SRS E-BULLETIN

June 2023

MPA SINGAPORE

MARITIME SINGAPORE

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Training Agreement with American Bureau of Shipping (ABS)

Maritime and Port Authority of Singapore (MPA) is thrilled to collaborate with ABS on a surveyor attachment program to train MPA surveyors both locally and overseas on the latest ABS technologies processes, methodologies, and techniques of remote surveys, methanol fuel vessels, and gas carriers' surveys.

Beyond ABS surveying and reporting, MPA trainees will participate in ABS remote surveys/audits, and updates on the most recent technology, such as batteries, methanol, ammonia, and biofuel modelling and simulation.

It also Includes on-the-job training on the most up-to-date simulation and modelling technologies used to evaluate ship performance and carbon efficiency.We are excited about this collaboration, and the positive impact both parties will gain on our operations and services and help us provide better maritime safety.

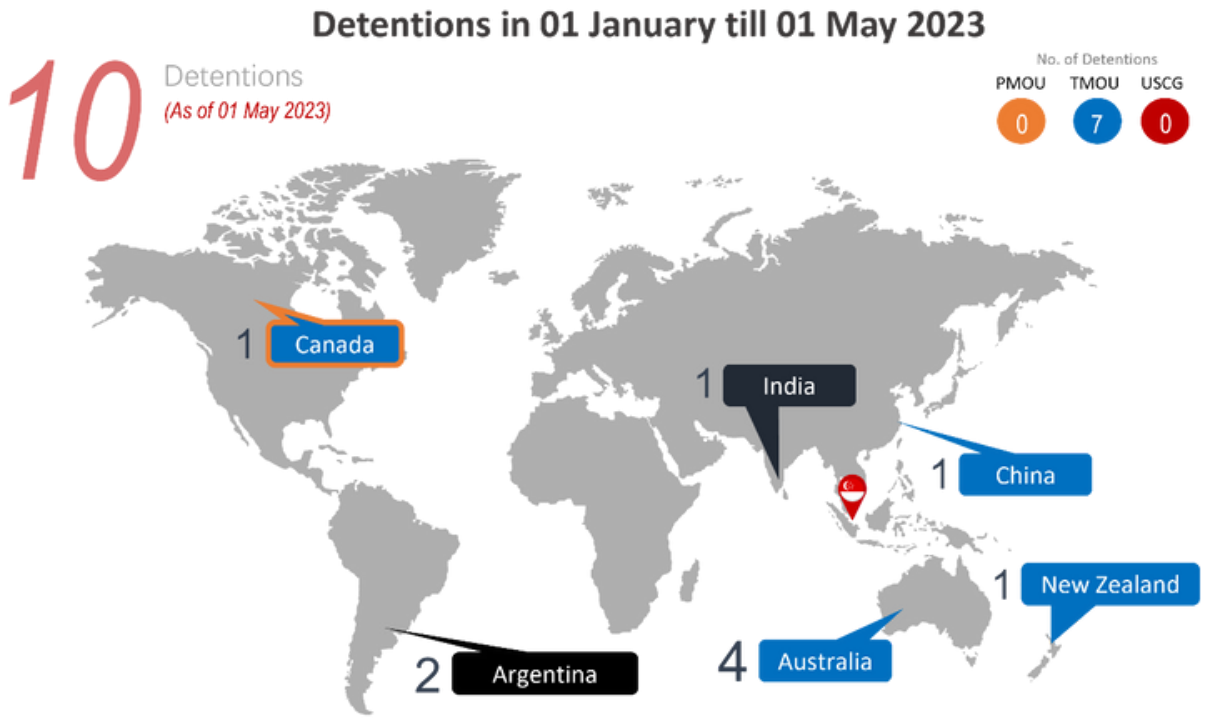
Fig 1: A photo of Mr Johnny M. Garrett Jr., Director of Operations, Southern Pacific Region (right) and Mr. Cheah Aun Aun, Director (Shipping) / Director of Marine, MPA

Singapore Registry of Ships (SRS) – Port State Control (PSC) Performance from 01 January to 01 May 2023

The Maritime and Port Authority of Singapore (MPA) is committed to maintain its status as a quality flag. We would like to take this opportunity to thank our ship owners, managers, and crew for doing their part in upholding the status of quality flag.

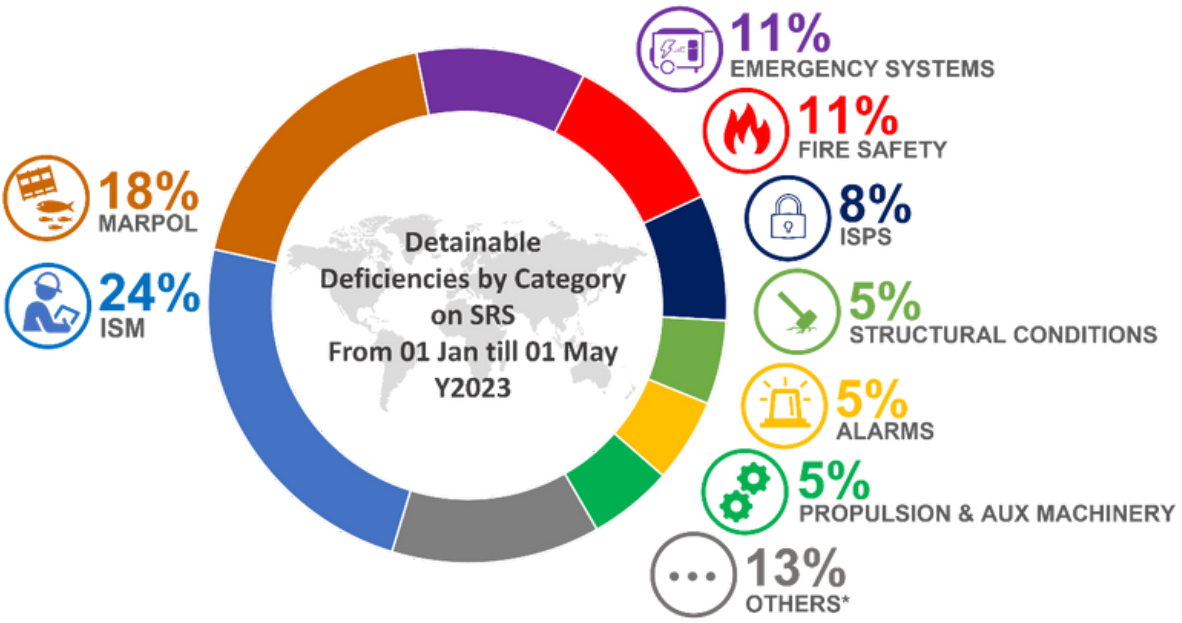
From the start of 2023 till 01 May 2023, a total of 667 SRS was inspected by PSC under the Tokyo MoU (TMoU) while 220 SRS were inspected by PSC under the Paris MoU (PMoU). Comparing to the same period in 2022, we see an increase in PSC activities by 30.5% and 15.2% in TMoU and PMoU respectively.

