FAIRMONT SHIPPING SINGAPORE
TAMAR SHIP MANAGEMENT

**Company Circular no. 04 - 2026**

**MONTHLY SAFETY CAMPAIGNS - APR 2026**

Dear Captain/CE

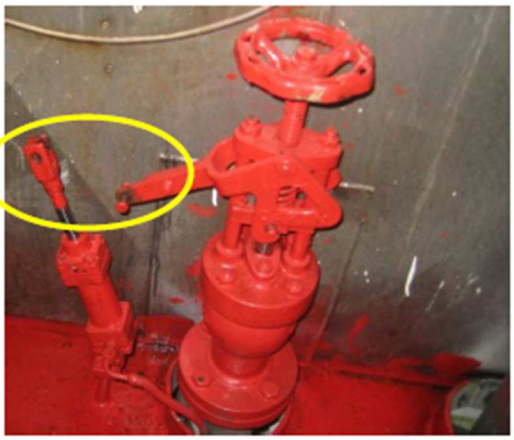
Please note as following for your compliance and discussion with all officers and crew members. Lessons Learned to be discussed during the monthly Safety Meeting.

## 1. ClassNK PSC Bulletins

### - Quick closing valves for fuel oil tanks – Refer attached NK-PSC-15

During PSC inspections, quick closing valves were inoperative due to seizing of the quick closing valves, air leakage and other circumstances caused by a failure in proper onboard maintenance.
Further, it has been reported that the closure of quick closing valves has been prevented intentionally by lashing or disconnection of air lines or supports to keep valves in open positions.
Whenever a defective condition of quick closing valves is detected, it should be recorded as defect. Further, there is a possibility that the deficiency might be judged as a lack of proper SMS implementation.
Given the above situation, please carry out visual inspection and proper maintenance of all quick closing valves, including air lines and operation test of quick closing valves as per PMS.

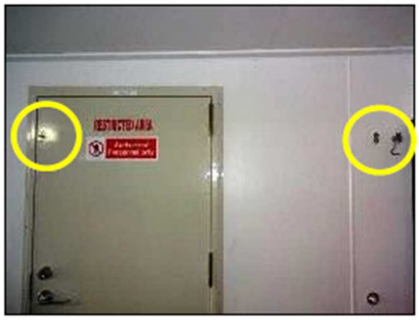
Quick closing valve lashed by rope



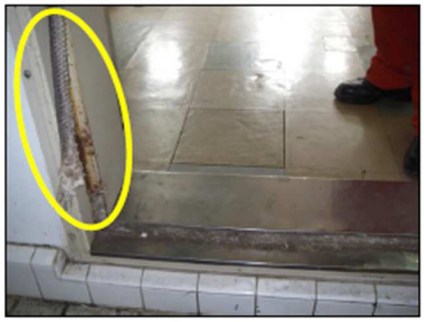
Disconnected control cylinder

### - Defects of fire doors– Refer attached NK-PSC-17

During PSC and RightShip inspections, the deficiencies related to defects of fire doors such as poor closing condition of fire doors, defects of self-closing doors, and so on. Further, there have also been frequent reports of intentional deteriorating fireproof performance by the crew such as securing self-closing fire doors with hold-back hooks or wires to keep fire doors in open positions, inappropriate cable penetration of fire doors / fire door frames, and so on. It is due to lack of proper weekly inspection and lack of crew training.
Please conduct a careful visual inspection and maintenance of all fire doors and operation tests of all self-closing devises at weekly intervals to ensure proper and safe operation. Educate crew against securing the fire door in open position.



