

SRS

E-BULLETIN

June 2025



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Singapore's qualification for continuance in the United States Coast Guard's Quality Shipping for the 21st Century (QUALSHIP 21) Program



USCG QUALSHIP 21 programme is a prestigious initiative that recognises shipowners, companies, operators, and vessels that demonstrate high levels of commitment to safety, quality, and full compliance with international standards and U.S. regulations. Qualification reflects not only the strong performance of individual vessels, but also the credibility and quality of the flag Administration.

Singapore has successfully retained its qualification for the USCG QUALSHIP 21 programme for the upcoming year from 1 July 2025 to 30 Jun 2026. In the assessment year of 2024, Singapore attained a 3-year rolling average detention ratio (2022 – 2024) of 0.37% with 689 safety examinations by USCG onboard Singapore-registered ships.

At present, nearly 400 Singapore-registered ships are enrolled in the QUALSHIP 21 programme. Ships under this programme benefit from incentives such as reduced Port State Control Inspections by the USCG.

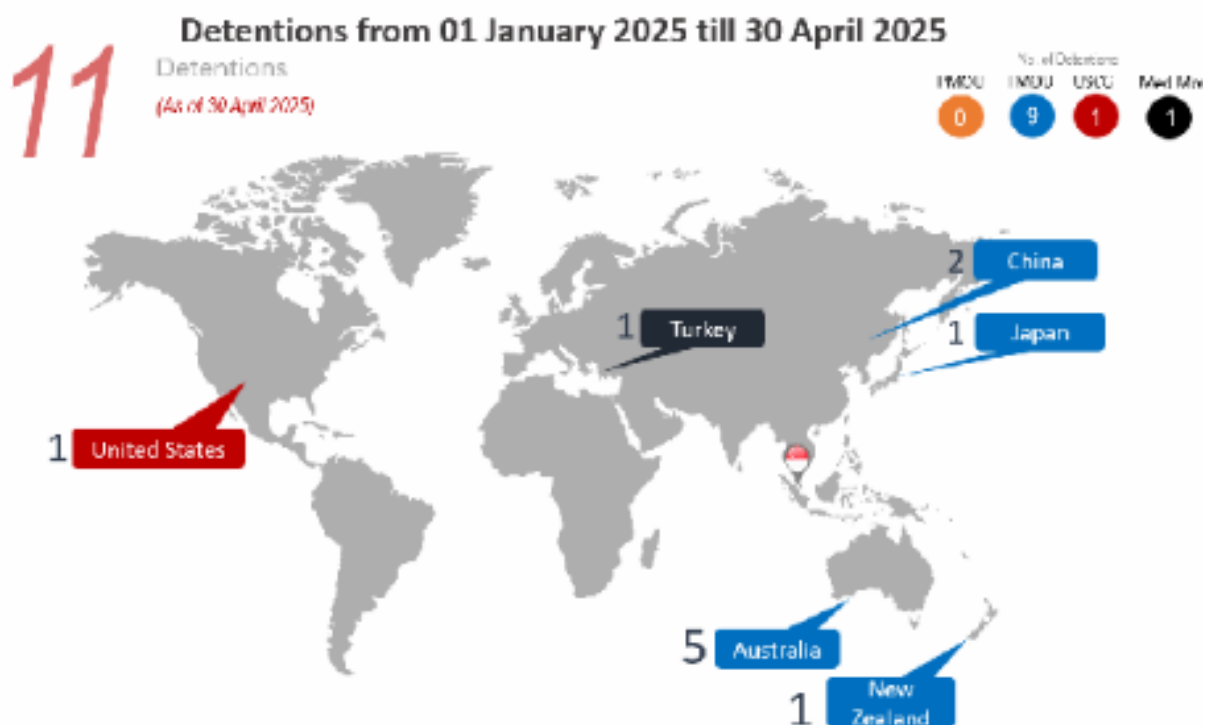
A heartfelt thank you to all operators of Singapore-registered ships for your continued dedication and excellence in upholding the Singapore Registry of Ships as a quality flag. Let us continue to work together to keep the Singapore flag flying high!

Port State Control (PSC) Performance of the SRS from 1 January to 30 April 2025

MPA is committed to maintaining the Singapore Registry of Ships (SRS) as a quality flag.