Thus far, 10 SRS were detained under Port State Control (PSC). Notably, 7 detentions were under TMoU of which 4 of those detentions were concentrated in Australia. Under the PMoU, no SRS were detained. There were no detentions by USCG.



SRS PERFORMANCE

Most of the detentions were due to common PSC deficiencies which could have been avoided with proper and timely planned maintenance. A breakdown below highlights the deficiency categories:



Others include categories such as MLC, safety of navigation, lifesaving appliances, certificates and documentation, water/weathertight conditions, etc.

Call to Action

SRS owners and managers are urged to monitor their ships performance and maintenance to ensure that they are in compliance with international rules and regulations. Any defects or non-conformities shall be promptly attended and rectified in accordance with the ISM Code.

For defects which cannot be promptly rectified, the ship master shall duly report and apply dispensation from MPA (shipping@mpa.gov.sg) and the Classification Society. The Master shall also report the deficiency to the competent authority when the vessel is calling at a port.

Singapore-Registered Ship, Success 9, Located and Crew safe

Since the boarding of the Singapore-registered ship, SUCCESS 9, by unidentified persons on 10 April 2023, the Maritime and Port Authority of Singapore (MPA) has been coordinating with the ship owner and multinational agencies through the Information Fusion Centre (IFC) and the Monrovia Regional Maritime Rescue Coordination Centre (MRCC) to search for the ship. These multinational agencies included the Maritime Domain Awareness for Trade – Gulf of Guinea, together with the regional security forces, the French navy, coast guards and maritime administrations from Côte d'Ivoire, Ghana, Guinea, Liberia, Sierra Leone and Nigeria. All nearby and passing commercial ships were also cued to help in the search for SUCCESS 9.

On 15 April 2023 at around 1700 hrs (Singapore time), MPA was updated that SUCCESS 9, has been located off the coast of Abidjan, Côte d'Ivoire.

Fig 1: MPA team with the IFC, Monrovia MRCC, Ivory Coast Navy, Multinational Maritime Coordination Centres, MDAT-GoG and Embassy representatives, teams from MPA involved in the search for SUCCESS 9

A commercial ship, MONJASA SPRINTER, passing by had earlier picked up a distress call from SUCCESS 9. The master of MONJASA SPRINTER then reported the location of SUCCESS 9 to the latter's Company Security Officer (CSO). The CSO updated MPA, who immediately informed the IFC and Monrovia Regional MRCC. A Côte d'Ivoire Navy patrol vessel was deployed to confirm and board SUCCESS 9. All crew, including the Singaporean crew, were safe and in good health.

MPA would like to call on all Singapore-registered ships to exercise caution and implement the guidelines in the Best Management Practices West Africa (BMP WA)[1], when operating in the region to mitigate piracy-associated threats.

Companies should also regularly review their ship security assessment and plan under the International Ship and Port Facility Security Code. Companies are advised to report all pirate activity, including both actual and attempted attacks, as well as suspicious sightings, to local authorities.

MPA would like to call on all Singapore-registered ships to exercise caution and implement the guidelines in the Best Management Practices West Africa (BMP WA)[1], when operating in the region to mitigate piracy-associated threats.


油轮“成功九”寻获20船员已安全抵达西非港口

订户

傅丽云 / 联合早报

发布 / 2023年4月17日 5:00 AM

新加坡海事及港务管理局局长张英智（中）与新加坡紧急行动中心团队，通过新加坡海军资信汇合中心和蒙罗维亚区域海事救援协调中心，不断与船主和跨国机构协调，最终搜寻到油轮。（新加坡海事及港务管理局提供）

Fig 2: Article extracted from Lian He Zao Bao reporting on the SUCCESS 9 incident

Please refer to the shipping circular 9 of 2023 https://www.mpa.gov.sg/media-centre/details/no.-9-of-2023---advisory-for-singapore-registered-ships-operating-off-the-coast-of-west-africa-including-the-gulf-of-guinea for more details

[1] The BMP West Africa – Best Management Practices to Deter Piracy and Enhance Maritime Security off the Coast of West Africa including the Gulf of Guinea, was published by the International Chamber of Shipping and other shipping industry associations in March 2020. The publication provides threat mitigation guidance on counter-piracy/armed robbery at sea.

Engagement with Towage community to prevent piracy and armed robbery in the Singapore Strait

Did you know - most sea robberies target slow-moving vessels with low freeboards and dimly lit sterns where sentries are absent? With over 100,000 vessels passing through the Singapore Strait every year, it is important to work together to safeguard the lives and livelihoods of our operators and ensure the smooth and secure flow of trade through this vital waterway.

The Singapore Registry of Ships held an engagement session with towage operators on 24 March 2023 to prevent piracy and sea robbery in the Singapore Strait. The event included presentations on piracy situations and enforcement efforts, as well as discussions on best practices to prevent and detect such incidences.

Tugboat operators are advised to stay vigilant and promptly report any suspicious activities at sea to MPA. This will help to deter sea robbery and ensure the safety and security of all personnel on board. Let's make the seas safer and more secure for everyone!

