Lack of compliance with SMS – The SMS procedures regarding the access ladder requirements from hatch cover to deck was not complied with by the ship staff. **Preventive action:** The Master shall ensure that all certificates are filed promptly in BASSNET once received from the Company. If any certificate is missing or if there are any doubts , the Company shall be consulted. The Master shall also ensure the following SMS requirements regarding helicopter operations: • Strength confirmation letter from the classification society shall be available for the helicopter landing hatch (if hatch is certified for landing) • The access from hatch cover to deck should be a fixed height inclined ladder with fixed handrails and front platform with operational load for two persons (150 KG). The ladder must have **“two persons up 150 kg”** marked on it. The steps and platforms should be made of non-slip materials. (a set of steps that will at all times provide the user with three points of contact two hands, one foot / two feet, one hand) . The platform shall be painted as per below photos.

- Master should ensure that, a minimum of two access/egress routes to and from the landing area is available to ensure that, in the event of an incident on the landing area, helicopter passengers and crew can escape upwind of the incident

5.8

Are suitable containment arrangements in place around the hydraulic components of deck machinery? (V)

Findings: The drain plug for the containment arrangement around the port windlass, had not been inserted and secured.

Root cause:
Lack of compliance with Company SMS requirements – The Chief officer's weekly checklist clearly specifies to check all the drain plugs which was not complied with paying attention in detail.

Preventive action:

- Ensure that all save-alls / containment arrangements are kept clean and empty of water , oil , rust , debris like ropes , rags etc and plugged in port (especially after draining any accumulated water) and the drain plug is secured with a strap chain to the save-all.
- The Chief officer shall carry checks as per the weekly deck inspection checklist paying attention in detail to each item.
- Compliance shall be verified by the Chief officer prior arrival each port before the hydraulics are activated.
- The OOW and ratings shall also periodically check the drain plugs of all save-alls as part of their watch keeping duties in port.

Bad practice

	Good practice 
5.12	If ballast tanks are located adjacent to fuel oil tanks, or there is a possibility of contamination by hydraulic oil, are ballast tank contents being sampled to ensure there has been no contamination of the water by oil prior to discharge?(V) **Findings:** There was no record of any sampling, prior to deballasting. A previous Right Ship corrective action had stipulated that the ballast should be sampled and the findings recorded in the Port Log, prior to commencing deballasting. **Root cause:** Lack of compliance with Company SMS procedures – The record keeping requirements after sampling the ballast tanks for oil contamination was not complied with by the ship staff. **Preventive action:** • The Chief officer shall ensure that the ballast tanks are sampled for oil contamination by using oil finding paste , using cloth attached to sounding tape , sense of smell etc. The vessel shall have sufficient oil finding paste onboard. • When daily soundings are taken and recorded , the Chief officer shall also make entries of sampling the ballast tanks for oil contamination. (**No oil contamination observed**)
14.4	Are the pipes on deck free of significant corrosion, pitting, soft patches or temporary repair and maintained in good condition? (V) **Findings:** The pneumatic line on the starboard side upper deck was severely corroded over approximately 30% of its length. Wastage of approximately 25% was noted over extended sections **Root cause:** • Lack of maintenance • Inadequate planning/preparation - Ship staff did not plan and complete the maintenance of the pneumatic line in a timely manner. **Preventive action:** • The Chief officer shall pay attention in detail and look out for excessive corroded areas while taking routine rounds on deck . • A maintenance plan shall be prepared by the Chief officer and the deck crew shall be instructed to carry out maintenance of these areas in a timely manner. • Sufficient stock of paints shall be always kept on board. • The ship Manager shall be informed if any materials are required for repair.

Before maintenance:

After maintenance:

Fleet Advisory 2023-12

PSC deficiencies at Taicang, China on 23 Nov 2023

<table>
<tr><td>S.No. / Code</td><td>Description</td></tr>
<tr><td>1/ 11104</td><td>Rescue boat operation instruction ingress broken.

<u>Comments:</u>
• Rescue boat operation instruction in the plastic enclosure displayed on bulkhead had moisture inside. Water had seeped through the cracked plastic sheet.
• Check the Lifeboat and Rescue boat operating instructions posted on board your vessel is legible, unfaded and free from the moisture. Replace if required. Use laminated sheet in place of plastic case.
• Ensure that operating instructions are posted under the emergency light.</td></tr>
<tr><td>2/ 11101</td><td>The smoke exhaust pipe for free fall lifeboat lack of some fire isolation material.

<u>Comments:</u>
• The insulation around the exhaust pipe was intact, it was the superficial covering/foil around the insulation material at small section of the smoke exhaust pipe, which was missing.
• The superficial covering around insulation was immediately installed after pointing out of the deficiency by inspector.
• Check and ensure that the smoke exhaust pipe in your lifeboat is covered with the insulation material for protecting persons from coming with hot parts accidently.

Refer LSA Code 4.4.6.9
The lifeboat engine, transmission and engine accessories shall be enclosed in a fire-retardant casing or other suitable arrangements providing similar protection. Such arrangements shall also protect persons from coming into accidental contact with hot or moving parts and protect the engine from exposure to weather and sea.

Photo of the insulation
 
Before Inspection | After covered by foil</td></tr>
</table>

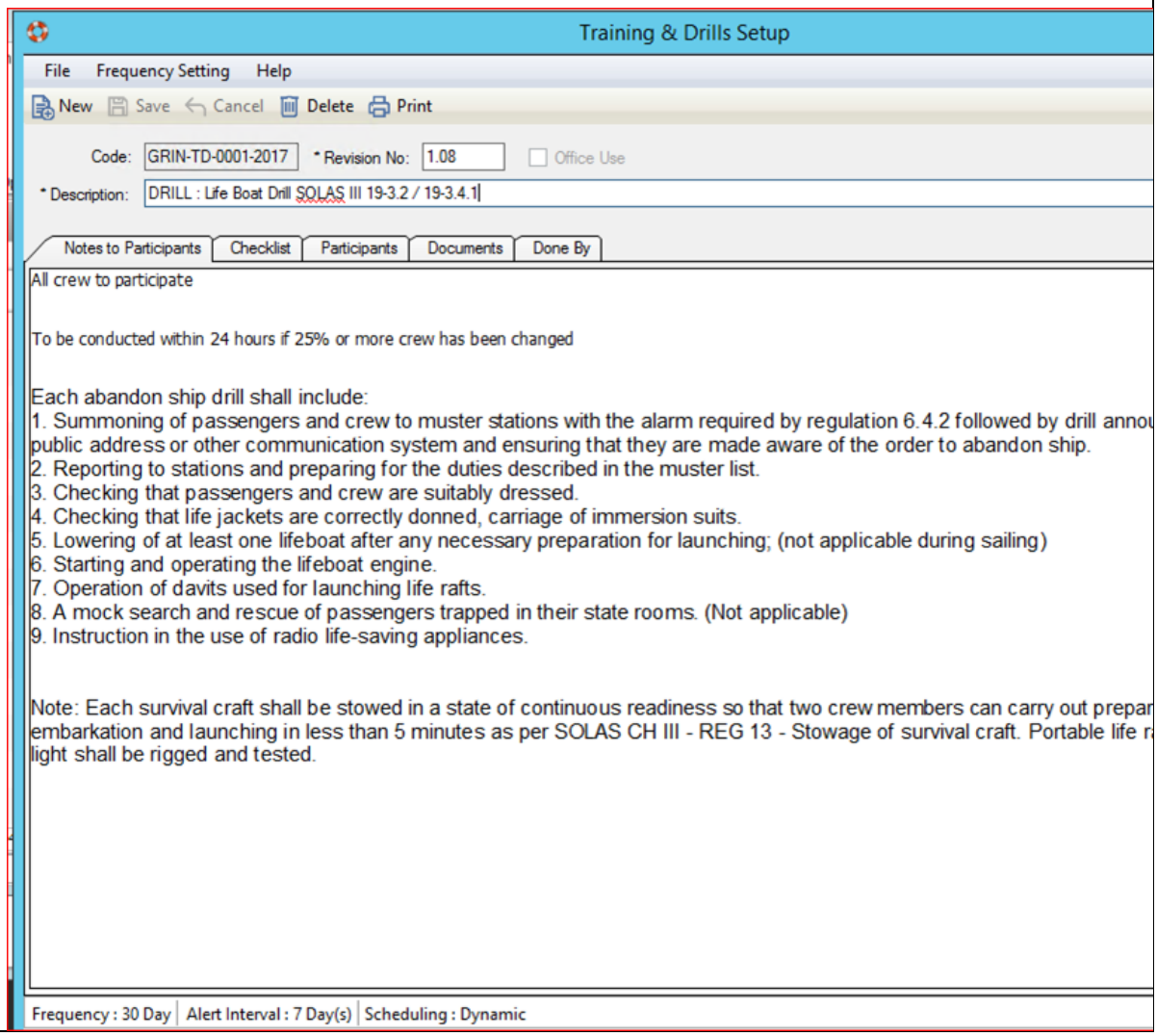
Fleet Advisory 2023-13 **DATE: 07 DEC 2023**

USCG INSPECTION FINDINGS

Dear Master

One of our vessel had undergone USCG inspection recently and following deficiency was issued. Kindly discuss this deficiency along with the preventive action with all crew onboard and take necessary measures to prevent recurrence.

REGULATION	Description
SOLAS III \ 13.1.3	**Deficiency:** Each Survival Craft shall be stowed in a state of continuous readiness so that two crew members can carry out preparations for embarkation and launching in less than **5 min**. During enhanced survey of forward life raft crew took **15 mins** to deploy up to embarkation. **Company Comments:** The USCG inspectors specifically asked for the Bosun and AB to complete the task of carrying the life raft to the side of the vessel, turning on the emergency lights, bringing the anti-exposure suits, donning the life jackets and rigging the embarkation ladder. The crew took about 15 minutes to deploy resulting in this deficiency. **Root Cause(s):** **Lack of familiarization** - The ship's crew were not aware of the requirements of SOLAS CH III - REG 13 - Stowage of survival craft "***Each survival craft shall be stowed in a state of continuous readiness so that two crew members can carry out preparations for embarkation and launching in less than 5 minutes".*** **Inadequate onboard training** - The ship's crew were not trained appropriately to carry out preparations for embarkation and launching of survival craft by 2 crew in less than 5 minutes. **Preventive Action** The Master shall ensure that each survival craft is stowed in a state of continuous readiness so that two crew members can carry out preparations for embarkation and launching in less than 5 minutes as per SOLAS CH III - REG 13 - Stowage of survival craft The following actions are to be completed within 5 minutes: • 2 crew moving the life raft to the side of the vessel • Same 2 crew shifting the embarkation ladder to the side of the vessel and rigging the same • Same 2 crew rigging and turning ON the life raft emergency light • Same 2 crew donning of immersion suits / lifejackets During abandon ship drill , the Master shall select any 2 crew at random (Combination of deck crew , engine crew , galley crew) and train them so that any 2 crew can carry out above actions within 5 minutes. For example combination of (oiler , chief cook) , (fitter , AB) , (OS , messman) , (Bosun , 3EO) etc The Drill schedule instructions in BASSNET has been modified to incorporate these requirements


Training & Drills Setup
File
Frequency Setting
Help
New
Save
Cancel
Delete
Print
Code: GRIN-TD-0001-2017
* Revision No: 1.08
Office Use
* Description: DRILL : Life Boat Drill SOLAS III 19-3.2 / 19-3.4.1
Notes to Participants
Checklist
Participants
Documents
Done By
All crew to participate
To be conducted within 24 hours if 25% or more crew has been changed
Each abandon ship drill shall include:
1. Summoning of passengers and crew to muster stations with the alarm required by regulation 6.4.2 followed by drill annou
public address or other communication system and ensuring that they are made aware of the order to abandon ship.
2. Reporting to stations and preparing for the duties described in the muster list.
3. Checking that passengers and crew are suitably dressed.
4. Checking that life jackets are correctly donned, carriage of immersion suits.
5. Lowering of at least one lifeboat after any necessary preparation for launching; (not applicable during sailing)
6. Starting and operating the lifeboat engine.
7. Operation of davits used for launching life rafts.
8. A mock search and rescue of passengers trapped in their state rooms. (Not applicable)
9. Instruction in the use of radio life-saving appliances.
Note: Each survival craft shall be stowed in a state of continuous readiness so that two crew members can carry out prepar
embarkation and launching in less than 5 minutes as per SOLAS CH III - REG 13 - Stowage of survival craft. Portable life r
light shall be rigged and tested.
Frequency : 30 Day
Alert Interval : 7 Day(s)
Scheduling : Dynamic

Fleet Advisory 2023-01 (Accumulated)

Fleet Advisory 2201 01: Rightship inspection at Kakinada on 20th Dec 2021

1.	**AE No.1 Fuel oil injection pump periodic inspection and replacement of various parts to be carried out at 4000 - 6000 hour interval (as per makers manual), present running hour was 7281 hour and overdue.** **Comments:** • The company Form 6.3.1 - Running Hours Record Sheet used to capture the running hours of the machinery had incomplete data. Form also contains the running hours interval for the periodic maintenance. The running hour interval for the periodic maintenance of AE fuel oil pump was recorded as 6000 hours without running hours maintenance range. Chief Engineer assumed that 6000 hour was the lower limit of the periodic maintenance and upper limit was 8000 hours. • Please cross check the company Form 6.3.1 to ensure that it contains the correct and complete interval of maintenance including lower and upper limit of running hours as per makers manual.
2.	**Chains replacing guard rails for port and starboard side pilot ladder rigging position, the height of top of chain sagging point to deck level was less than 1.0 m (about 89 cms on port side and 95 cms on starboard side).** **Comments:** • The securing eyes of the chains replacing guard rails are correctly positioned at 1.0m level from the deck. It was the sagging of the chain which was natural with such securing arrangement. • Refer International Convention on Load Lines1966, Regulation 25 Protection of the crew - (2) The height of the bulwarks or guard rails shall be **at least 1 m from the deck** (3) Guard rails fitted on superstructure and freeboard decks shall have at least three courses. The opening below the lowest course of the guard rails shall not exceed 230 mm. The other courses shall be not more than 380 mm apart. • Ships provided with the chains at guard rails opening, please replace with the guard rail as per attached photo. Submit proposal and request for hot work to your Ship Manager for modification.
3.	**Critical spares for Emergency fire pump (Impeller, mouth ring, line bearing cover, vacuum pump casing) and Main air compressor spares (Plate, spring, O'ring, valve cover, piston, disk) were not available on board. (Note: Spares ordered on 11-Dec-2021)** **Comments:** • New critical spares were identified based on the company periodical risk assessment on the critical equipment. These critical spares for emergency fire pump and main air compressor were recently added in the BASSnet critical spare parts after above risk assessment. • Please refer Critical Spare parts in BASSnet and raise the requisition for the newly identified critical spares if not yet done so to ensure that all critical spare parts as required are on board. (Refer BASSnet critical spare parts, Technical Procedure Manual, 7.0. Repairs and Maintenance/3.5. Critical Equipment)

4.	**Serial no. or Mfg no. of No.4 crane was not marked anywhere on the crane** **Comments:** • Crane number 1,2 and 3 had the marking plate intact but it was missing on No.4 Crane. • Please check that marking plates are intact and legible on all the 4 cranes. If plate markings are not legible or plate is missing, please inform your Ship Manager for replacement.
5.	**Port side midship draft mark was not painted in contrasting colour from 7.0 m - 6.0 (waterline) drafts.** **Comments:** • Check the load line and draft marks at anchorage and when alongside, if paint has faded/rusted due to rubbing at fenders, paint these at earliest opportunity. • Load line and midship draft marks are prone to wear and tear due to rubbing at fenders when vessel is alongside, please keep checking these markings and paint them as and when opportunity arises.
6.	**Flashback arrestor was not fitted on the oxygen and acetylene working cylinder near the pressure regulator** **Comments:** • The flashback arrestors are to be fitted on both at cylinders storage space and at gas cabinet in engine room workshop side. • Please check if flash back arrestors are fitted on both side and raise requisition if missing. • The Company has incorporated PMS routines for inspection and maintenance of flash back arrestors for the entire fleet. Refer attached screen shot.