Hold-back hook fitted on self-closing door



Detached fire door packing

## 2. Hatch cover crush fatality

(**As edited from Marine Department (Hong Kong) report published October 2022)**

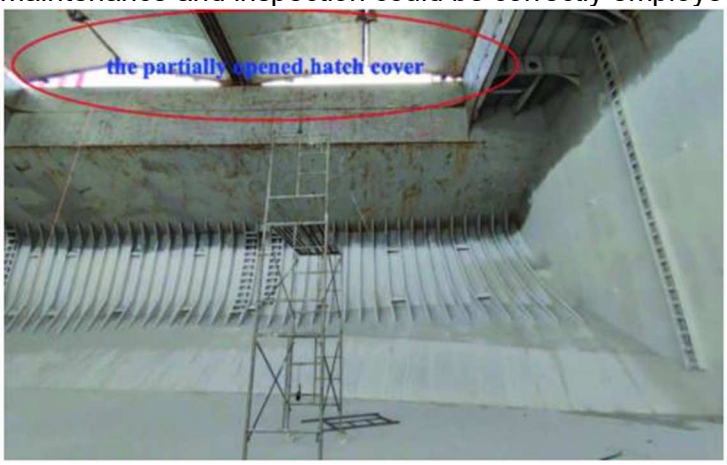
A bulk carrier in ballast was underway for the next port of loading. The deck crew were coating the vessel's holds with lime in preparation for cargo. Some crew were in the hold applying the lime while others, in support, were on deck.

In the late afternoon the hold coating operation work was nearing completion. The officer in charge needed to take photos of the coated holds, as required by the charterer. He slipped in between the partially open hatch cover and the hatch coaming to take the pictures. The crew members in the cargo hold heard the sound of the hatch cover moving and a loud yell.

The officer was then found caught between the now closed hatch cover and the coaming. A return hydraulic oil hose for the hatch cover operation had ruptured and the hydraulic oil spilled on deck. This had caused the closure of the hatch by gravity.

The victim was killed instantly. His body was recovered from the scene as soon as the hatch cover control was repaired. Two days later, upon arrival at port the victim's body was delivered to shore authorities.

The investigation found, among others, that the hatch cover hydraulic lines and fittings were not incorporated into the vessel's planned maintenance system (PMS) so that the manufacturer's recommendations for use, maintenance and inspection could be correctly employed.




**Lessons learned**

- The victim probably did not realise he was putting himself in a dangerous position – only the hydraulic pressure was keeping the hatch cover open. When this pressure was released due to a line failure the hatch cover quickly closed by gravity.
- Keeping hatches slightly open using only hydraulic pressure is a dangerous practice. Any deficiency in the hydraulic line can cause the hatch to quickly close without warning. The hatch covers must be completely opened and secured in line with the manufacturer's recommendations during cargo hold cleaning and cargo operation.
- When end folding hatch cover panels are partially opened and not secured, they can place massive strains and back pressure on the hatch cover's hydraulic system, leading to failure of one or more hydraulic system components, such as hydraulic pipes, and accidental hatch cover closure. This unintentional closure may raise the risk of injury to those working near the hatch cover.
- The hydraulic system, pipes, flexible hoses are to be inspected and maintained in good condition as per PMS.

## 3. Fleet Advisory 2025-03

Attached Fleet Advisory 2025-03 containing RightShip findings pointed out on board our vessel. 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 30th April 2026.

## 4. Update on Fishery Farms around Rizhao and Lanshan ports, China (Oasis Circular No.: 2603 19 Mar 2026)

Attached please find Japan P&I News update on Fishery Farms around Rizhao and Lanshan ports, China.
New fishery farm has been identified around Rizhao and Lanshan ports.
The Oasis Circular No 2603 contains geographic coordinates and recommended navigation route.
The locations of fishery farms are subject to change without notice. When navigating, maintain a proper lookout, checking AIS and radar, and always obtaining the latest information using Navtext / INM-C.

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

### - RTM_2026_005 - Navigation Safety & Fishing Activities in the South China Sea

The recent MSA circular highlights an increase in incidents involving merchant vessels running over marine farms and collisions with fishing vessels in the South China Sea, coinciding with a surge in fishing activity during the spring season following the Chinese New Year.

**Key Risks:**
Dense fishing vessel clusters, limited fish-farm information, poorly lit or AIS/VHF-inactive craft (often radar-hard to detect), and AIS net markers can create navigational hazards and distort ECDIS/radar interpretation.

**Recommendation as per MSA circular:**
Maintain continuous shore monitoring, conduct risk-based voyage planning and pre-entry safety meetings, take early and clear collision-avoidance actions with prescribed CPA limits, use appropriate warning signals and safe passing practices around fishing vessels, and prioritise lifesaving with immediate notification to authorities in emergencies.