Fig 1: MPA's Director of Marine (Shipping), Mr. Cheah Aun Aun, Director (Shipping) / Director of Marine, MPA giving an opening speech at the engagement session

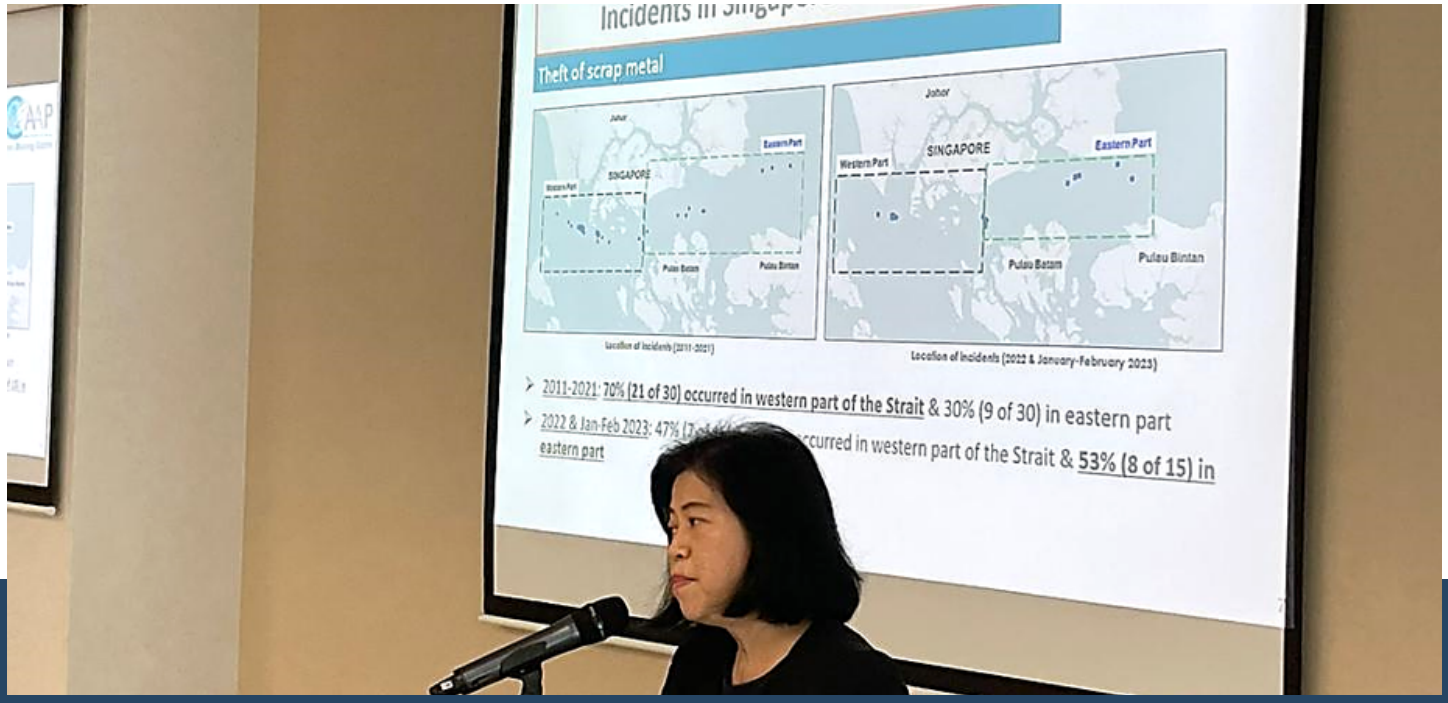


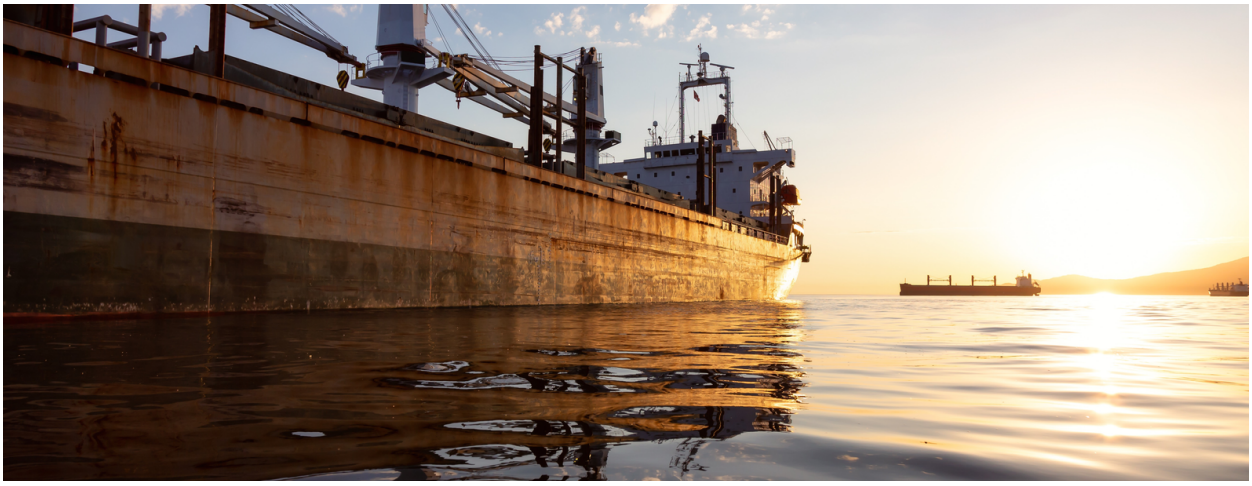
Fig 2: Presentation by Ms Lee Yin Mui, ReCAAP Information Sharing Centre (ISC)

Fig 3: Participants at the engagement session

Minimum Safe Manning Document (MSMD) Review for Singapore Registered Ships

The Minimum Safe Manning Document (MSMD) sets out the minimum number and competency of personnel necessary on board. The MSMD is issued under the provisions of Regulation V/14 of the International Convention for the Safety of Life at Sea (SOLAS) 1974, as amended, taking into account the "Principles of Minimum Safe Manning" adopted by the International Maritime Organisation (IMO) Resolution A. 1047(27).

In June 2022, upon completion of a review of the Minimum Safe Manning Scale (MSMS), Maritime and Port Authority of Singapore (MPA) published a shipping circular no. 10 of 2022, notifying relevant stakeholders of the latest MSMS for Singapore Registered Ships. Subsequently, vessels seeking dispensation and/or require an amendment on the MSMD, were re-issued with a revised minimum manning – if the vessel's current MSMD does not align with the latest MSMS.



Beginning late 2022, MPA noticed an increased number of Port State Control (PSC) deficiency in relation to Singapore's MSMD for not reflecting the cook rank. MPA remain guided by the principle that the MSMD is issued under the provisions of SOLAS regulation V/14 and the IMO Resolution A.1047(27). It lays out the required minimum safe manning (of deck officers, marine engineer officers and deck and engine ratings or GP crew) for the ship to be operated safely, securely and the environment protected. It does not include consideration for cooks and crew in the catering department which are required under the Maritime Labour Convention (MLC).

After due considerations, from March 2023, MPA updated the supplementary note found in the MSMD. Essentially, the supplementary note now provides clarification to relevant stakeholders on the principle behind why the cook capacity is not found in the MSMD.