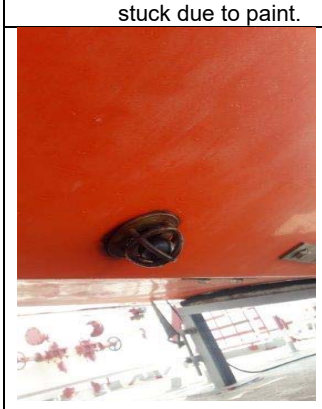
Fleet Advisory 2022-02

PSC deficiencies at Osaka, Japan on 05th Jan 2022

S.No./ Code	Description
01214	**Endorsement by flag state of C/E only copy** **Comments:** • The CEO did not check whether his certificate file contained the original certificate of endorsement issued by the by flag state prior joining vessel. He carried only copy of the endorsement prior joining the vessel. • In this case, the original certificate of endorsement was in the crewing department office and the person in charge of checking documents did not ensure that the original was handed over to the CEO prior joining vessel. • It is the responsibility of the seafarer that original STCW documents are carried with him on board. It is ensured by company SIGN ON Form 4.1.16 which is completed by on-signer himself. Please check documents before completing this Form. • The company's SIGN ON Form 4.1.16 clearly mentions that the Master must verify the original certificate when the crew signs on the vessel. However, the Master checked only the copy and assumed that the CEO had the original certificate of endorsement.
11117	**Self-igniting light with lifebuoy stored on the port side upper deck not lit.** **Comments:** • Lifebuoy Self-igniting lights were inspected on the 22 Dec 2021 and were found in good order. However, during the PSC inspection on the 05 Jan 2022, the port side self-igniting light batteries failed (Though the batteries were only expiring in Nov. 2022) • The unexpected light failure was due to supply of poor quality of batteries. • Henceforth request only for good quality and long-lasting batteries like Duracell for safety. • Please mark the battery replacement and expiry date on the Self-igniting light.
11102	**Water proof electric torch of stbd side lifeboat not lit**. **Comments:** • The stbd side L/B torch was last tested on 22 Dec 2021 and was found in good order. However, during the PSC inspection on the 05 Jan 2022, the stbd side torch failed (Though the batteries were only expiring in Oct. 2022). • The unexpected torch light failure was due to supply of poor quality of batteries. • Henceforth request only for good quality and long-lasting batteries like Duracell for safety. • Please mark the battery replacement and expiry date on the torch.
18407	**Illumination light in the CO2 room and Bosun store not lit.** **Comments:** • One lamp in the CO2 room and one lamp in the Bosun store were found busted during the inspection. • The Company has decided to henceforth supply only good quality / long lasting LED lamps to all vessels.The Ship managers and purchasing department were instructed accordingly. • While carrying out the daily maintenance routines, the ship staff shall report if any bulbs are found busted. • Also prior arrival port all the lights on board (deck lights, store lights, CO2 room lights, emergency lights etc) shall be additionally checked and busted bulbs if any shall be replaced.

11101	**Starboard side lifeboat (1) Link stoppers (fore and aft) on boat fall hook was stuck (2) Bottom plug not connected to the boat.** **<u>Comments:</u>** • Starboard side lifeboat link stoppers were recently painted due to which it was stuck. Movable parts should be not painted. Please ensure whenever a device is painted around a moving part, it is exercised to move free.

Stbd side L/B forward part link stopper stuck due to paint.



- Bottom plug for the stbd lifeboat was fitted in place but the chain connecting the plug to the boat was found missing during the inspection. Refer SOLAS regulation:

===
LSA Code/4.4.7 Lifeboat fittings
4.4.7.1 All lifeboats except free-fall lifeboats shall be provided with at least one drain valve fitted near the lowest point in the hull, which shall automatically open to drain water from the hull when the lifeboat is not waterborne and shall automatically close to prevent entry of water when the lifeboat is waterborne. **Each drain valve shall be provided with a cap or plug to close the valve, which shall be attached to the lifeboat by a <u>lanyard, a chain, or other suitable means</u>. Drain valves shall be readily accessible from inside the lifeboat and their <u>position shall be clearly indicated</u>.**
===

Kindly ensure the following to avoid PSC deficiency:

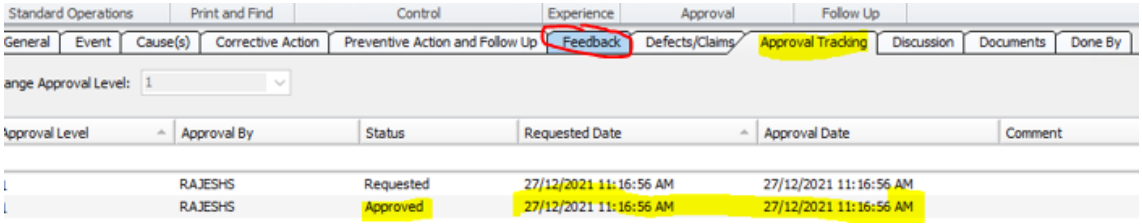
- Drain plug is marked as per above photo “ALWAYS KEEP CLOSED IF YOU DO NOT DRAIN WATER” (Laminate and post if not provided)
- Drain plug is fitted with chain / wire
- Drain plug is kept closed at all times except while draining water.
- Drain ball is in good condition and not seized/damaged/ worn out
- Crutch is attached to lifeboat by chain
- Adjacent lifeboat seat belts are of different colour (contrasting). If not please inform us and make requisition.

Above has been read and understood

Fleet Advisory 2022-03

PSC deficiencies at Mina Zayed/Abu Dhabi, UAE on 17th Jan 2022

S.No./ Code	Description
1/ 09198	**Non-contact infrared thermometer for monitoring body temp. as part of covid-19 was not in use, and the AB watch was maintaining fake figures.** **Comments:** • PSC inspector was greeted by Bosun who checked his identity, entered his details in the visitor's log and called duty officer to escort PSC inspector. After PSC inspector entered the accommodation, Bosun realized that he missed out to check his body temperature. Out of panic and afraid of being reprimanded by C/O, Bosun entered false temperature reading in the log. • During deck rounds, inspector saw the poster at the gangway stating body temperature of the visitors must be checked and inspector checked the visitor's log which had the false temperature reading entered. • If some entry is missed out due to lapse, please don't make any false entry to correct the mistake. Please inform it to your superior for such non-compliance so that a non-conformity can be raised to correct the mistake. • False entries in official documents may lead to trouble to concerned staff/Master and to legal action in some cases.
09108	Several lights cover was observed with died insects. **Comments:** • These lights within the accommodation were mainly on upper deck alleyway prone to insects when door is opened to enter/exit the accommodation as these lights are not air/weather tight and insects enter these covers. • Please pay attention to these lights during weekly accommodation inspection and clean if required.
3/ 03199	**On random check of sounding pipes observed self-closing device missing spring.** **Comments:** • Please refer following SOLAS II-2/Regulation 4/2.2.3.5.1.3: == .3 the terminations of sounding pipes are fitted with **self-closing blanking devices** and with a small-diameter **self-closing control cock** located below the blanking device for the purpose of ascertaining before the blanking device is opened that oil fuel is not present. Provisions shall be made so as to ensure that any spillage of oil fuel through the control cock involves no ignition hazard. == • There is a monthly routine PMS for the maintenance of self-closing device of sounding pipes in E/R in BASSnet. It was observed that on some ships that the PMS was missing which will be added shortly. • Ensure maintenance is carried out as per PMS. • Check **self-closing blanking devices** and the small-diameter **self-closing control cock** for operation when using these sounding pipes.
4/ 09210	**General housekeeping required for E/R floor in all levels.** **Comments:** • Engine room floors were well maintained and clean prior arrival in port, but during port stay 5 units of main engine pistons were pulled out to carry out preventive maintenance

	and engine crew was in the process of cleaning the E/R floor when PSC inspector boarded the vessel and inspected engine room. • Please ensure E/R floors are kept clean at all times and the floors shall be cleaned as soon as possible after any maintenance work
5/ 15199	**No management feedback / approval for near misses reports.** **<u>Comments:</u>** There were three near misses reported in the month of Dec 2021 and all three reports were closed out by office. A closed out of near miss itself indicates that it has been approved by office. Please note as following: • Close out of each Near miss and other reports is only Office function. • A near miss report in BASSnet can only be closed after mandatory fields as indicated by ''asterisk sign'' have been completed. • An activity history is captured in the BASSnet with the name of the person and timing of accessing the report in the ''Approval Tracking'' and ''Done By'' fields. Pease check by clicking on these buttons on any near miss in the BASSnet. • ''Feedback'' field in BASSnet is an entirely Optional field where the Office or Vessel can enter feedback on the report for any item if there is a need for it. As there was no requirement of it, nothing was added in the Feedback filed. • Please show approval tracking and explain above if similar point is raised in future by an external party. 

Fleet Advisory 2022-04

USCG PSC deficiencies at Stockton, CA on 09 Feb 2022

S.No./ Code	Description
1/ 07106	**The following Fire protection systems shall be kept in good order so as to ensure their required performance if a fire occurs: Fire Detection and Fire Alarm systems, PSCO observed non-operational heat detector in the engine control room.** (**SOLAS II - 2/14.2.1.1.2)** **Comments:** • Inadequate routine inspection - Heat detector was not ensured in operational condition by weekly routine tests as required by company PMS. • The detector was dismounted, cleaned and tested again for the operation to the satisfaction of USCG. • All FFA shall be kept in state of operational readiness at all times. • The ship staff shall routinely and diligently test all the detectors on board the vessel as per the PMS routine and ensure they are fully operational. • If any detector is not operational, it shall be investigated and replaced as required. • The chief engineer shall randomly witness the testing of the detector and activation of the alarm
2/ 16105	**At security level 1, the following shall be carried out: controlling access to the ship. Gangway watchman failed to check 01 ID card out of 06 Coastguard personnel and failed to properly log visitors.** (**SOLAS X1-2/4.1, ISPS code 7.2.2)** **Comments:** • Six USCG inspectors boarded the vessel and approached the gangway desk at the same time. The gangway watch keeper checked the ID card of 5 USCG inspectors but failed to check the ID of the 6th USCG inspector and log entries properly in the visitor log. The gangway watch keeper got panicked and lacked attention upon seeing 6 USCG inspectors approaching the gangway desk at the same time. • The SSO arrived at the gangway security desk and ensured that each USCG officers ID was checked individually and logged. • The gangway watch keeper shall be always alert and assertive when keeping the gangway watch. The watch keeper shall remain calm and not panic if several public authorities like USCG officials board vessel. • If several visitors board vessel at the same time, the gangway watch keeper shall request them to stand in a line and then attend to each visitor. The gangway watch keeper shall keep each visitor in sight and ensure that visitor pass is issued to each visitor and proper entries are made in the visitor log. • If there is any situation which cannot be controlled by the gangway watch keeper, the duty officer or SSO shall be immediately informed. • The duty officer shall also crosscheck the visitor log during each watch for accurate, legible and complete entries. The Master / SSO shall check visitors log at random and ensure that it is properly maintained in accordance with the SSP. • All vessels are requested to conduct on the job training on security duties (OJT 031) to prevent recurrence of this deficiency.