**What Good looks like**:

- All vessels consistently receive MSA circulars, and the Masters ensure crew are fully briefed and familiar with the requirements.
- Shore management maintains proactive monitoring, relaying fishing-zone updates and risk alerts to vessels promptly.
- Voyage plans are risk-based and compliant, avoiding high-risk fishing areas and marine farms in line with MSA guidance.
- Crew competency is assured through targeted training on precautions, collision-avoidance measures, and emergency response actions.
- Follow-up actions are recorded and verified, ensuring fleet-wide compliance through regular reviews and operational oversight.
- Enhanced lookout is required with a two-person watch, and manual steering should be used in dense fishing areas.
- Collision-avoidance actions must be taken early, wide, and clear.
- Voyage plans should avoid fishing hotspots and use the China Coastal Main Public Routes where possible.
- All navigation equipment must remain fully operational, and Masters and OOWs should study the China coastal collision-prevention guidelines and safety notice.

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## 6. Stop Work Authority

To comply with RISQ 4.8 Stop Work Authority, our SMS - HSE Procedure Manual (refer Chapter 4.25 Safety Culture and Stop Work Authority/section 2) has been revised on company procedure on Stop Work Authority, the screenshot of same attached.
Company authorizes all crew members to immediately stop work when unsafe conditions, equipment, or behaviour is observed and report the matter to the Head of the Department or Safety Officer. The stop work is brought to the attention of Master. Personnel who exercise Stop Work Authority in good faith is protected from any form of disciplinary action or retaliation. It applies to all shipboard operations, including but not limited to cargo handling, maintenance, and shore personnel.
Form 5.3.1c Safety Committee Meeting Minutes was also revised to report the Stop Work Authority exercised on board the vessel. Please use revised Form.

**b) Near miss reports, Stop Work Authority exercised since last meeting**

Please discuss above with staff on board.

RISQ 4.8

**Stop Work Authority (SWA) Policy:**
The company should establish a Stop Work Authority (SWA) policy that empowers all personnel, regardless of role or rank, to halt any work activity that poses a risk to health, safety, the environment, or equipment.

This policy should clearly outline the following key requirements for implementation across all operations:
1. Universal Authority: Every individual has the right and responsibility to stop work when unsafe conditions or behaviours are observed.
2. No Retaliation: Personnel who exercise SWA in good faith should be protected from any form of disciplinary action or retaliation.
3. Immediate Response: Work should be stopped immediately upon identification of a hazard, and the issue should be reported without delay.
4. Assessment & Resolution: The hazard should be assessed, corrective actions taken, and the situation resolved before work resumes.
5. Training: All personnel should receive training on the SWA policy during induction and through ongoing safety briefings.
6. Leadership Support: Managers should actively support and promote the SWA policy to foster a strong and proactive safety culture.

**Stop Work Authority (SWA)**

The SMS should include a Stop Work Authority (SWA) policy and procedure. SWA recognizes the importance of encouraging any employee on board a vessel to express concern if they believe that an operation is being incorrectly undertaken or unsafe. SWA gives crewmembers the responsibility and obligation to intervene and stop work if they see something unsafe that may cause an accident.

A typical SWA is comprised of six steps:
Stop – When you or a colleague perceive condition(s) or behaviour(s) that pose imminent danger to person(s), equipment, or the environment, they must immediately initiate a stop work intervention with the person(s) potentially at risk.
Notify – Notify affected personnel and supervision of the stop work action.
Investigate – Affected personnel will discuss the situation and come to an agreement on the stop work action.
Correct – The affected area(s) will then be inspected by qualified experts to verify completeness of the modifications and ensure all safety issues have been properly resolved.
Resume – All affected personnel will be notified of what corrective actions were implemented, and the affected area(s) will be reopened for work by personnel with restart authority.
Follow-up – The Safety Manager will publish the incident details regarding the stop work action to all Operations Managers and employees, outlining the issue, corrective action, and lessons learned.

## 7. KARCO TRAINING

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

- **Enclosed Space Entry & One More Tragic Casualty**
- **Mooring Accidents**
- **Just Culture**

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.

## 8. RIGHTSHIP – RISQ Frequently Raised and High-Risk Findings

Attached RISQ Frequently Raised and High-Risk Findings. Please check each point and revert with the items which are not in compliance by 30th April 2026.
Master/CE to ensure that each section is checked diligently by respective officer in charge. Please upload the last signed page in the Share Point by end April 2026.