To prevent operational disruptions, the replacement of existing MSMD will be made progressively. Relevant stakeholders are encouraged to review their MSMD against the MSMS found in shipping circular no. 10 of 2022. Amendments relating to the above 2 updates are non-chargeable, while amendments in addition/non-relating to the above 2 updates will remain chargeable.

Company may request for the above change by writing to mmo_mpa@mpa.gov.sg.

Engagement with Singapore Registry of Ships (SRS) shipowners and managers to uphold Singapore quality flag status

Round table discussions with SRS shipowners and managers

In the year of 2022, 18 SRS was detained by Australian Maritime Safety Authority (AMSA). As part of the Maritime and Port Authority (MPA)'s effort to upkeep its status as quality flag, we have arranged two round table discussion with our SRS shipowners, managers and eight Recognised Organisations (ROs) that was held on 15 February and 22 March 2023. The round table discussions were attended by 155 participants, covering 53 companies.

The aim of the round table discussions was to highlight the common deficiencies found by AMSA inspectors in the year of 2022. In addition, with the ease of border restriction and increased port State control activities by China Maritime Safety Administration (MSA), the participants were shared with the importance of reporting defect to the port Authority and flag State to avoid Port State Control (PSC) detention. The round table discussions also invited participants to share good practices adopted by the company to improve and prepare vessels prior to entry to Australian and China ports. Nevertheless, we thank all participants for their active participations and sharing and making these round table discussions a success.

Fig 1: Round table discussion held on 15 February 2023

Fig 2: Round table discussion held on 22 March 2023

Dialogue Session with SRS bunker tanker operators

Dialogue session was arranged with SRS bunker tanker operators and eight ROs on 9 March 2023. A total of 29 SRS bunker operators attended this dialogue session. Flag State control inspection was carried out on 9 SRS bunker tankers from 1 January to 1 March 2023 and these tankers were observed with multiple deficiencies. The purpose of the dialogue session was to highlight the importance of unkeeping the bunker tankers safety standards and environmental protection requirements and to share what are the common deficiencies. The dialogue session concluded by thanking the participants for their active participations and to continue maintaining quality and safe ships.

Fig 3: Photo taken at the dialogue session

Get-together session for Bureau Veritas (BV) and Maritime and Port Authority of Singapore (MPA)

Get-together session between Bureau Veritas (BV) and Maritime and Port Authority of Singapore (MPA) took placed on 19 May 2023 at Bureau Veritas Singapore Office and was attended by MPA's Shipping Division Officers.

The Get-Together session was an informal meeting for MPA Officers to get to know BV office staffs and field surveyors, and vice-versa. The meeting was aim at improving better communication and understanding including addressing "Hot Burning" questions from office and field surveyors.

Several questions were raised and discussed relating to deficiencies issued by Flag and Port State Control inspections. MPA stressed on the importance of collaboration and appreciate BV, as our Recognised Organization, for their hard work and cooperation to uphold Singapore Registry of Ships as a quality flag.
It was a fruitful get-together session for MPA Officers to understand the work of BV and most importantly, making friends!

Fig 1: Group photo of BV staffs and MPA officers

Marine Fuel Forum 2023

Maritime and Port Authority of Singapore (MPA)'s Flag State Control (FSC) department shared and discussed on the statistics of 1st Quarter 2023 on bunker craft Flag State Control (FSC) inspections and detentions, Maritime Labour Convention (MLC) and safety requirements during Marine Fuel Forum 2023 held at M Hotel in May 2023.

During the sharing session, bunker craft operators are urged to ensure regular inspection and maintenance of the vessel including improving crew competency in operation and maintenance of Life Saving Appliances (LSA) and Fire Fighting Appliances (FFA) items.

The sharing also stressed on the importance of keeping gangway / pilot ladder in satisfactory conditions and bunkering related oil spills due to operational lapse which could be prevented if all necessary precautions are taken.

Fig 1: Event photo Marine Fuel Forum 2023

Failure to implement proper shipboard Safety Management System (SMS) and Security Measures (ISPS)

It is not uncommon for ship owners to engage shore contractors to service their vessels. The ISPS Code requires the contractors' identities to be recorded in the ship's visitor log when they report on board for work. The company's safety management system (SMS) has procedures to orientate these shore contractors before they are allowed to commence work, i.e., when they are on board, the contractors must comply with the ship's Safety and Security policies after successfully completing shipboard safety familiarization conducted by qualified ship's personnel.

Case study 1 – Fire and explosion in the pumproom

The ship was at a repair berth to fit new equipment in the pumproom. Its owner engaged a shore company to carry out the above job. The company sent six of its workers on board, but the ship's visitor logbook did not have record of these workers boarding her. This implied that gangway duty crew either did not ask for the workers' personal detail to be recorded in the visitor logbook or no proper gangway watch was in place. When on board, and although it was part of the SMS, there was no evidence of shipboard safety familiarization being conducted for these workers.

The Master and Chief Officer have endorsed some work-related SMS documents, e.g., pumproom/compressor room entry permit and permit to work etc. prior to work being permitted to be carried out in such spaces. Personnel who were permitted to work were identified in the documents but the six workers who were engaged to work in the pumproom was not identified in those documents. This implied that the workers would not be involved in the above work that required permit to work.

Thereafter, the workers carried out hot work in the pumproom. There was no permit or other SMS required documents, e.g., hot work permit, risk assessment, etc. issued for such work. Bridge duty officer (BDO) and his deck watch crew (DWC) were not aware of the activity in the pumproom. However, DWC did see one worker standing outside the pumproom entrance. He also saw 'flashing lights coming from the pumproom'. DWC did not include the above pumproom situation when he reported to BDO the status of his half-hourly safety deck rounds and checks. Suddenly, an explosion sound was heard from the pumproom, followed by fire. All workers managed to escape from the pumproom except one. Subsequently, ship crew managed to evacuate the latter, who was unresponsive. Shore medical team arrived at the ship to treat the unresponsive worker and pronounced him dead at the scene.

Why did it happen?

Despite having an SMS that requires safety familiarization for contractors working on board, the master, who was designated to ensure the completion of the above safety familiarization did not do so as per the SMS.

Despite not being briefed on the shipboard SMS and obtaining formal approval from the ship, the workers proceeded to carry out work activity without SMS guidance and on their own without permission.

DWC's safety deck rounds were not effective because when he saw some pumproom activities during his watch, he neither clarify with the worker nor BDO when he saw a worker standing outside pumproom and the 'flashing light' from the pumproom.