Above has been read and understood

Fleet Advisory 2022-05

PSC deficiencies at Derince, Turkey on 23rd Feb 2022

S.No./ Code	Description
1/ 07199	**Battery room ventilation has no closing device from outside acc. to Fire Plan**. **<u>Comments:</u>** • Battery room was provided with two ventilators, one ventilator was fitted with the closing device and other ventilator was without closing device as per the yard design but the fire plan indicated this ventilator fitted with the closing device due to which it resulted in this deficiency. • The closing devices were not mandatory for battery room vent for the vessel as per MSC.1/Circ.1434 / SOLAS Regulation II-2/5.2.1.1– Closing appliances and stopping devices of ventilation as following: === **Regulation II-2/5.2.1.1 – Closing appliances and stopping devices of ventilation** 1 Battery room ventilators should be fitted with a means of closing whenever: .1 the battery room does not open directly onto an exposed deck; .2 the ventilation opening for the battery room is required to be fitted with a closing device according to the Load Line Convention (i.e. the height of the opening does not extend to more than 4.5 m (14.8 feet) above the deck for position 1 or to more than 2.3 m (7.5 feet) above the deck in position 2; or .3 the battery room is fitted with a fixed gas fire-extinguishing system. 2 Where a battery room ventilator is fitted with a closing device, then a warning notice stating, for example "This closing device is to be kept open and only closed in the event of fire or other emergency – Explosive gas", should be provided at the closing device to mitigate the possibility of inadvertent closing. === The ship's battery room was not corresponding to paragraph 1.1 to 1.3 above and need not to be fitted with a closing device with its ventilator. • Class was invited to attend the vessel and to amend the Fire Plan • **Please cross check the battery room ventilators against the Fire Plan and report any discrepancy to your Ship Manager.**

Fleet Advisory 2022-06

PSC deficiencies at La Coruna, Spain on 23rd Feb 2022

S.No./ Code	Description
1/ 02117	**Defective item: Decks corrosion, Nature of defect: Not as required, Additional comments: Light corrosion (LL SOLAS)** **<u>Comments:</u>** • Deck maintenance had suffered due to carriage of logs on deck/hatch covers in the month of Nov 2021. • The paint could not be supplied earlier in New Zealand and in China due to Covid-19 restrictions. This also prevented deck maintenance during intermittent period available for deck maintenance during trade. • Please update your Ship Manager whenever deck maintenance suffers due to any reason and support required to keep up with the maintenance.
2/ 18420	**Defective item: Cleanliness of engine room, Nature of defect: Not as required, Additional comments: Cleanliness of E/R needs to be improved (LL SOLAS) Cleanliness of engine room – not as required. (MLC)** **<u>Comments:</u>** • Area pointed out by PSC inspector was in the purifier room space. The oily marks in the purifier room space were of the ongoing maintenance work. Space was also lacking cosmetic appearance. • The purifier room floor plates and area were immediately cleaned and were painted subsequently. • Please clean E/R floor plates as soon as possible after any maintenance work is carried out.

Fleet Advisory 2022-07

USCG PSC deficiencies at Mobile, AL, USA on 16 Feb 2022

S.No./ Code	Description
1/ 03105	**Bulk carriers shall comply with the maintenance requirements provided in regulation II-1/3-1 and the standards for owners' inspection and maintenance of Bulk Carrier Hatch covers, adopted by the organization by resolution MSC 169(79). PSCO observed the last monthly hatch cover maintenance was completed on 01 Dec 2021.** **(74 SOLAS (20) XII/7.2)** . **Comments:** • The monthly maintenance schedule for the inspection and maintenance of Bulk Carrier Hatch covers as required by resolution MSC 169(79) is there in BASSnet PMS under scheduled jobs. • Vessel had carried out partial maintenance of hatch covers externally during loaded passage without opening the hatch cover due to the nature of cargo inside the holds but same was not informed to USCG PSC team. • When vessel is unable to complete the maintenance as required without opening the hatch cover due to weather/nature of the cargo, carry out the maintenance which can be carried out externally and enter same in the BASSnet PMS with reasons of not carrying out the complete maintenance.
2/	**Each Ballast Water Management System manufactured under coast guard approval must have a name plate which is securely fastened to the BWMS and plainly marked by the manufacturer with the information listed in paragraph (b) of this section.** **PSCO noted approved BWMS was not marked with a name plate. (46CFR 162.060-22a)** **Comments:** • This deficiency resulted due to the mistake in relaying to the USCG PSC inspection team that the vessel was equipped with USCG Type approved Ballast Water Treatment System (BWTS). The BWTS (Make-PANASIA/Type-GloEN-Patrol/Model-GloEn-P800) fitted on board is not yet upgraded to USCG Type approval but it is Alternate Management System (AMS) approved. As AMS doesn't require marking of the name plate on the system, hence BWTS was not marked with the information as required by USCG requirement. • Panasia BWTS fitted on board are not yet fully compliant with USCG Type approved standard. But these units are AMS approved by USCG for period of 5 years from the extended compliant date. • The USCG AMS approval letter for Panasia and USCG letter for the extension of the compliance date should be produced to USCG PSC team if requested during inspection. • The Panasia BWTS require modification and upgrade to fully comply with USCG Type approved standard before marking the BWTS with a name plate. We are in contact with the manufacturer for upgrading the BWTS. • The vessels equipped with BWTS of other than Panasia, please check BWTS for the marking of a name plate and advise your Ship Manager if unit is not marked with following information: (1) Coast Guard approval number assigned to the BWMS in the certificate of approval. (2) Name of the manufacturer. (3) Name and model number of the BWMS. (4) The manufacturer's serial number for the BWMS. (5) The month and year of manufacture completion. (6) The maximum allowable working pressure for the BWMS.

Above has been read and understood

Fleet Advisory 2022-08

PSC deficiencies at San Lorenzo port, Argentina on 09 May 2022

S.No./ Code	Description
1/ 04103	**Some deck lights are out of service**. **Comments:** • One light on accommodation exterior port side and one light on accommodation exterior stbd side were found busted during the inspection. • Carry out proper inspection of all lights (paying attention in detail to each light) during routine inspections and maintenance. • Any light found non-functional, having dead insects, having missing screws, cracked or broken found should be immediately reported & necessary action to be taken. • All emergency lights shall be also checked during boat drill. • As there is a possibility that lights can bust off anytime due to vibrations, lights are to be also checked prior arrival port as per the Company's prearrival checklist and upon berthing and defective lights if any to be renewed. • During cargo operations, deck crew shall check if all the lights are in good order. If any defective light is observed, it shall be informed to the officer in charge and replaced with new one. • Vessel shall have sufficient spare bulbs on board.
2/ 13102	**Refrigeration sea water pump of main engine has leaks.** **Comments:** • The leakage was from Cooling SW Pump (ME) gland packing. • Enhance the inspection and maintenance regime and ensure that ships equipment / machinery are kept in good working order at all times. • All vessels shall strictly comply with the PMS and defect management procedures as per Technical Manual section 7 and to report any defects noted on the vessel in a timely manner. All defects shall be brought to the attention of the Master and the Company. • Ship staff shall pay attention in detail and look out for leaks, malfunctions, unusual noise and other abnormalities while carrying out any maintenance routine or while taking rounds. • Leaks or malfunction on any equipment shall be attended and rectified immediately or entered in the Defects list form for repair at the earliest opportunity. • Master, Chief engineer and Safety officer shall check the maintenance and upkeep of equipment and machinery during their routine rounds and during safety inspections. • Crew is to be warned not to overtighten glands and damage cooling properties in the glands by heat build-up.
3/ 13102	**Refrigeration sea water pump of the Generator 3 has leaks.** **Comments:** • The leakage was from SW service Pump (GE) gland packing. • Enhance the inspection and maintenance regime and ensure that ships equipment / machinery are kept in good working order at all times. • All vessels shall strictly comply with the PMS and defect management procedures as per Technical Manual section 7 and to report any defects noted on the vessel in a timely manner. All defects shall be brought to the attention of the Master and the Company. • Ship staff shall pay attention in detail and look out for leaks, malfunctions, unusual noise and other abnormalities while carrying out any maintenance routine or while taking rounds.

	• Leaks or malfunction on any equipment shall be attended and rectified immediately or entered in the Defects list form for repair at the earliest opportunity. • Master, Chief engineer and Safety officer shall check the maintenance and upkeep of equipment and machinery during their routine rounds and during safety inspections. • Crew is to be warned not to overtighten glands and damage cooling properties in the glands by heat build-up.
4/ 13103	**Electrical panels in the engine room do not have rubber insulation on the floor.** **<u>Comments:</u>** • The panel for engine room lights (stbd side) and panel for ballast pumps did not have rubber insulation on the floor. • This deficiency is not valid as per SOLAS II-1 Reg.45 2. ➢ Where necessary non-conducting mats or gratings shall be provided **at the front and rear of the switchboard**. (SOLAS II-1/45. 2). ➢ Non-conducting deck coverings, such as non-conducting mats or gratings, suitable for the specific switchboard voltage should be installed for personnel protection at the front and rear of the switchboard and should extend the entire length of and be of sufficient width to suit, the operating space. (USCG 46 CFR 111.30-11.) ➢ Insulating matting is only required at the front and rear of switchboards. ➢ Individual machinery **starter boxes** throughout the Machinery space are **NOT considered switchboards** and do not require insulating matting in front or behind them • Be aware of SOLAS II-1 Reg.45 2 which requires non-conducting mats or gratings at the front and rear of the **switchboard** so that PSC inspector can be explained. Individual machinery starter boxes throughout the Machinery space are NOT considered switchboards and do not require insulating matting in front or behind them. • All mats not required by SOLAS are to be removed to prevent tripping hazards.

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Fleet Advisory 2022-09

PSC deficiencies at Port Hedland, Australia on 08th June 2022

S.No./ Code	Description
1/ 03108	**Fore peak ballast tank vents port and stbd defective**. **<u>Comments:</u>** • Nine Air vent heads were dismantled for the internal inspection as required by PSCO. The floats of forepeak tank were found defective. The bush guide piece welded at upper side of the float was found missing. The defective floats were replaced by new spare floats available on board, same was verified by PSCO. • It is suspected that the bush guide piece got dislodged from the floats due to frequent operation of float during shipping seas which is more pronounced at forward part of the vessel. • As per company PMS, the air vent heads were inspected/overhauled internally in June 2021. • The maintenance interval for internal inspection and overhauling of the air vents is being reduced from annual to 6 months in BASSnet to prevent recurrence. • The job on air vent maintenance will show up in BASSnet on monthly basis, dismantle air vent heads of few tanks for internal inspection and overhauling so that all air vents are inspected/overhauled at 6 monthly cycles. Carry out maintenance as per the job description in BASSnet. • Mark the overhauling date on the vent head after maintenance. • Enter maintenance report/comment in the BASSnet identifying the air vents inspected internally, their condition and maintenance carried out. • Ensure that any replacement spare has been ordered so that minimum spares as required are available on board.

Fleet Advisory 2022-10

AMSA PSC deficiencies at New Castle, Australia on 7th July 2022

Code	Description
07115	**Port side engine room ventilation fan fire damper defective**. **(Vessel was detained on this deficiency)** **Comments** • Inspector requested to have the grids beneath the cowling removed. The pneumatic actuator was then used to close the damper. The inspector went inside the vent between the base and the mushroom and observed that flaps were not closed. The linkage affixed to one of the fins (end fin) by welding, had given way which made that fin inoperable. • Monthly test of ventilators and fire damper was last done on 16 June 2022. • The dampers are function tested monthly. The position of the damper cannot be observed from outside as there was no inspection port. While testing the damper was thought to be closed when it wasn't. The fact that the damper was not fully closed was only noticed by removing the protective grating and looking inside**.** • The weld on the stub piece was rewelded, affixed to the damper fin to make the dampers in good working order. The PSC inspector verified the operation and closed the deficiency. • **Ensure a ship specific procedure for testing and ensuring positive closure of the flap is prepared on board your vessel.** • **An inspection port (if not provided) will require to be fabricated to ensure visual confirmation of positive closure of the flap. Please liaise with your Ship Manager in case inspection port is to be installed on the air vent on board your vessel.**
03108	**Float defective at double bottom tank No.2 (Port) Aft air vent.** **Comments:** • Ten air vent heads were opened for inspection as required by AMSA inspector. Nine vents were found in good order. The float of No. 2 (Port) air vent was found defective. • On No 2 (Port) vent, the stub guide piece welded on the floating disk was found broken off. The welding repair was carried out for joining the stub guide piece with the float disk during the last overhauling of the air vent. • All water ballast tanks air vents were internally inspected and overhauled in accordance with the company PMS and welding repairs were carried out for joining the stub piece on some floats as required. • Despite the fact that all ventilators were overhauled, the lack of quality of welding workmanship resulted in the failure of the ballast vent float. • Defective float was replaced by a float which was supplied at Newcastle by a local Engineering Company. The AMSA PSC inspector closed the deficiency after verification of the same. • **During routine inspection and overhauling, pay close attention at the joint of stub guide piece with the float disk. Any defective float detached with stub guide piece is to be replaced by the new. No welding repair should be attempted on board. Henceforth the defective float shall be replaced by the new spare float.** • **Ensure sufficient spare vents and floats are there on board your vessel. Please liaise with your Ship manager for number of floats to be kept as spare and place order as required.**
18408	**Low insulation in 220V feeder panel in emergency generator room.** **Comments:**