Commentary

This was a situation where ship personnel had shown lapse in control by letting 'strangers' (shore workers in this case) on board their ship to carry out activities without prior approval of the ship staff. The master and his crew omitted in exercising their duty and responsibility on the shore workers in accordance with the shipboard SMS for assessment and approval of work to be carried out safely by external parties. If they would have done so, injury and fatality might had been averted. Notwithstanding the master and his crew's omission, the shore workers contributed to the mishap in some extent.

Grounding Incident within Singapore Port Limit

There were several occurrences of bunker tankers running aground within the vicinity of Singapore anchorages. Notwithstanding ship handling skills, Masters' assessment of root cause pointed towards the state of strong current and wind.

Case study 2(a) – Visual navigation and grounding incident

B casted off from a bunker receiving vessel in the vicinity of Senang buoy and headed toward Raffles Petroleum Anchorage (RPA). B's gyro compass was not working properly hence causing abnormal function of her radar simultaneously. Unable to use the radar, the master saw one of his company's vessels (CV) anchored at RPA and decided to visually navigate B by referring to CV. He took a magnetic bearing of CV and continued to steer B to head CV at the same magnetic bearing, around North Westerly. The master confirmed that he was aware of the prevailing current and wind conditions, i.e., both elements were pushing B to her port, i.e., current set at 247° (T) with 1.0 kts drift, increasing; with 20 kts wind from Northeast. B eventually grounded, 12 minutes after casting off from bunker receiving vessel. See Figure 1 below.

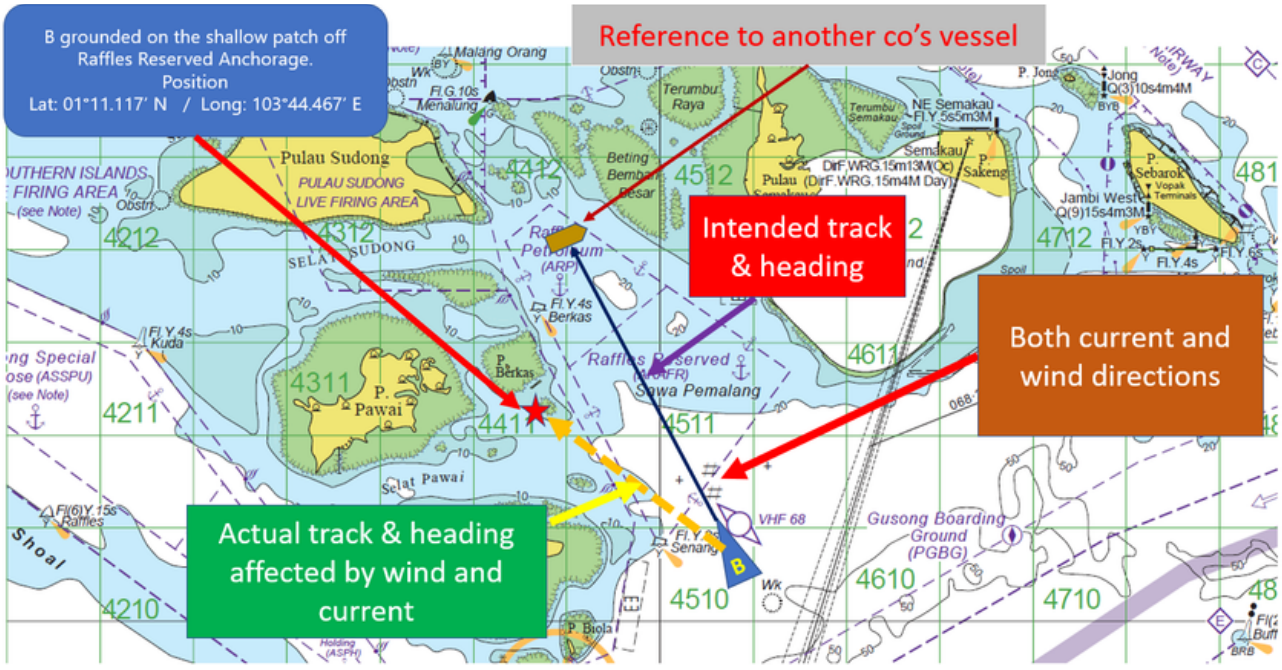


Figure 1

Case study 2(b) – Gut feel and grounding incident

C weighed anchor in Raffles Petroleum Anchorage (RPA) and heading for Sebarok beacon to pick up pilot. The master made a 'U' turn to head for Sebarok beacon. C's echo sounder, in digital readout was never switched off and not referred to timely.

The master was aware of the prevailing current and wind conditions, i.e., pushing C towards her starboard or north-easterly direction.

The master decided to turn to starboard because C's drafts were light: D_F 1.5m, D_A 2.5m. He felt that the current of 1.1 kts was not effective on C's drafts.

Hence, his decision to turn C to starboard to make the 'U' turn. C went aground 5 minutes after anchor aweigh. See Figure 3 on the right.

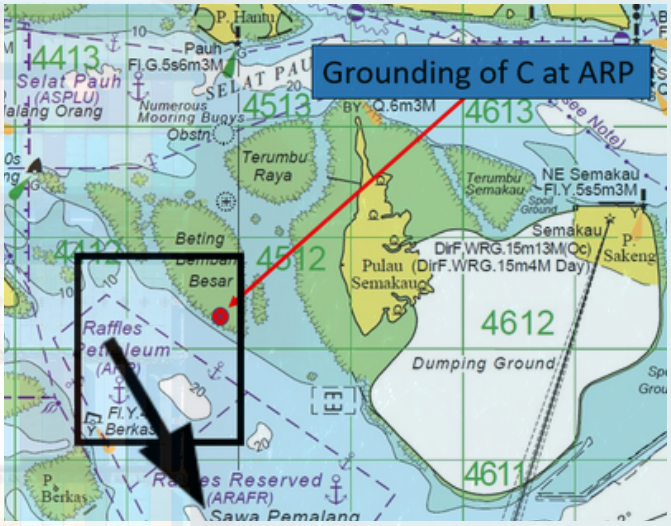


Figure 2

Why did it happen?

Both grounding incidents happened within the same vicinity. The weather conditions were similar at the material time. In both cases, masters had not appreciated the strong current and wind weather conditions. Instead of steering the vessels based on course made good, both had concentrated on their respective vessel's heading. In case study 2(b), both current and wind were pushing his vessel from the port and the master turned his vessel to the starboard, which assisted her grounding (see Figure 3, above).

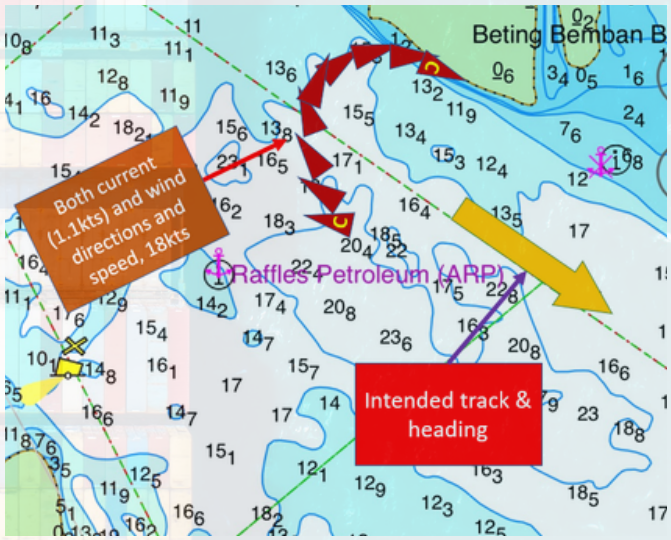


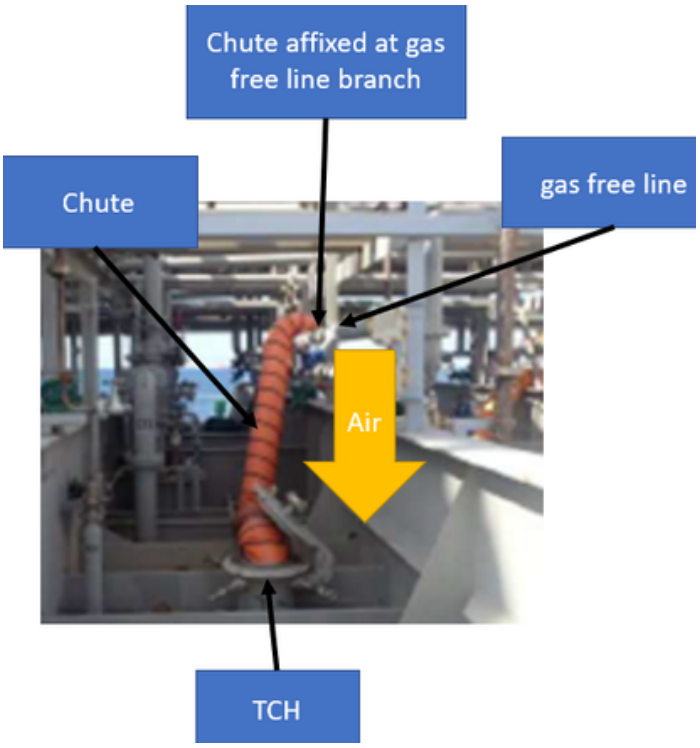
Figure 3

Commentary

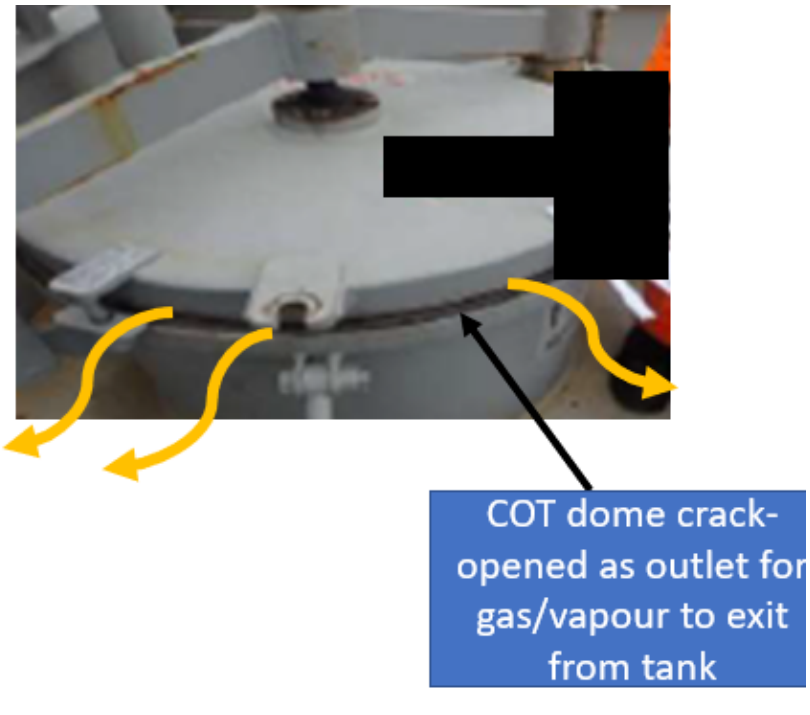
It was noted that in most cases, despite the requirements of having additional bridge team member(s) on the bridge as per company's safety management system (SMS), navigation was usually carried out by the master alone.

Crew Fatality during Cargo Oil Tank Gas-freeing Operations

A chemical tanker (CT) gas free her cargo oil tanks (COT) by using a fixed gas-freeing fan which is connected to a main gas-freeing pipeline, which then branched to individual COT's. A gas-freeing chute ("chute") is affixed to the branch line and lowered into the COT that required gas freed through a tank cleaning hatch (TCH); see images below.



Fresh air from the fixed gas-freeing fan is supplied to COT through the chute. The air that is mixed with cargo vapour in the COT during gas freeing process exits through the COT's pressure/vacuum valve (PVV) outlet and COT dome that is slightly opened.



Case study – fatality incident when shifting gas-freeing chute between cargo oil tanks

Chief Officer (CO) of CT drew out a duty roster for his crew to sequentially shifting chute between designated COT that were to be gas freed. During a 12-4 watch, at about 0208 hours LT, the 12-4 bridge lookout AB (AB) left the bridge to carry out the above duty without donning any personal protective equipment (PPE). Light relative wind at that time was from astern of CT. At about 0234 hours, bridge duty officer 2O called AB on the walkie-talkie but in vain. 2O then informed CO. CO found AB lying unconscious on the starboard main deck near xx COT at 0255 hours. Master and his crew carried out measures to assist and try to resuscitate the AB. Subsequently, the AB was declared dead.

Why did it happen?