	• During the load testing of the emergency generator, it was noted that there is a 220V low insulation in the lighting circuit. Recent heavy flooding rain when the vessel was alongside in port resulted in moisture drawn into the light fitting via seals due to light vacuum when light is cooling**.** • The ship staff noticed the 220V low insulation and identified the cause and intended to fix the problem after cargo operations were completed. There was improper sealing of electrical gland connection on emergency light on deck. • Electrical officer was instructed to identify and rectify the low insulation fault immediately after deficiency was pointed out. The lighting fixture was opened and dried by means of a heat gun and gland fittings/glass housing seals refurbished to ensure proper sealing and the low insulation alarm was rectified. • **CEO to brief all engineers to be more vigilant while keeping the engineering watch and attend and rectify any identified electrical faults at the earliest opportunity and also to record any identified electrical defects in the defect log and report the same to the CEO.** • **The routine weekly testing of the emergency generator now requires switching on all decks lights to see if any earth faults appear.** • **Carry out regular checks of the feeder panel and low insulation alarm or defects if any to be properly investigated and rectified at earliest opportunity. If unable to find cause for low insulation, Ship Manager is to be informed.** • **Ensure that electrical fittings are properly maintained and sealed appropriately to avoid moisture/water ingress. Particular emphasis to be given to the inspection and proper sealing of the items like terminal boxes of the deck lights, wipers etc from direct sea spray and rain as it is one of the major causes for low insulation.** • **Class rules require a minimum insulation resistance of 1 mega ohm (1 million ohms). Good practice suggests that a much higher standard, as near to infinity as possible, but not less than 5 mega ohms, should be aimed for.** • **The engineer on watch to check the status of electrical panels during his watch. Chief engineer also to check the status of electrical panels while taking rounds in engine room.**
07199	**Heat insulation defective at auxiliary engine No. 3 exhaust turbo charger manifold.** **Comments:** • During the inspection of the generator engines, the inspector climbed up onto the bedplate to get a better view of the exhaust manifold, he found lagging material to be insufficient. • SOLAS – CH – II - Regulation 4 - Probability of Ignition - 2.2.6 Protection of high-temperature surfaces. 2.2.6.1 Surfaces with temperatures above 220°C which may be impinged as a result of a fuel system failure shall be properly insulated. 2.2.6.2 Precautions shall be taken to prevent any oil that may escape under pressure from any pump, filter or heater from coming into contact with heated surfaces. • Appropriate lagging was added to the exposed areas of the turbocharger. The ship staff have carried out thorough checks in the engine room and confirmed all other pipes requiring insulation/lagging are in good condition. • Such deficiencies pose a fire hazard and ensure that engine officers and crew follow proper housekeeping and maintenance on the lagging of the machineries. • **CEO to ensure stringent inspection and maintenance as per PMS and report if any lagging is missing from any equipment/ machinery. Laggings shall be adequate, covering the entire surface and not missing at any area and the lagging and insulation shall be in good condition, tight and free from oil. If the laggings are not in good condition, they shall be renewed.** • **Engineering Officers, while doing their watch keeping rounds shall ensure that general inspection of equipment / machineries and housekeeping requirements are being met. Complacency is to be guarded against. Any potential item that**

	can cause hazard/danger to the vessel, crew and environment must be rectified on the spot. • **The ship staff shall also ensure that all PMS routines are completed in a timely manner. If unable to complete the same, the ship manager has to be informed with valid reasons and the job schedule to be postponed to a further date with ship managers comments and approval.**
07106	**Smoke detector defective at forward hydraulic room.** **Comments** • All the detectors were operational on board and there was no alarm. While the AMSA inspector was conducting the bridge inspection, the fault alarm sounded alerting the inspector who enquired about the source of the fault. Upon investigation it was found that the recently replaced Smoke detector was defective in forward hydraulic room. Weekly testing of fire detection and alarm system was last done on 04 July 2022. • Electronic component failure: The fire alarm system was clear of alarms and tests were up to date however the failure occurred during the time of inspection. • The circuit and loop were checked for continuity, loose connection and any other defects. The smoke detector was promptly replaced with new spare. After replacement of the new sensor there has been no further alarm form the system and system tested fully functional. • **Ensure sufficient spares for each type of detector are carried on board in case of unexpected failure of the detectors.**
05110	**INMARSAT-C not set up to receive AUSCOAST warnings for current sea area.** **Comments:** • During the inspection the AMSA inspector wanted to see what regions were selected on the INMARSAT-C for the AUSCOAST Maritime Safety Information. The Australian coast is divided into 8 coastal regions from A-H and the area as per vessels position was region “C”. The INMARSAT -C was only set to receive Maritime Safety Information for areas A and B. The second officer immediately selected the region C in the presence of the PSC inspector and the deficiency was closed. • **The OOW to configure the required Nav areas in EGC / Navtex carefully to ensure that all Maritime Safety Information (MSI) necessary for the intended voyage is received. Country specific requirements like AUSCOAST navigational warnings shall also be complied with referring to the publications. Refer on the job training on AUSCOAST Maritime Safety Information.** • **The areas set in INMARSAT -C to receive Maritime Safety Information by one officer shall also be cross checked by the other navigational officers so as to avoid one man error.**
04114	**Tachometer defective at emergency generator control panel.** **Comments** • During the testing of the emergency generator, the AMSA inspector observed that tachometer on the generator board was faulty. The vessel already had a spare tachometer on board but could not renew the same as it was of wrong specification which was due to inadequate purchasing by office and subsequent inadequate communication by ship staff on wrong supply. • **The ship staff to always check the spares received on board immediately upon receipt or at the earliest opportunity and ensure that they are of the correct specification as per maker manual.** • **If the spares received are not correct, then the supplier and ship manager shall be informed and the spare shall be returned back and new requisition raised if deemed necessary.** • **The vessel shall follow up the requisition with the ship manager until the spare is received.** • **The Ship manager shall also track the requisition and endeavour to supply the items at convenient port.**

	• **The Company has revised the PMS routines to include checking of the tachometer during testing of the emergency generator.**

Fleet Advisory 2022-11

PSC deficiencies at Hirohata (Himeji), Japan on 25th July 2022

Code	Description
04103	**Emergency light for forward life raft broken.** **Regulation:** SOLAS > Chapter III - Life-Saving Appliances- Regulation 9 - Operating Instructions (Posters or signs shall be provided on or in the vicinity of survival craft and their launching controls and shall be easily seen under emergency lighting condition) **Comments:** • The vessel's last cargo was logs and the light was damaged by the stevedores during the discharge of logs in Lanshan, China. The ship staff were aware of this damage which occurred during cargo operations in the last port and there was a spare new fitting on board. The new light was not fitted in a timely manner which resulted in this deficiency. • Upon pointing out the deficiency, emergency light was immediately renewed. The operation of the light was verified and the deficiency was closed by the attending PSC inspector. • **Please comply strictly with the defect management procedures as per SMS and report any defects noted on the vessel in a timely manner. All defects shall be brought to the attention of the Master and the Company. This includes the relevant forms for reporting (Form 6.5.1) and the distribution of them when completed.** • **Any observed safety equipment in sub-standard condition to be attended and rectified at the earliest opportunity. If unable to complete the same, the Ship Manager is to be informed with valid reasons and the job schedule to be postponed to a further date with Ship Managers comments and approval.** • **Please comply with SOLAS Chapter I - General Provisions - Regulation 1 and any defect in safety equipment (if unable to rectify in a timely manner) shall be reported to the flag state authority (Through the Company) and an appropriate dispensation shall be obtained from the flag state and the defect shall also be reported to the appropriate port authorities of the calling ports.** • **The Master, Chief Engineer and Safety officer to check the maintenance and upkeep of equipment and machinery during their routine rounds and during safety inspections.**
04113	**Water ingress alarm for No1 cargo hold activated main alarm although there is no water in the hold.** **Regulation:** SOLAS > Chapter XII - Additional Safety Measures for Bulk Carriers - Regulation 12 - Hold, Ballast and Dry Space Water Ingress Alarms **Comments:** • The alarm had activated on the evening of 24 JULY one day prior to the PSC inspection. The vessel was alongside and loading in other holds except CARGO HOLD NO 1 which was checked and confirmed dry. • The alarm condition was accepted by the ship staff with the intention of further investigation the next morning. At 0830 hrs however the relevant personnel commenced a pre-arranged life and rescue boat launch to make use of the opportunity to launch boats before a long voyage. The PSC boarded the vessel during the drills and the ship staff had not yet had the chance to check the cause of the faulty reading on the Ingress Panel.

	• Upon pointing out the deficiency, the sensor was immediately changed and the cargo hold alarm condition was rectified. The PSC inspector rechecked the bridge panel and closed the deficiency. • **Any observed safety equipment in sub-standard condition to be attended and rectified at the earliest opportunity. Any safety related defects which are not completed in time prior arrival port are to be reported to the flag state through Ship Manager and dispensation obtained for the same.** • **Please comply with SOLAS Chapter I - General Provisions - Regulation 1 and any defect in safety equipment (if unable to rectify in a timely manner) shall be reported to the flag state authority (Through the Company) and an appropriate dispensation shall be obtained from the flag state and the defect shall also be reported to the appropriate port authorities of the calling ports.** • **Each vessel is required to have spare sensor on board.**

Fleet Advisory 2022-12

PSC deficiencies at Hiroshima (Etajima), Japan on 18 Oct 2022

Code	Description
11104	**Painter for the rescue boat not attached to the release device.** **Comments** • Rescue boat was lowered into the water on 13th Oct 2022. Crew failed to reconnect the painter to the release device after its re-stowage. • Please note following SOLAS regulation (LSA Code 5.1.2.2.5): === a painter of sufficient length and strength, **attached to the release device** complying with the requirements of paragraph 4.4.7.7 and placed at the forward end of the rescue boat; ==== • All officers on board to familiarize themselves with the above regulation and same is to be discussed with all crew on board during next safety training session. • 3NO - PIC of LSA is responsible for ensuring that painter is attached to the release device upon re-stowage after routine lowering of the rescue boat.
03103	**Bulwark and Guard rail (S-side) –** **1. Bulwark on upper deck (S-side, Fr.66) was cracked** **2. The lowest guard rails (S-side) were missing or broken partly** **Comments:** • Please inspect the bulwark and guard rails on board your vessel for any crack/ deformation, broken/missing guard rails and inform your Ship Manager if any repair is required. • Carry out maintenance on Bulwark and Guard rails as and when required.

Fleet Advisory 2022-13

RightShip Inspection at Port Klang on 06 Dec 2022

Reference RightShip Inspection Ship Questionnaire (RISQ) 2.0 – Sept. 2022

RISQ 4.39	**The strength confirmation letter for all hatch covers was issued by shipbuilders but not by class. The size of markings of helideck was not as required by ICS guide to helicopter/ship operations. The access ladder to no.5 hatch cover was not suitable.** **Comments:** • Vessel was in compliance with AMSA Marine Orders Part 57 with the strength confirmation letter issued by shipbuilder. However, RightShip Inspection Ship Questionnaire (RISQ) requires strength confirmation letter from Class. Please contact your Ship Manager for getting this letter. • Ensure helicopter landing/winching area (as applicable) is marked in accordance with the Guide to Helicopter/Ship operations 5th Edition: ➢ Marking a landing area – refer section 4.3.3 in conjunction with section 4.1.2 and figures 4.2 and 4.3 ➢ Marking a winching area – refer section 4.4.3 in conjunction with section 4.1.3 and figure 4.4 • The access from hatch cover to deck should be a fixed height inclined ladder with fixed handrails and front platform with operational load for two persons (150 KG). The steps and platforms should be made of non-slip materials.(AMSA Marine Orders Part 57) For sample photo of the ladder, refer HSE Procedures Manual, 4.14 Helicopter operation / section 3.
4.42	**Lifebuoys on bridge wings (P & S) lifeline were brittled due to UV damage.** **Comments:** • The renewal of grabline (lifeline) around the lifebuoys on bridge wings was in hand, accordingly two new lifebuoys were ordered by Master and same were supplied prior to inspection. However, above observation resulted due to delay in replacing the lifebuoys. • Check the condition of lifebuoys and attachments - grabline/lifeline/lights and markings during routine inspection and take corrective action as required.
5.12	**Fuel oil Centre tanks were fitted adjacent to water ballast tanks, however there were no procedures in place to sampled ballast water before pumping out.** **Comments:** • The fuel oil and adjacent ballast tanks are double bottom tanks, it is impractical to sample the ballast water prior to discharge due to location of the tanks and manholes. • The following procedure has been added in HSE Procedure manual/6.14 Ballast Water management/section 11 which please comply: ==Quote== **Ballast water check for oil contamination** The water ballast tanks adjacent to the fuel oil tanks shall be checked for oil contamination prior to discharge and during voyage. The result shall be entered in the port log prior discharge. It is impractical to sight the surface of the water or sample the water from the double bottom ballast tanks due to their location and construction. In this scenario until practical solution of sampling the water is established, the water ballast adjacent to fuel oil tanks shall be observed as following to establish that water is uncontaminated before discharge: • The adjacent ballast tanks shall be sounded using oil finding paste and by observing the rainbow or black oil around the sounding rod.

	• The adjacent fuel oil tanks shall be sounded using water finding paste Any oil contamination in the ballast tank or water ingress in the fuel tank shall be reported to Chief Officer and ballast from the contaminated tank shall not be discharged ashore. ==
8A.6	**There was no record available on board for approved test condition of loading computer made in the presence of class surveyor during renewal/ special survey in July 2022.** **Comments:** • Refer Cargo Manual/11.0 Stress and Stability/section 1 for loading computer accuracy check: == The accuracy of the loading computer shall be checked at each annual survey by applying at least one approved test loading condition (other than light ship) and endorsed by the class surveyor. At each renewal survey this checking for all approved loading conditions is to be done in the presence of the class surveyor. == • Print the accuracy check conditions as above in the presence of Class surveyor and get these endorsed by Class surveyor during annual and renewal surveys.
8A.16	**The vessel carried steel coils from 19 July to 21 Aug 2022(02 Ports loading and 03 ports discharging). The record of temperature and dew points of all holds and outside area was recorded same figures.** **Comments** • Voyage was from Korean ports to Indonesian ports. As vessel sailed from cold to warm region, no ventilation was required, refer Cargo Manual/12.1 Cargo Ventilation/ sections 4.1 and 4.2. • The wet and dry temperatures were measured inaccurately at the booby hatch entrance without entering inside the cargo holds resulting in the same figures. These temperatures are to be measured of the inside air of the cargo hold. • "The wet/dry temperatures and dew point of the cargo hold atmosphere is not required when Three Degree Rule is to be applied for deciding the ventilation unless there is a specific instruction from the charterer'' has been added in the Cargo Temperature and Ventilation Form 2.3.13.
9A.6	**The rubber washers for Quick acting cleats fitted on no.1 hatch covers were covered with paint. Total 06 pcs.** **Comments:** • The rubber washers, moving joints and pivots, rubber joints/packing, grease nipples, brake band drum etc are not to be painted over. Cover these fittings with the masking tape prior painting the area close to these.
10.1	**The Line Management plan did not include General Ship Particulars as required by INTERTANKO guidelines section 2 Part A.** **Comments:** • Our Line Management Plan is contained in the HSE Procedure Manual, Chapter 4.12/Section 9. Line Management Plan (Maintenance, Inspection, Wear Zone Management, Retirement and Renewal of Mooring Lines) • As per INTERTANKO guidelines section 2, Line Management Plan also requires Part A – General Ship Particulars which is being added for all ships in the shared folder under 9. Manual and Drawings/9.09.11 – Line Management plan.