Stipulated procedures as per the company's Safety Management System (SMS) for gas freeing operation was not followed, i.e., the correct method to gas free COT in this case was to be through closed system where fresh air supplied by gas freeing fan will pass through cargo manifold connection thence enter the designated COT through drop line of that COT; and COT gas mixture will emit through PVV only. In this case, opening of TCH and COT dome caused gas mixture in COT to escape and accumulate around the vicinity. Gas mixture accumulation built up on deck over time as there was no air flow on deck due to the prevailing relative wind condition.

There was no risk assessment, permit to work, toolbox meeting and other applicable SMS requirements being carried out for the task in question, i.e., gas freeing operation and chute shifting. Relevant deck officers did not comply with the SMS including ensuring that appropriate PPE was available and used by their deck personnel when they instructed them to carry out the task in question.

Commentary

The SMS was in place for the task in question. However, it was not implemented. This includes correct method to gas free COT. Master and responsible ship personnel shall ensure safe operations and always follow appropriate SMS.

Material Safety Data Sheet (MSDS) / Safety Data Sheet (SDS)

Case study 3(a) – Inhalation of fumes on deck

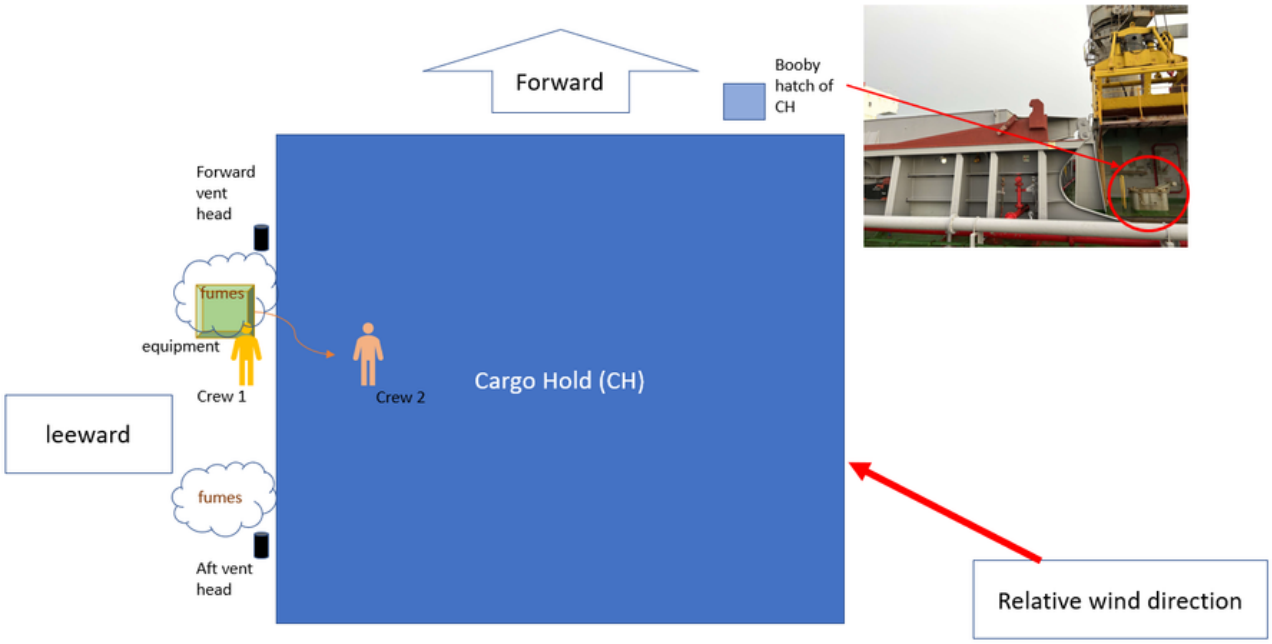


Figure 1

Crew 1 inhaled the fumes emitted from nearby fuel tank vent head for about 30 minutes while transferring work equipment to Crew 2, who was in the cargo hold. Thereafter, Crew 1 assisted Crew 2 in CH for maintenance. While assisting Crew 2, Crew 1 informed that he was not feeling well, and he was asked to rest for the whole day. Crew 1 continued to feel unwell for the next 12 days and stayed in his cabin. Crew 1 experienced headache, stomach discomfort, body muscular ache and diarrhoea. During this time, master and chief officer communicated with the company personnel (CP) to update Crew 1's condition. CP also consulted local doctor twice regarding Crew 1's condition and relay the doctor's advice to the vessel. On the morning of day 12, Crew 1 was found dead in his cabin.

Why did it happen?

Risk assessment was completed for the CH job. However, inhalation of fuel oil fumes was not identified as part of the hazards. Furthermore, Crew 1 was standing at the leeway side when transferring work equipment to Crew 2 where fuel oil fumes from the vent heads accumulated. No one consulted the fuel oil's MSDS to acknowledge remedial action for inhalation. With reference to the autopsy report, the medicine recommended by the local doctor was suitable for Crew 1's condition, however, it was not relayed by CP to the master.

Commentary

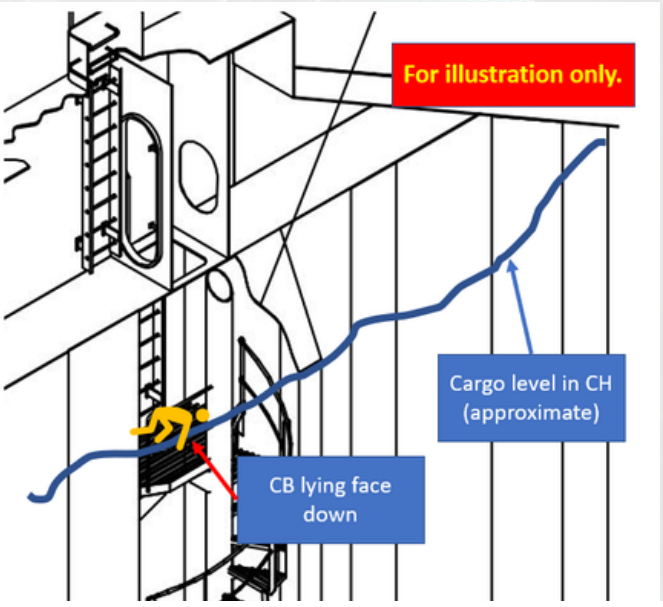
Although there were other probable contributing factors to this incident, the focus here is on MSDS to serve as a reminder that it is an important reference document when dealing with the related incident. For this case, it is fuel oil.