10.6	**A headline passing from stbd side on forecastle deck and secured on bitts was brittle due to UV damage.** **Comments:** • Inspect the mooring lines on board for any damage and for retirement, refer Line Management Plan in HSE Procedure Manual/chapter 4.12 • UV radiation causes mooring lines' colour to fade and accelerates ageing. Prolonged exposure to the sun causes a rope to lose elasticity and become stiff. Rope abrades and rubs off easier when used. Fibre ropes should not be left exposed to sunlight whilst at sea; they should either be covered by a thick canvas material or stored in forward/aft stores.
10.19	**Anchor (S) was not tightly secured in the hawse pipe. Rectified during inspection.** **Comments:** • Starboard anchor not tightly secured in the hawse pipe. During the inspection, there was a gap of about 20cm from hawse pipe. Loose flukes may cause damage to the hull around hawse pipe mouth area. • The CNO shall inspect the anchor by looking overside and confirm that the anchor is properly housed and secured. Same is to be reported to Master on bridge.
10.20	**Anchor chains (P & S) bitter end were secured inside the chain locker.** **Comments:** • The chain locker was designed in this manner. • All bolts/nuts of the chain lockers are to be kept greased, a dedicated hammer and spanner is to be kept in readiness nearby for opening the chain locker cover so that bitter end can be released in event of an emergency immediately.
14.9	**The forward mast stays were covered with sheathed plastic. Rectified during the inspection.** **Comments:** • Refer Technical Procedure manual – Chapter 12 – TESTING AND EXAMINATION OF EQUIPMENT clearly specifies that wire ropes on board are not to be covered with plastic sheathing, as these covers do not allow for thorough inspections and lubrication of the wires. • Check wires fitted with gangway, lifeboat, mast stays etc and remove if any plastic sheathing is found around wires.
14.14	**The dryers located inside laundry on Captains deck were not free of lint build-up. Rectified during inspection.** **Comments:** • Refer HSE Procedure Manual – 4.22- Fire precautions specifies that dryers shall be kept free of lint as it is a fire hazard. • Post "Clean the filter after and before use" on the dryer. • Ensure compliance through weekly accommodation inspection. Inspection Form (5.2.1A) specifies that laundry equipment shall be kept free of lint.

14.18	**The ship hospital was used for storage of covid related PPE. Rectified during inspection.** **Comments:** • A large amount of Covid PPE was stored in the hospital instead of storing in a locker. • The Company's weekly accommodation form clearly specifies that hospital shall not be used as a storage space for stores/spares. This was not complied and resulted in this nonconformity • The 2NO is responsible for proper housekeeping of the hospital and for ensuring that the hospital is clean, hygienic and not used as a storage space for any stores/spares. • Master to cross check the house keeping of the hospital as part of weekly inspection of crew accommodation (Form 5.2.1 A) and ensure compliance.

Fleet Advisory 2021-01

PSC deficiencies at Constanta, Romania on 25th Nav 2021

S.No./ Code	Description
10129	The official logbook found with incomplete records. (e.g. incomplete details as such courses steered, speed and distance sailed, position fixing **during the ship's manoeuvrings**). Master instructed to keep proper records from now on. **<u>Comments:</u>** • The incomplete records of courses and speed as pointed out pertain to various courses and speeds which were steered during manoeuvring arrival/berthing when pilot was on board at port of inspection. As there are numerous courses and speeds during such period, it is customary recorded as ''various courses and speeds as per pilot's advice'' in the deck logbook. It is not practical to record frequent course/speed changes during manoeuvring within the limited time frame and space of the deck logbook. The extra recording during watch also distracts the OOW from his other essential duties when voyage records containing course/speed/position are available in the ECDIS/VDR/EU MRV & IMO data collection program. The engine movements are recorded in telegraph printer and various other records such as position at EOSP/POB/Breakwater & buoys transits etc are recorded in the bell book. • However, initial pages of the company deck logbook require some information from the bell book to be transferred to deck logbook and this information was missing for one watch duration from 'End of Sea Passage' to 'All lines fast.' • Please ensure that **the deck logbook entries are completed immediately after the watch as required by the instructions provided in the initial pages of the book. Refer column 23 with regard to the entries which are to be transferred from the bell book.** • Refer SOLAS-Chapter V – Reg. 28.1 === All ships engaged on international voyages shall keep on board a record of navigational activities and incidents which are of importance to safety of navigation and which must contain sufficient detail to restore a complete record of the voyage, taking into account the recommendations adopted by the Organization.* When such information is not maintained in the ship's log-book, it shall be maintained in another form approved by the Administration. ===
14503	Insufficient storage capacity available on board for the Plastic (Cat. A), Operational Waste (Cat. F), E-Waste (Cat. I) and Cargo Residues (Cat. K and J). **<u>Comments:</u>** • This deficiency resulted due to the disposal quantity of the garbage at last few shore reception facilities was more than the storing capacity provided on board. • The existing garbage compactors provided on board our fleet vessels will be replaced in due course with the better performing compactors which we have already tried on board our two vessels with good feedback. Compactor will bring down the volume of few categories of the garbage considerably. • Please plan garbage disposal ashore as and when vessel visits ports provided with the shore reception facilities. • Incinerate garbage as permissible.
10129	In the coastal waters there is no evidence that the ship's position was checked by an independent means of position fixing at required period. Master instructed to check the ship's position as per requirements from now on.

	Comments: • Company SMS requires verification of the GPS position accuracy in ECDIS at the interval not more than 12 minutes in confined waters, not more than 30 minutes during coastal navigation and not more than 2 hours during ocean passage. The topic is well covered in the company SMS. • All deck officers to familiarize with the Nautical Manual/Chapter 7B ECDIS / section 3.2 – Monitoring Accuracy of GNSS Position in ECDIS • The frequency and method of position verification is required by passage plan which should be complied. • Master shall ensure compliance on board • We will be carrying out at random checks on the GPS position verification on vessels by requiring submitting us the voyage ECDIS record/screenshots. Messages will be sent in this regard.
18315	Rotten vegetables were found in the provision room during the PSC inspection. **Comments:** • Rotten vegetables were the remnants of the last provision which was picked up a month before. The replenishment of the provisions at the port of inspection was due and was in process. • Master to brief Cooks to remove as and when any rotten vegetables is noticed. • Master to ensure the removal of any rotten vegetable by his weekly inspection checklist for crew accommodation, food and water.
01214	The endorsement by flag state for several ship's officers were missing. (the Certificate of receipt application were expired during the last voyage) **Comments:** • The missing endorsement by flag state were immediately sent by email attachment and same were verified by the PSCO. • Please inform Crewing if any crew certificate is approaching expiry date. • We will strengthen our monitoring of the crew certificates in office.
04109 / Fire drills	Rescue procedures not properly followed and the mask of one breathing apparatus was found malfunctioning. The two-way portable radiotelephone apparatus for fire-fighter's communication not used during exercise. **Comments:** • The drill scenario was to extinguish the fire in the galley where there was lack of oxygen and a person to rescue. • The drill as required was conducted. The crew members donned with fireman outfit and fire hose entered in the galley along with the stretcher for rescuing the person. Inspector was not satisfied with the stretcher carrying it in the galley as it delayed the entry to galley. • The clip from one of the fastening straps of SCBA face mask had come off during tightening. Ensure face mask is checked after donning. • The SCBA donning is to be practiced during trainings and drills. • Ensure a drill is conducted covering all points as required by SOLAS-III, Reg.19/3.5.2, refer OJT003 in SHEQ/Crew Training.
15150 / ISM	Deficiencies marked ISM are objective evidence of failure, or lack of effectiveness of the implementation of the ISM Code. The ship will be eligible for re-inspection after 3 months from the final date of the report. **Comments:** For your information, this deficiency was pointed out based on the nature and number of the deficiencies.

Above has been read and understood

CNO	2NO	3NO	X2NO/X3NO	D/C
2EO	3EO	4EO	EEO	E/C

Verified by: Master/CEO

Please file duly signed last page of fleet advisory 2024-01 in OneDrive/ 3.2.3 Training folder

IMPA Safety Campaign Results 2025

The IMPA Safety Campaign ran from 16 to 30 May 2025, during which they received over 5,200 reports from across multiple regions.

Following excerpt from Safety Campaign IMPA 2025 highlighting the non-compliances.

Please brief crew on following non-compliances to prevent same on board your vessel.

NON-COMPLIANCE BY TYPE OF DEFECT PILOT LADDER

Defect	Total	% of all pilot ladder defects
Incorrectly rigged retrieval line	234	35
Steps not horizontal	100	15
Pilot ladder not against the hull throughout its entire vertical length	56	8
Pilot ladder not within the midships half length of the ship	50	8
Incorrect step fitting	28	4
Sideropes of unsuitable material	17	3
Steps slippery or contaminated	16	2
Steps not evenly spaced	13	2
Climb on pilot ladder greater than 9m	10	2
Steps painted or varnished	5	1
Steps broken	14	2
Steps made of a material other than hardwood, plastic or rubber	2	0.3
Other	120	18

NON-COMPLIANCE BY TYPE OF DEFECT ACCESS TO THE DECK

Defect	Total	% of all access to the deck defects
Ladder not secured to strongpoints	40	23
No stanchions	37	21
Stanchions diameter to large/small	18	10
Ladder rigged from deckhead of shipside opening	8	5
No bulwark ladder	5	3
Ladder rigged forward of shipside platform	3	2
Other	65	37

NON-COMPLIANCE BY TYPE OF DEFECT
COMBINATION ARRANGEMENT

Defect	Total	% of all combination arrangement defects
Obstructions prevent safe use of trapdoor	2	1
Lower platform less than 5 metres above the sea	36	21
Pilot ladder not attached 1.5m above accommodation ladder	33	20
Lower platform of accommodation ladder not secured to ship side	28	17
Trapdoor not secure	4	2
Accommodation ladder too steep (>45 degrees)	19	11
Other	47	28

NON-COMPLIANCE BY TYPE OF DEFECT
SAFETY EQUIPMENT

Defect	Total	% of all safety equipment defects
No lifebuoy	40	21
No responsible officer	37	20
No heaving line provided	31	17
Lifebuoy does not have self-igniting light	17	9
Inadequate lighting at night	9	5
No communications with the bridge	5	3
Manropes not rigged through the top of stanchions	9	5
Manropes not rigged from strongpoints on the deck	12	7
Manropes requested but not provided	6	3
Manropes have knots	3	2
Manropes contaminated	3	2
Other	15	8

THE REPUBLIC OF LIBERIA
LIBERIA MARITIME AUTHORITY

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25 February 2026
Marine Advisory: 03/2026

Subject: ENGINE ROOM FIRE PREVENTION – COMPLIANCE WITH SAFETY REGULATIONS, MARINE NOTICES, AND MANDATORY ENGINE ROOM SAFETY STANDARDS

Ref:

(a) SOLAS Chapter II-2
(b) ISM Code – Sections 1.2.2, 7, 10
(c) International Code for Fire Safety Systems (FSS Code)
(d) MSC.1/Circ.1321- Guidelines for Measures to Prevent Fires in Engine-Rooms and Cargo Pump-Rooms
(e) Liberian Marine Notice FIR-001 – Fire-Protection Systems & Appliances
(f) Liberian Marine Notice INS-001 – Safety Inspections of Liberian Ships
(g) Liberian Marine Notice SAF-003 – Enclosed Space Safety & Procedures
(h) Marine Advisory 02/2026 – CO_2 Actuating Heads
(i) Marine Advisory 07/2024 – PSC Engine Room Fire Safety Focus

Dear Shipowners/Operators/Masters/Engine Department Personnel:

The purpose of this Marine Advisory is to reinforce the **mandatory compliance requirements** that govern Engine Room fire prevention, fire protection readiness, and safe machinery-space operations on Liberian-flagged vessels.

Recent Engine Room fire incidents indicate that non-compliance with established regulations, Marine Notices, and safety requirements remains a significant causal factor.

This Advisory summarizes:

- Required compliance elements
- Common areas of non-compliance
- Lessons learned through anonymized examples
- Mandatory actions to ensure conformity with Liberian and IMO standards

This Advisory does not address investigation procedures, evidence collection, or reporting steps beyond basic regulatory obligations.

Engine Room Fire Trends

Fires aboard Liberian-flagged vessels during 2025–2026 have been reviewed and the number of incidents in the Engine Room have been identified as follows:

- 46 fires in 2025, of which 21 involved the Engine Room
- 7 fires in 2026 (YTD), of which 4 involved the Engine Room

The pattern continues to show that heat sources combined with fuel/oil spray, incomplete ventilation shutdown, improper system readiness, and inadequate training remain core risks.

Marine Casualty Summaries -Background:

The Administration has reviewed recent Engine Room fire incidents with similar root causes and a summary of representative, anonymized cases provided below.

First Case – Engine Room Fire During Navigation Under Pilotage

A fire originated in the vicinity of auxiliary diesel generator machinery. Ventilation flaps, particularly upper-level closures, could not be fully secured, allowing continued oxygen supply and enabling rapid fire growth.
Crew members assigned to activate the CO_2 system were not fully familiar with the activation sequence, resulting in incomplete cylinder discharge.

Second Case – Auxiliary Engine Internal Mechanical Failure

A sudden mechanical failure caused fuel and lubricating oil to spray onto hot engine surfaces. Heavy smoke forced the evacuation of the Engine Room. The water mist system did not activate due to a lack of emergency power interconnection, resulting in significant structural and equipment damage.

Third Case – Fuel System Component Failure (Filter Cover Failure)

A diesel engine filter cover failed during operation, resulting in lubricating-oil spray onto the lubricating oil and exhaust components. The fire was extinguished, but the surrounding cabling, lights, and machinery sustained heat and smoke damage.

Fourth Case – High-Pressure Fuel Pipe Failure (Main Engine)

A high-pressure fuel line ruptured, projecting atomized fuel onto the exhaust manifold and causing immediate ignition. Ventilation was secured, and CO_2 was released, extinguishing the fire. Affected main-engine units and Engine Room systems require further engineering assessment and root-cause analysis.

Key Safety Failures Identified in four outlined cases

- Fuel/oil spray contacting uninsulated or inadequately shielded hot surfaces.

- Missing, damaged, oil-soaked, or deteriorated thermal insulation.
- Incomplete closing of Engine Room ventilation flaps and dampers.
- Crew unfamiliarity with CO_2 activation sequence, remote cabinet use, and pilot cylinder initiation.
- Water-mist systems are not fully functional on emergency power.
- Improper torque, workmanship deficiencies, or vibration leading to component failure.
- Emergency response without full PPE and BA sets.
- Inadequate maintenance records or incomplete testing logs.

Flag Administration Requirements and best practices

Review and Amend Safety Procedures

- Update Safety Management Systems (SMS) to reflect Engine Room fire trends and lessons learned.
- Ensure emergency shutdown, ventilation closure, and CO_2 activation procedures are clearly documented and practiced.
- Verify all fixed firefighting systems meet the requirements of Marine Notice FIR-001.

Enhance Crew Training

- Train crew on fuel system integrity, hot-surface shielding, emergency CO_2 activation, ventilation control, and water-mist operation and the relevant maintain records.
- Drill full-cycle Engine Room fire response, including blackout scenarios and smoke-filled conditions.
- Ensure engineering crew are trained, through actual scenarios, in escaping the engine room for familiarity with ship specific installations.

Improve Supervisory Oversight

- Require verification of critical machinery-space conditions (fuel lines, lagging, closures, firefighting equipment status) during routine rounds and before high-risk operations.
- Include fire-risk assessment in superintendent and internal audit checklists.

Fleet-Wide Awareness

- Issue internal fleet safety alerts summarizing deficiencies and corrections.
- Incorporate lessons learned into pre-joining briefings and recurrent training.

Required Actions to Prevent Recurrence

These fleet-wide actions are mandatory and align with Liberian regulatory requirements:

1. **Fuel System Integrity**

    - Inspect all high-pressure fuel pipes, clamps, and shielding for wear, corrosion, improper torque, or vibration marks.
    - Replace any suspect components immediately.

- Verify proper torqueing and alignment practices.

2. **Hot-Surface Prevention**

   - Restore or replace all missing or deteriorated insulation.
   - Remove oil-soaked lagging without delay.
   - Establish routine inspections for hot-surface exposure risks.

3. **Ventilation & Emergency Shutdowns**

   - Test and verify the full closure of **all** Engine Room flaps, dampers, skylights, and ventilation stops as per prescribed rules and Company procedures.
   - Document closure times and defects for corrective action.

4. **CO_2 System Readiness**

   - Verify all actuating heads are correctly configured for operational readiness.
   - Conduct regular CO_2 activation drills, including simulated remote cabinet and pilot cylinder activation.
   - Maintain complete testing and maintenance records as required by FIR-001.

5. **Water-Mist and Foam Systems**

   - Ensure water-mist systems operate in accordance with their approved design and power-supply arrangement.
   - Replace any restricted or unapproved firefighting media.
   - Perform functional and distribution testing. Following testing of water-mist, a blow through of the spray heads is recommended to clear any potential debris from forming clogs.

6. **PPE and Fire Party Readiness**

   - Ensure fire suits, BA sets, and radios are fully functional and readily available.
   - Require full PPE for all Engine Room fire responses and drills.

7. **Safety Inspections**

   - Comply fully with the safety inspections as per INS-001, including Engine Room fire-risk checks.
   - Where crew are permitted to perform inspections and maintenance per FIR-001, ensure they have the proper training and are provided with the necessary maker's instructions.

The Administration reminds all operators that robust Engine Room fire prevention is a mandatory requirement and a critical safety obligation.

For more information, please contact the Investigations Department at investigations@liscr.com.

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FAIRMONT SHIPPING SINGAPORE
TAMAR SHIP MANAGEMENT

Vessel information

Vessel name	IMO No.	Management company
ANGELIC ANNA	9422809	Fairmont Ship Management Pte. Ltd.

Product information

Product label	Brand (Maker)	Product type (Model)	Serial no.
Pilot ladder port	Shipyard	Pilot Ladder	
Builder (Manufacturer)	**Operating system**	**Location**	**Running hours**
Shipyard	Deck machinery	Deck	

Activity information

Activity	Job ID	Class required	Class ID
Monthly Check	374287	No	
Critical product	**Critical activity**	**Risk level**	**Date done**
No	No	Not defined	
Reason for activity	**Product condition**	**Time since last job**	

Work instruction

PILOT LADDER AND ARRANGEMENTS MAINTENANCE

REFERENCE: SOLAS CH V, REG 23 and Resolution A.1045(27)

1. Each pilot ladder clearly marked as “For Marine Transfers only”	✓	✗	⊘
2. Check if pilot ladder is clean and properly stowed in a dry area away from chemicals and contaminants . Cosmetic appearance to be satisfactory and ladder is to be kept clean of grease, oil, or cargo residue.	✓	✗	⊘
3. Pilot ladder to be stowed in a store when not in use to protect from exposure to the marine environment.	✓	✗	⊘
4. Check condition of side ropes internally and externally for signs of deterioration, undue wear or damage. Refer HSE manual 4.34 - NATURAL FIBRE ROPES AND ROPE LADDER on how to inspect fibre ropes.	✓	✗	⊘
5. Check condition of wooden and rubber steps for cracks ,splits and distortion. Steps should not be painted, oily, dirty or slippery.	✓	✗	⊘
6. Check that steps are horizontal / parallel and the last four steps made of rubber.	✓	✗	⊘
7. Check condition of spreaders for cracks and distortion.	✓	✗	⊘
8. Check interval between any spreader step and the next does not exceed nine steps.	✓	✗	⊘
9. Check if all chocks/wedges are in position and tightly secured at top and bottom. Check condition of whippings and ensure no poorly whipped rope ends or untidy splices	✓	✗	⊘
10. Check condition of securing arrangements (strong point like pad eyes, deck fittings , thimbles and shackles) for corrosion , cracks , damages etc and grease shackles. Check if shackle pins are screwed firmly into the shackle body .	✓	✗	⊘
11. Check condition of stanchions for defects , damages etc.	✓	✗	⊘
12. Check if vessel provided with magnets for securing pilot ladder to ship side and magnets are in working condition.	✓	✗	⊘
13. Check if pilot ladder is marked at one meter throughout the length of the ladder in order to facilitate the rigging of the ladder to the required height and is clearly visible. Re-mark if necessary.	✓	✗	⊘
14. If pilot ladder is more than 24 months from date of manufacture or if not in good condition, replace the ladder	✓	✗	⊘
15. Check condition of manropes internally and externally for signs of deterioration, undue wear or damage. If manrope is more than 12 months from the date of manufacture or if not in good condition, replace the manrope (Any damage to or degradation of manrope or ladder should be carefully evaluated. If deemed necessary, or if any doubt exists, rope and ladder should be removed from service and replaced).	✓	✗	⊘
16. Check condition of ropes used for rolling hitch knot to secure the pilot ladder to strong point and replace them if required. (Associated ropes used to secure the pilot ladder to a strong point on deck must be of sufficient strength, construction and certified. These ropes should be renewed no later than 12 months from the date of manufacture or if not in good condition and records to be maintained)	✓	✗	⊘
17. Check manufacturer’s certificate is available on board and is in compliance with IMO Resolution A.1045 (27).	✓	✗	⊘
18. Check if certificate is available for manropes and associated ropes used for securing.	✓	✗	⊘
19. Check if man ropes and side ropes dimensions are in accordance with REQUIRED BOARDING ARRANGEMENTS FOR PILOT poster displayed on bridge	✓	✗	⊘
20. Check if certificate is marked with the date each pilot ladder and manrope and associated ropes is placed into service	✓	✗	⊘
21. Check if serial number on the name plate matches with serial number on manufacturer’s certificate.	✓	✗	⊘

22. Check if the trip hazards in the pilot transfer area are highlighted with contrasting paint	✓	✗	⊘
23. Enter the result of any repairs effected (if carried out)	✓	✗	⊘

Footer

Form ID
7100

Revision
2

Entered by
Rajesh Sharma

Rank and name/signature of responsible officer

Approved by

Remark

RioTinto HSE Notification RTM/2026/003

Title: **Mooring Winches and Windlasses Condition Checks**

Date:	28/02/2026	Contact person:	Marine Safety & Vetting
Type of notification:	HSE Notification	Contact number (or email)	Vetting@riotinto.com
Category	Human / Equipment / Procedure	Type of Alert	Shared learning from incidents

Distribution of notice to: Rio Tinto Marine Associates

Details:

Industry incidents, P&I alerts, & port authority inspections continue to identify cases of degraded mooring winch & windlass performance. Findings include worn brake linings, pitted brake surfaces, incorrect brake support (clearance) bolt, & deficiencies in brake rendering capacity. Inadequate brake performance only becomes apparent under peak loads, increasing the risk of mooring line failure, vessel movement alongside, & serious injury. Effective pre-arrival checks, correct brake adjustment, & adherence to recognised mooring equipment guidance are essential safety barriers.

Key Points:

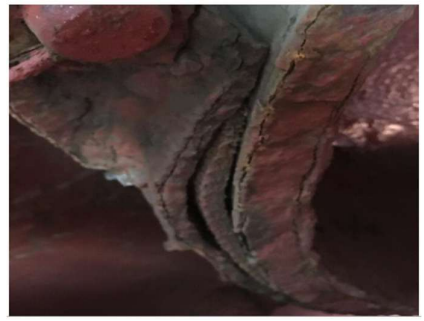
- Mooring equipment deficiencies are often latent and load-dependent
- Brake holding capacity alone can mask loss of safe load behaviour
- Mooring line failure risk increases when the system response is not understood
- PMS expectations differ for manual, electric, and hydraulic brakes
- Changes in rope type and equipment design can alter mooring load dynamics

Causal Factors / Root Causes:

- Worn, glazed, or contaminated brake linings
- Excessive brake band clearance at the support bolt
- Incorrect brake adjustment or manual over-tightening
- Brake rendering tests not conducted or recorded
- PMS not addressing brake wear based on usage
- Degraded motor condition affecting smooth paying/heaving
- HMPE rope characteristics and non-split winch design not addressed in MSMP / LMP

Prevention:

- Inspect brake bands, linings, and drums for wear and contamination
- Verify brake band clearance against OEM limits
- Conduct brake rendering tests at defined intervals
- Align testing with OEM instructions and OCIMF guidance
- Ensure PMS addresses brake wear based on usage
- Inspect motors for condition affecting controlled paying/heaving
- Review the suitability of the winch design and controls for HMPE rope use
- Address equipment and operational limitations in MSMP / LMP
- Record pre-arrival functional checks and adjustments



Poor Condition of Band Plate

Correct Brake Mark

Next Steps

Review ship-specific mooring & anchoring procedures & PMS to confirm adequate coverage of pre-arrival brake & motor condition checks, including brake band wear, clearance bolt adjustment, brake rendering tests, & crew awareness of correct brake rendering behaviour.
For further Information: https://www.ocimf.org/publications/books/mooring-equipment-guidelines-meg4 ; https://www.pilbaraports.com.au/ports/port-of-port-hedland/safety-and-security/marine-safety-bulletins ; https://141142183.hs-sites-eu1.com/hubfs/Safety%20Insights%20-%20Mooring%20Safety.pdf?hsCtaAttrib=253502814439
Please reach out to vetting@riotinto.com in case of any feedback.

RioTinto HSE Notification RTM/2026/004

Title: Harassment & Bullying in the Maritime Concept

Date:	20/02/2026	Contact person:	Marine Safety & Vetting
Type of notification:	HSE Notification	Contact number (or email)	Vetting@riotinto.com
Category	Human / Equipment / Procedure	Type of Alert	Good Value Share

Distribution of notice to: Rio Tinto Marine Associates

Details:

Harassment and bullying remain serious safety risks in the maritime industry due to isolation at sea, confined living conditions, rigid hierarchies, and multicultural crews. Such behaviour—ranging from verbal abuse and intimidation to discrimination and misuse of authority—often goes unreported due to fear of retaliation, particularly among junior crew. Beyond personal harm, bullying undermines trust, morale, and safety, as intimidated seafarers may hesitate to report hazards or challenge unsafe practices.

To address this, STCW Code amendments effective 01st January 2026 mandate training for ship staff, which includes, but is not limited to, the following points:

- Competence to prevent violence and harassment at sea
- Identify, intervene, and report incidents in line with STCW 2026 behavioural competencies
- Apply trauma-informed responses, verified through training and onboarding
- Reinforce that harassment and bullying are safety-critical risks
- Application of basic trauma-informed responses.
- Support diversity, equity, and inclusion by ensuring a respectful and safe shipboard environment.

Prevention:

Clearly define SMS expectations and articulate what ***good looks like***, using proven practices from a mature management programme.

- Strengthening controls using incidents, industry insight, and seafarer feedback
- Reinforce respectful leadership across ranks and genders
- Ensure simple, confidential and communicated frequently to overcome hesitancy in raising concerns.
- Recognize that vulnerable groups may face a higher harassment risk and that psychological safety is essential for sound awareness and decision-making onboard.

Image Courtesy: 2024 Guidance on Eliminating Shipboard Harassment and Bullying from ICS – By Maritime Cyprus

Next Steps

Please refer to the following websites for additional information:

- https://www.itfglobal.org/sites/default/files/resources-files/harassment-guide.pdf
- https://www.steamshipmutual.com/sites/default/files/medialibrary/files/MHSS%20Bullying_0.pdf

Please reach out to vetting@riotinto.com in case of any feedback.