Case study (3b) – Fell on cargo hold vertical ladder landing while climbing the ladder

Crew were assigned to collect cargo, Pet Coke sample inside the cargo hold (CH). The method to collect sample in this case was to have one crew (CA) standing on deck outside CH booby hatch, and another crew (CB) climbed down the vertical ladder to collect the sample. A bucket was lowered by CA on deck to CB inside the CH. All CH hatch covers were partially opened to ventilate the CH for safe man entry. However, the moment CH hatch covers were opened, crew members immediately proceeded to collect samples.

After filling sample in CH, CA pulled up the bucket while CB climbed up the vertical ladder of CH. CA heard CB, who was still inside CH, shouted. Thereafter, CA saw CB lying face down on CH's vertical ladder landing area. CA called for help.

Subsequently, ship crew managed to bring CB on deck. Master sought assistance from shore to convey CB to shore medical facility. Meantime, second officer administered CPR on CB while waiting for shore medical transportation. When CB was conveyed to hospital, he was pronounced dead on arrival.



Why did it happen?

Vessel was provided with a safety data sheet (SDS) on Pet Coke, which is a cargo dust. The SDS outlined comprehensive safety precaution when handling Pet Coke, including inhalation, skin and eye contact; along with exposure controls with appropriate personal protective equipment to be donned. None of the requirements in the SDS was complied with. There was no risk assessment for the task of entering CH to collect cargo sample being carried out. The vessel had personal multiple gas detection meters; crew who entered the CH did not wear them. It was noted that none of the requirements in the SDS was complied with.

Crew carried out toolbox meeting on the day of incident for connect crane grab, drop anchor and enclosed space entry. Such meeting was documented in a form. The hazard categories in the form were checked for weather, moving objects, manual handling, unfamiliar personnel, tools and other. There was a hazard category of 'Hazardous subs', which were not checked.

Commentary

Similar to case study 3(a) above, there were other probable contributing factors to this incident, e.g., failure in crew in complying with SMS, etc. However, the focus here is on SDS, which could not be emphasised enough of its importance even before carrying out a planned task.

SAFETY ALERT

No. 1/2023 - SAFE TRANSFER OF PERSONS BETWEEN VESSELS AT ANCHORAGES

INTRODUCTION

There has been an increase of incidents where personnel falling overboard during transfer between vessels at the anchorages. These incidents have resulted in injuries and loss of lives, which could have been prevented.

The purpose of this safety notice is to raise awareness of all personnel (ship, shore) working over water when boarding vessels at the anchorages.

RECOMMENDATIONS

To prevent incidents during transfer between vessels at the anchorages, the following measures should be considered:

- **Risk Assessment:** It is important for personnel to understand the hazards and the risks associated with the tasks they are undertaking when transferring between vessels.
- **Favourable circumstances and conditions**: Personnel should consider the weather conditions and sea state before deciding if to proceed with the transfer at the anchorages. The personnel should not proceed if he/she do not feel well.
- **Suitable boarding arrangements**: Access to the vessel such as the accommodation ladder, pilot ladder and/or combination ladder, must be properly rigged and assessed safe for use by a responsible person from the vessel providing the boarding arrangements.
- **Situation awareness:** Maintain good situation awareness at all times and exercise extreme caution. Be vigilant of the risks associated during the transfer operation.
- **Personal Protective Equipment (PPE):** Personnel transferring between vessels should wear appropriate PPE, including a regularly serviced / inspected SOLAS type-approved life-jacket to keep them afloat should they fall into the water.
- **Maintain 3-points contact:** Personnel when embarking or disembarking a vessel at anchorage, should always maintain a 3-point contact on the boarding arrangements at all times during the transfer.
- **Embarkation / disembarkation areas:** Service boats embarkation / disembarkation areas shall be free of slipping or tripping hazards, have sufficient handholds/ railings, be free of obstructions, be within line-of-sight of the boat's coxswain / operator, and be sufficiently illuminated during hours of darkness.
- **S.T.O.P:** If in doubt, apply this rule of thumb "STOP, THINK, OBSERVE and PROCEED"

FOR FURTHER INFORMATION (See Annex 1)

WSH Workplace Safety and Health (https://sso.agc.gov.sg/SL/WSHA2006 -RG1?DocDate=20221220#pr23-)

ANNEX 1 - WSH Workplace Safety and Health (General Provisions) Regulation 23

Measures to be taken to prevent falls

23.—(1) It shall be the duty of the occupier of a workplace to ensure that all openings in floors of the workplace are securely covered or fenced unless the nature of the work renders such covering or fencing impracticable. [S 277/2014 wef 01/05/2014]

(2) [Deleted by S 277/2014 wef 01/05/2014]
(3) [Deleted by S 277/2014 wef 01/05/2014]
(4) [Deleted by S 277/2014 wef 01/05/2014]
(5) [Deleted by S 277/2014 wef 01/05/2014]
(6) [Deleted by S 277/2014 wef 01/05/2014]

(7) Subject to paragraph (8), any person who has to work at a place from which he would be liable to fall — (a) a distance of more than 2 metres; or (b) into any substance which is likely to cause drowning or asphyxiation, shall be provided with a secure foothold and handhold at the place so far as is reasonably practicable for ensuring his safety.

(8) Where it is not reasonably practicable to provide a secure foothold or handhold as required under paragraph (7), other suitable means such as a safety harness or safety belt shall be provided for ensuring the safety of every person working at such places.

(9) Where a safety harness or safety belt is provided under paragraph (8) — (a) there shall be sufficient and secured anchorage, by means of a life line or otherwise for the safety harness or safety belt; and (b) the anchorage shall not be lower than the level of the working position of the person wearing the safety harness or safety belt.

(10) It shall be the duty of the employer of the person referred to in paragraph (7) to comply with paragraphs (7), (8) and (9).

(11) It shall be the duty of the employer of a person who is exposed to the risk of falling into water and of drowning to provide — (a) equipment and means of rescuing and resuscitating drowning persons; and (b) suitable life jackets or other equipment for keeping such persons afloat in the event that they fall into the water.

(12) No person shall require, permit or direct any person to work at a place from which he would be liable to fall — (a) a distance of more than 2 metres; or (b) into any substance which is likely to cause drowning or asphyxiation, unless the requirements of paragraphs (7), (8) and (9) have been complied with.

(13) Any person who contravenes paragraph (12) shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $20,000 or to imprisonment for a term not exceeding 2 years or to both.

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