SN	Deficiency Group	Deficiency Code		Action Code	Deficiencies	Detention Port/Country
1	Alarms	02139	Water ingress alarm panel	30	Water ingress alarm panel in fault. Fore peak tank in alarm meanwhile FPT is empty.	Dunkirk, France
		08107	Machinery controls alarm	17	The engine room alarm beacon located in the purifier room was observed to have missing beacon covers which show what the alarm is related to (Abandon ship/fire/etc).	Immingham/UK
		08108	Fuel oil module alarm	30	The fuel oil module was found with the following active alarms: filter clogged, high temperature, and high viscosity. The system could not be restored to an alarm-free condition.	Quebec City, Canada
2	Emergency Systems	04102	Emergency fire pump	30	Emergency fire pump not readily available. Defective air extracting system (repetitive deficiency from last PSC-Vancouver 21/11/2024).	Dunkirk, France
3	Fire Safety	07101	Structural integrity	17	There are AC units installed on the port and starboard bridge and in the officers and crew mess rooms. The bulkhead penetrations do not match the structural fire protection of the bulkhead they pass through.	Immingham/UK
		07105	Fire Door	17	A number of fire doors indicated as self closing where observed to be not self closing at the time of the inspection. These include bridge toilet, bridge to stairway, Dry store & port side main deck.	Immingham/UK
		07106	Cargo hold fire detection system	17	At the time of the inspection it was observed that the fire detection system for the cargo spaces located in the fire locker, had all the sampling pipes disconnected from the detection unit.	Immingham/UK
		07110	Firefighting equipment and appliances	17	One fireman breathing apparatus found with air leakage during the fire drill.	Dunkirk, France
		07110	Fire Hose condition	30	Some fire hoses found cracked and holed during the fire drill (repetitive deficiency from last PSC - Vancouver 21/11/2024).	Dunkirk, France
		07114	Generator Thermal insulation	17	At the time of the inspection it was observed that the turbo charger outlets on generators 1, 2 & 3 had missing and damaged exhaust lagging leading to exposed hot surfaces exceeding the SOLAS allowable limit.	Immingham/UK
		07114	Remote means of conrol	30	MDO settling tank 15&16 quick closing valves inoperative.	Dunkirk, France
		07117	Oil leaking	17	MDO leakage on emergency generator gauge level.	Dunkirk, France
		07125	Crew Performance in Fire Drill	30	Crew fire drill was unsuccessful. Equipment not donned correctly lack of command and control. Persons entered the fore area without BA. Crew walking with lifejackets prior to commencement of the drill. Ventilation flaps not closed.	Immingham/UK
		07125	Crew Performance in Fire Drill	17	Fire drill not satisfactory. Evidence of lack of crew familiarity.	Dunkirk, France
4	ISM	15150	Safety Management System	30	Safety management audit by the Administration is required before departure of the ship. Deficiency(s) marked ISM is (are) objective evidence of a serious failure, or lack of effectiveness, of implementation of the ISM Code.	Immingham/UK
		15150	Safety Management System	30	Safety management audit by the Administration is required before departure of the ship. Deficiency(s) marked ISM is (are) objective evidence of a serious failure, or lack of effectiveness, of implementation of the ISM Code.	Dunkirk, France
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SN	Deficiency Group	Deficiency Code		Action Code	Deficiencies	Detention Port/Country
		15150	Safety Management System	30	Safety management audit by the Administration is required before departure of the ship. Deficiency(s) marked ISM is (are) objective evidence of a serious failure, or lack of effectiveness, of implementation of the ISM Code.	Quebec City, Canada
5	Labour Condition-Accommodation	18302	Sanitary Facilities	17	The tap in the engine room toilet does not function. General condition poor broken tiles.	Immingham/UK
		18302	Sanitary Facilities	30	Ships engine crew shower room totally out of service missing shower water (repetitive deficiency from last PSC-Vancouver 21/11/2024).	Dunkirk, France
		18313	Food personal hygiene	17	Amounts of rotten and mouldy food found under the counters in the galley. Broken glass under the counters in the crew pantry. General condition of cleanliness is poor. Cloth used for cleaning black with dirt.	Immingham/UK
		18313	Living Condition	30	Live infestation of cockroaches and various insects observed in the galley and food preparation areas.	Quebec City, Canada
		18317	Food personal hygiene	17	At the time of the inspection the crew were unable to provide evidence of provision store temperature logs been taken.	Immingham/UK
		18328	Record keeping of Inspection	99	Records of accommodation inspection do not reflect actual condition. Master to ensure from 22/01/2026 accurate records are kept.	Immingham/UK
		18427	Crew cabin condition	17	The Motorman 5 crew cabin is full of ships stores. This is a cabin and has not been designated a store room as per ships plan.	Immingham/UK
6	Labour Condition-Health Protection	01307	Rest Hours	99	A number of officers have breached the minimum rest requirements due to operational requirements. Master instructed that officers are to have minimum hours and plan accordingly for routine vessel operations.	Immingham/UK
		18312	Galley, handlingroom (maintenance)	17	The refrigerated meat provision room onboard was observed to have a significant accumulation of ice on the deck, posing both a food safety risk and a risk of accident.	Immingham/UK
		18321	Aircon compressor	17	The air conditioning compressor was found none functional and no cooling is possible for the ventilation system.	Immingham/UK
		18408	Electrical cables protection	17	A number of outside lights onboard was observed to have electrical cables showing exposed inner cores of the cable at the gland entry. These include ''B'' deck STBD light, FWD forecastle light & Aft deck light around accommodation. Additionally the Air conditioning outdoor unit on the port side of the bridge deck had the electrical cover missing exposing the electrical connections, Within the air conditioning room the thermostatic cover on the AC handling unit was missing exposing the electrical connections. In addition, it was observed that unterminated cables where on the bridge monkey island and down the STBD side of the cargo area near the gangway.	Immingham/UK
		18408	Electrical cables protection	17	The air conditioning in the officers and crew mess has has the main breaker fitted directly onto the bulkhead leaving exposed wires. Risk of electrical shock.	Immingham/UK
		18409	Unsafe Condition of ladder	17	A rotten ladder is present on the portside used for reading drafts. When asked the crew explained that this was used for climbing down. Observed to be anuncertified ladder that is poorly secured and in poor condition.	Immingham/UK
		18410	Gas Instruments	17	No means were available onboard to carry out bump testing of the portable gas detector.	Quebec City, Canada

SN	Deficiency Group	Deficiency Code		Action Code	Deficiencies	Detention Port/Country
		18414	Protection machines/parts	17	No belt guard on the belts on the emergency generator- risk of injury due to auto start.	Immingham/UK
		18420	Cleanliness of E/R	17	E/R deck 1& steering gear room floor found slippery.	Dunkirk, France
		18425	Accommodation ladder cable condition	17	The STBD side accommodation gangway limit switch was observed to have the cable pulled out of the limit switch gland, exposing inner cores of the electrical cable. The operation of the limit switch was not possible to be tested.	Immingham/UK
		18427	Safety data sheet	17	Safety data sheets (MSDS) where not available for the chemicals sampled within the steering gear compartment.	Immingham/UK
		18427	Accident prevention	17	Deck grating on the main deck between holds in not secured in places and damaged in places. Corrosion and degradation apparent.	Immingham/UK
		18428	Readiness of eye wash	17	The eye wash in the paint store forward and the steering compartment were open used.	Immingham/UK
		18428	Safety latch of lifting appliances	17	The following hooks safety latches are broken or not operating as required. Life boat recovery hooks. Deck cranes, stores cranes port and starboard.	Immingham/UK
		18428	Accident prevention	17	There is heavy spare parts stored on the aft mooring deck including hydraulic rams that are inadequately secured.	Immingham/UK
		18499	Improper storage of materials in accommodation	17	Significant quantities of combustible cardboard boxes and stores where observed to be stored in the machinery space office located in the accommodation. The space is not designated as a store on the fire plan and therefore doesn't have the relevant structural fire protection/detection or suppression needed for such a significant quantity of combustible material. Additionally the storage of the boxes was particularly hazardous posing a risk to anyone entering the space.	Immingham/UK
7	Life Saving Appliance	11129	Rescue boat engine	30	During functional testing of the rescue boat engine, the ahead/astern throttle control was found inoperative.	Quebec City, Canada
		18427	Liferaft launching procedure	17	LSA signage adjacent to port and STBD life rafts do not detail the correct information for the life raft launching procedures required for the rafts onboard.	Immingham/UK
8	MARPOL -Ballast Water	14811	Ballast Water Management System	17	Ballast pump No.1 found with water leakage.	Dunkirk, France
		14899	Other BWM	17	Stbd WBT 5 valve seriously damaged.	Dunkirk, France
9	Navigation Safety	10105	Magnetic Compass	17	The 220volt light for the magnetic compass does not work.	Immingham/UK
		10109	NUC Light	17	NUC lower light not working.	Immingham/UK
		10109	Bridge main Whistle	17	At the time of the inspection it was observed that the ships main whistle was disconnected for the normal air source. Additionally the bridge penetration pipe for the remote whistle operation cable was corroded and sheeted, preventing the movement of the cable and therefore the bridge operation of the whistle.	Immingham/UK
		10109	Stern light	17	Main stern light inoperative.	Dunkirk, France
		10114	VDR	17	The VDR acoustic beacon battery was found not connected and without wiring.	Immingham/UK
		10114	VDR microphones	30	VDR microphones failed since 28/01/2026, No action taken by the crew.	Dunkirk, France
		10117	Echo Sounder	30	Echo sounder malfunctionning. Wrong Depth indication.	Dunkirk, France
		10128	Bridge wiper	30	Bridge wipers inoperative.	Dunkirk, France

SN	Deficiency Group	Deficiency Code		Action Code	Deficiencies	Detention Port/Country
10	Propulsion and Auxiliary Machinery	13103	Gauges,thermometer s, etc	17	At the time of the inspection a number of gauges were observed to be broken/damaged or non-operational. These gauges include the engine room fire pump, Both GS pumps in the engine room and the incinerator supply line. Additionally, it was observed that the speed indication at the local control point for the main engine was loose and insecure in the panel. At the time of the inspection the alternator jacket water temperature controller was also observed to be defective.	Immingham/UK
		13103	Gauges,thermometers, etc	17	Several gauges & thermometers not readable in E/R(purifier room, deck 1 tank top..)	Dunkirk, France
11	Structural Condition	02107	Fuel oil/Lub oil tank opening	17	The means of ascertaining the amount of oil/fuel contained in the emergency generator fuel tank was observed to be held open. Additionally the engine lub storage tanks level gauges where observed to be held open.	Immingham/UK
		02108	Emergency generator low insulation alarm	17	Upon testing the emergency generator on load it was observed that the 440 volt low insulation alarm indication was flashing on the emergency switchboard.	Immingham/UK
		02111	Structure corrosion	30	Corossion & wastage on deck steel plates thinned and holed between bosun store and cargo hold (repetitive deficiency from last PSC - Vancouver 21/11/2024).	Dunkirk, France
		02140	Towing and mooring equipment	17	Aft mooring hydraulic unit in steering gear room found with lub oil leakage.	Dunkirk, France
		13104	Bilge alarm	30	Fwd portside bilge alarm inoperative.	Dunkirk, France
12	Water/weathertight Condition	03108	Sounding pipe cap	17	The fore peak tank sounding pipe has no means of weathertight closure.	Immingham/UK
		03110	Manhole cover	17	Man hole covers for Ballast tank NO 2 TST S, 2 x covers missing bolts.	Immingham/UK
		02101	Closing device	17	The port side bridge wing access door was found difficult to operate and could not be readily closed and secured.	Quebec City, Canada
		03104	Structure damage	30	Hatch cover clamping device rubber pads were found severely damaged.	Quebec City, Canada

Joint Maritime Information Center

Update 004 to JMIC Advisory Note:

01 - 04 March 2026

Regional Tension - Impact on Maritime Security

Area of Concern:

Middle East Maritime Security Posture

JMIC# 001-26

Regional Threat Level: CRITICAL

1. Regional Risk Level Assessment

Overall Maritime Risk Level: 🔴 CRITICAL

JMIC Threat Scale: 🟢 Low | 🟡 Moderate | 🟠 Substantial | 🟠 Severe | 🔴 Critical

Threat remains CRITICAL (indicates an attack is almost certain)

Confirmed missile and drone attacks continue against commercial vessels. Over the past 24-hours this included vessels within the Strait of Hormuz, Gulf of Oman TTW and approaches.

Recent incidents have reported unexploded ordinance found on vessels. In accordance with BMP-MS, the wellbeing of seafarers must be prioritised. If a ship is attacked by a UAV, missile or similar projectile it is possible the munition may not explode leaving Unexploded Ordnance (UXO). Please refer to BMP-MS page 44 for post-incident procedures.

While no formal legal closure of the Strait of Hormuz (SoH) has been declared, the operational environment reflects active kinetic hazard conditions in this area.

2. Industry Coordination & Maritime Security Planning Update

JMIC acknowledges the recent public statements from U.S. leadership on 03 March indicates intent to enhance maritime security support for commercial shipping operating within the Arabian Gulf and adjacent waters.

JMIC appreciates the continued professionalism and patience of maritime operators during this period of critical threat conditions.

3. Confirmed/known Vessel Incidents – Approximately Past 24 Hours

Incident	Vessel Name / Type	Status During Attack	Damage	Location
009-26	PELAGIA / Bulk	Drifting	No	Int'l Waters (Gulf of Oman)

010-26	GOLD OAK / Bulk	Anchorage	Yes - minimal	Fujairah TTW
011-26	LIBRA TRADER / Tanker	Transit	Yes - minimal	10NM off UAE
012-26	SAFEEN PRESTIGE/ Container	Transit	Yes	SoH Eastbound

All crew safe and no environmental concerns have been identified

JMIC has not yet identified any definitive operational or political associations that would render non-U.S. or Israeli vessels as likely targets for attack. These incidents underscore the ongoing risks posed by stand-off missile and drone activity in the waters of the Gulf of Oman, the Strait of Hormuz, and adjacent approaches. Currently, there are no verified reports of sea mine deployment or detonation.

4. Confirmed/known Marine infrastructure attacks – Approximately Past 24 Hours

No confirmed large-scale Iranian missile attacks against Arabian Gulf or Gulf of Oman port infrastructure have been independently verified within the last 24 hours. Recent activity has focused on isolated vessel impacts rather than sustained port-targeting operations.

5. Port & Anchorage Congestion Risk (NO CHANGE)

A higher concentration of vessels is anticipated near UAE coastal ports, Omani approaches, and Strait of Hormuz anchorages as operators postpone discretionary transits until further guidance is provided. The congestion is further complicated by EMI, AIS spoofing and jamming. Increased congestion in these areas may contribute to secondary navigational hazards, such as limited maneuvering space, anchor dragging, and heightened risk of collision. It is recommended that bridge teams employ robust resource management practices and maintain disciplined VHF/AIS communication protocols.

U.S. and Israeli-affiliated or flagged vessels are advised to minimize time spent pier-side or at anchor within high-risk zones to reduce vulnerability of targeting. Maintaining movement and avoiding predictable patterns remains critical for mitigating the risk of targeted strikes or collateral damage.

6. Strait of Hormuz Traffic Assessment

Historical Average Daily Transit: ~138 vessels per 24-hour period.

Recent AIS review indicates transits have reduced to single-digit levels, with only one confirmed commercial transit observed in the past 24 hours.

While this represents a near-total temporary pause in routine commercial traffic, no formal legal closure of the Strait has been declared. The reduction likely reflects a combination of risk avoidance, insurance gating factors, and operational uncertainty rather than a declared blockade. Continued monitoring is required to determine whether traffic resumes in a structured manner or remains functionally constrained.

VESSELS TRANSITS COMPARISON 28 FEB AND MARCH 3, 2026

CARGO VESSELS TRANSITS COMPARISON 28 FEB AND MARCH 2026

Date	28 Feb	1 Mar	2 Mar	3 Mar	4 Mar	5 Mar	6 Mar
SoH E	55	12	5	1			
SoH W	43	6	2	0			
SoH Total	**98**	**18**	**7**	**1**			
BAM NW	7	10	11	19			
BAM SE	9	7	6	17			
BAM Total	**16**	**17**	**17**	**36**			

Source: S&P. Data based on cargo carrying vessels 1000 GT and above transmitting AIS

TANKERS (ALL TYPES) VESSELS TRANSITS COMPARISON 28 FEB AND MARCH 2026

Date	28 Feb	1 Mar	2 Mar	3 Mar	4 Mar	5 Mar	6 Mar
SoH E	30	2	3	0			
SoH W	20	1	0	0			
SoH Total	**50**	**3**	**3**	**0**			
BAM NW	4	2	6	7			
BAM SE	7	2	2	6			
BAM Total	**11**	**4**	**8**	**13**			

Source: S&P. Data based on cargo carrying vessels 1000 GT and above transmitting AIS

7. GNSS / GPS Interference Environment (NO CHANGE)

Significant GNSS interference continues across the Strait of Hormuz approaches, Gulf of Oman, and the Arabian Gulf. Observed impacts include positional offsets, AIS anomalies, and intermittent signal degradation. In the Eastern Mediterranean, experience heightened frequent electronic interference around naval activity. Following the commencement of regional security operations on February 28, 2026, mariners should expect a surge in GNSS/GPS inconsistencies.

Under current threat, the added navigational challenges due to congestion and degraded positional integrity acts as a risk amplifier, increasing probability of navigational incident or miscalculation.

Recommended Measures:

• Cross-check GPS position with radar ranges and visual bearings.

• Validate ECDIS with secondary navigation systems.

• Increase bridge manning in constrained waters.

• Treat anomalous VHF communications cautiously and verify identity.

• Include offshore activities and port operations in all threat and risk assessments.

8. War Risk Insurance Status – Market Escalation (NO CHANGE)

The Joint War Committee (JWLA-033) expansion of Listed Areas across the Arabian Gulf, Gulf of Oman, and adjacent waters is expected to trigger voyage declarations and Additional Premium (AP) negotiations under most Hull War policies. Market conditions indicate tightening underwriting posture and elevated AP requirements for Gulf and Iran-adjacent waters.

While no blanket cancellation of cover has been formally declared, insurance terms may act as a practical gating factor for transit decisions independent of any legal navigational closure.

Current insurance market posture is consistent with a sustained 🔴 CRITICAL maritime threat environment.

9. Outlook (24–48 Hours)

The regional maritime threat environment remains assessed at **JMIC Threat Level: CRITICAL**. Current reporting reflects sustained hostile operating conditions consistent with this designation rather than a new elevation in risk. Active kinetic hazards including missiles, UAV, and stand-off strike capabilities remain across the Strait of Hormuz, Gulf of Oman, Arabian Gulf and adjacent approaches.

GNSS/GPS interference continues to degrade positional reliability, acting as a compounding navigational risk amplifier in congested transit corridors.

No recognized authority has declared a formal legal closure of the Strait of Hormuz. However, operational conditions reflect a restricted and highly sensitive transit environment characterized by:

- Continued military presence and posturing
- Intermittent VHF interference and unofficial transit advisories
- Reduced commercial traffic volumes
- Insurance market tightening and war-risk gating factors
- The aerial threat from missiles and drones is expected to remain elevated
- The risk of collateral damage remains high

At present, there are no confirmed indicators of de-escalation or normalization of regional security conditions. Mining activity remains a key escalation variable, though no confirmed deployment has been reported.

All merchant vessels, regardless of flag or affiliation, should continue to operate under the assumption of sustained high-end threat exposure.

Operational decision-making should focus on exposure minimization, navigational redundancy, and real-time intelligence validation rather than expectations of short-term stabilization.

Shipping companies are strongly advised to conduct real-time risk assessments, review emergency protocols, and maintain constant communication with UKMTO and MSCIO if needed.

A. Strait of Hormuz and Arabian Gulf

The maritime security situation in the Strait of Hormuz **continues to reflect** critical kinetic risk following sustained military operations in the area over the last 24 hours. Iranian naval units continue VHF hails, claiming to enforce "temporary security zones" that lack official NAVAREA recognition. Mariners continue to report severe GNSS/GPS spoofing that significantly impacts bridge navigation and AIS reliability. The risk of misidentification remains critical as naval operations are conducted in proximity to commercial lanes. Several major carriers continue to suspend or defer transits, and vessels remaining in the area are urged to maximize distance from all military assets.

B. Strait of Bab-el-Mandeb

The situation remains substantial due to regional conflicts, with risk of Houthi actions in the Red Sea / Bab-el-Mandeb; however, no vessel attacks have been identified. Houthi forces have issued renewed threats against vessels perceived to have regional or Western affiliations, driving down commercial transits. Electronic interference is now being reported as a persistent factor, complicating navigation through the narrow chokepoints. Strict adherence to BMP-MS and use of the Maritime Security Transit Corridor (MSTC) is **strongly advised** for any vessel attempting transit, particularly if operating under naval escort.

C. Gulf of Oman and the Arabian Sea

The security environment in the Gulf of Oman and the Arabian Sea continues to demonstrate a high level of operational risk, with new reports of unidentified fast attack craft (FAC) shadowing commercial tankers. Sophisticated GPS spoofing is persistent near the Iranian coast. The threat environment **continues to reflect** direct kinetic risk to commercial vessels, including projectile/UAV incidents. Multiple vessels have sustained damage from unknown projectiles off the coast of Oman; however, no environmental risks have been identified. Beyond the kinetic threat, the risk of "limpet mine" or sea-drone attacks in regional terminals remains a significant concern for the energy sector. Limpet-style underwater attacks remain a historical risk pattern. International naval forces patrols are present, and vessels are advised to maintain a 24-hour visual and radar watch.

D. Eastern Mediterranean Sea

The Eastern Mediterranean, spanning from the northern entrance of the Suez Canal to the Lebanese coast and around Cyprus, is experiencing heightened naval presence and electronic warfare activity. Significant GPS jamming and spoofing have been reported in the vicinity of Cyprus and the Levant, affecting safe navigation and port approaches. Vessels operating near the Lebanese and Israeli coastlines face an elevated risk of collateral damage due to potential cross-border kinetic exchanges and drone activity. Increased naval presence from NATO and regional task forces is likely; however, mariners should exercise extreme caution and avoid loitering near military exclusion zones. Several ports and operators are operating under heightened ISPS measures and enhanced access control. This follows a confirmed UAV strike on the British sovereign base at Akrotiri, Cyprus. Additionally, the IDF Lebanon activity

remains land-focused with air operations over Lebanon, but this has not translated into commercial maritime targeting in the Med. An increase in naval presence can be expected.

There are no verified reports of:

- Missile strikes on Eastern Mediterranean ports
- Commercial vessel UAV strikes in Med waters
- Mining or chokepoint denial activity

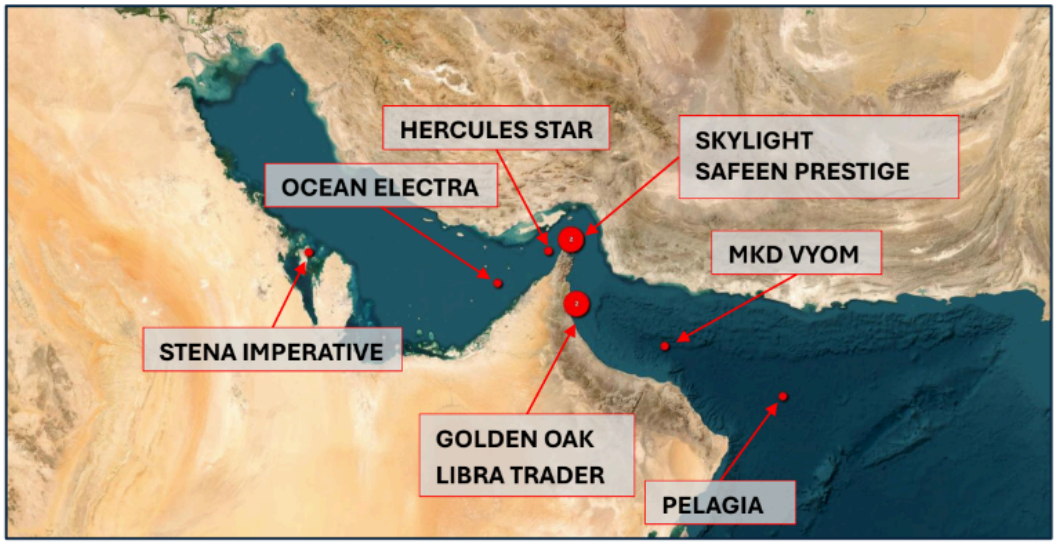
JMIC Regional Threat Levels

Threat Level	Definition
Low	An attack is highly unlikely
Moderate	An attack is possible but not likely
Substantial	An attack is a strong possibility
Severe	An attack is highly likely
Critical	An attack is almost certain

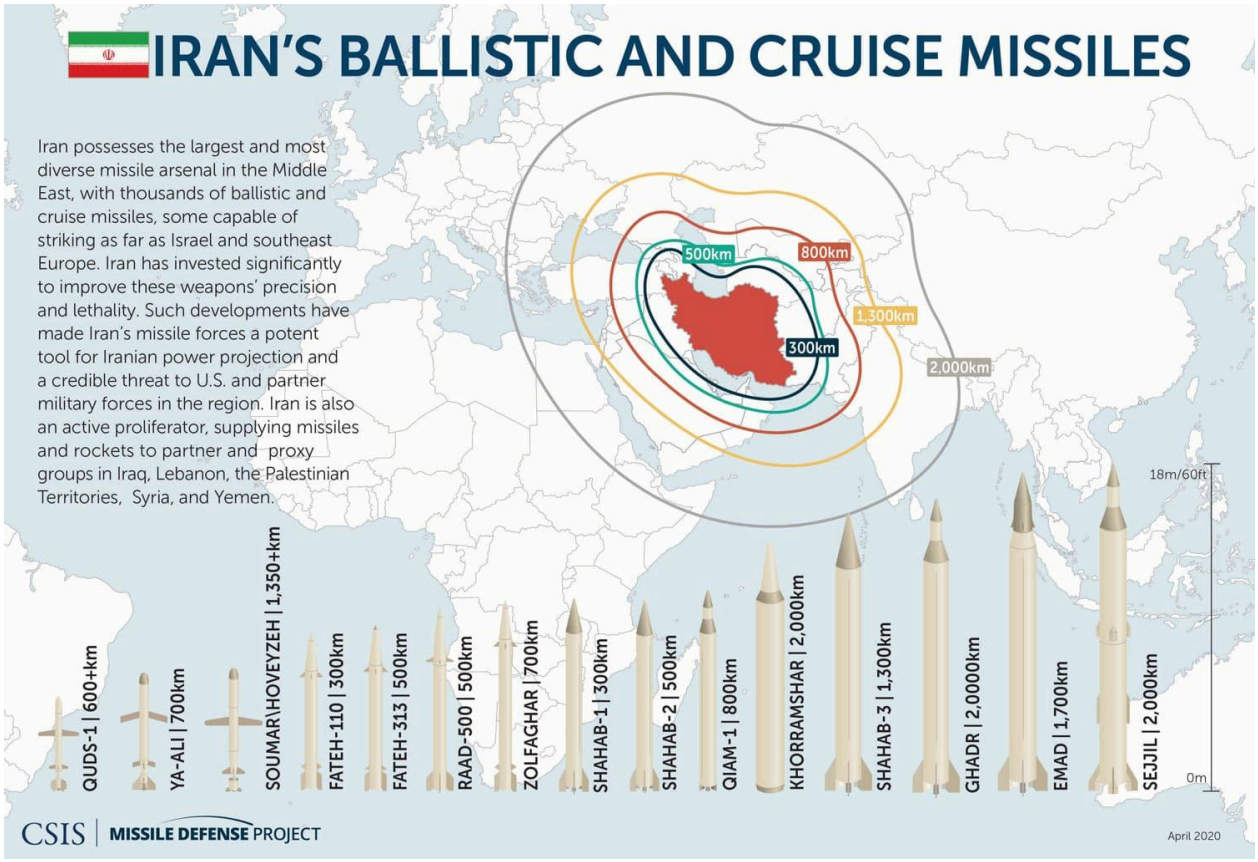
OPERATION EPIC FURY SITREP

Maritime events reported to UKMTO *ICOD: 04/03/2026 13:000UTC*

UKMTO
UK Maritime Trade Operations



Iranian Weapons Capability Range



JMIC will continue monitoring and issue updates as the situation warrants. The next JMIC updates will be on 05 March.

Issued by: Joint Maritime Information Center (JMIC) in consultation with UKMTO & MSCIO