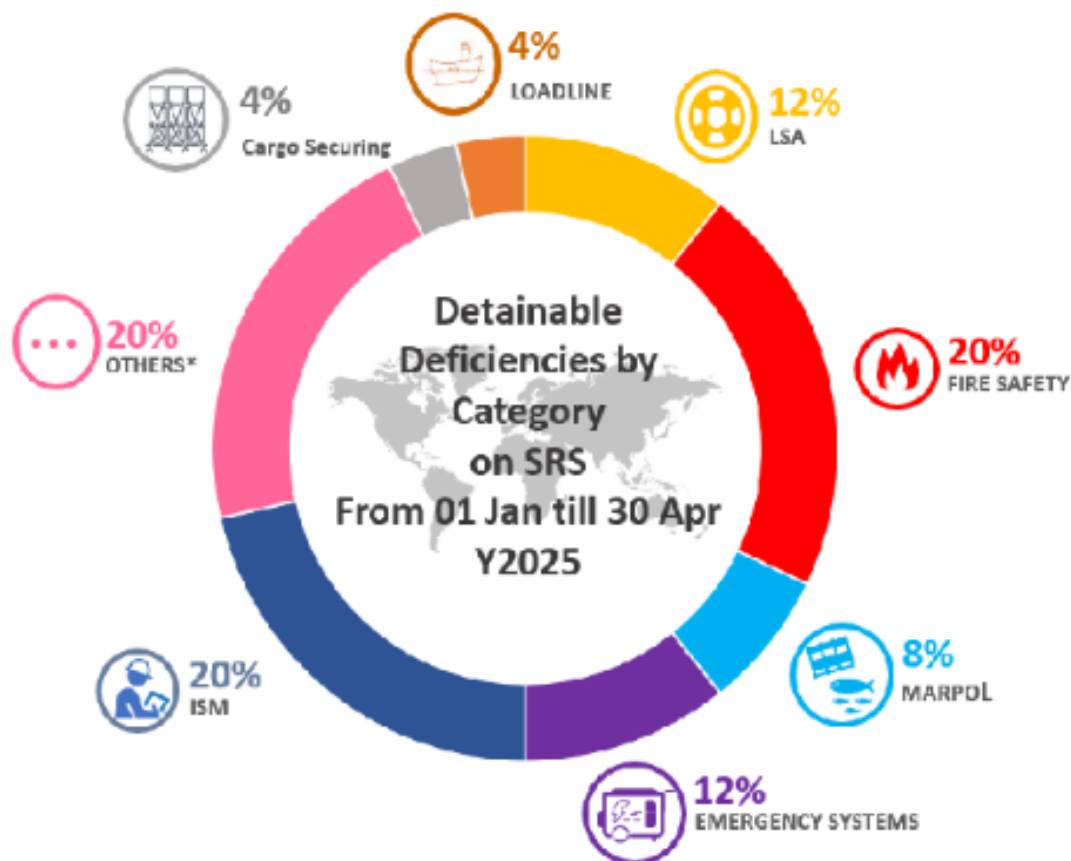
From 1 January till 30 April 2025, a total of 782 SRS and 174 SRS were inspected by PSC authorities under the Tokyo MOU and Paris MOU regimes, respectively. As compared to the number of SRS inspected during the same period in 2024, there was an increase of 8.8% in Tokyo MOU and a decrease of 15.5% in Paris MOU.

To date, 11 SRS have been detained under the various PSC regimes in 2025. Notably, nine detentions were recorded under the Tokyo MOU (five of which occurred in Australia), and there was one detention each under the USCG and Mediterranean MOU. The SRS performed well under the Paris MOU, with no PSC detentions recorded thus far.



SRS PERFORMANCE

Broadly, the detentions were due to common PSC deficiencies which could be avoided with proper planned maintenance and reporting of the defects. A breakdown of the deficiencies according to categories is shown below.



MPA would like to thank all shipowners, ISM managers, and crew for their contributions and support in ensuring compliance with international rules and regulations and keeping Singapore flag flying high.

Any defects or non-conformities should be promptly attended to and rectified in accordance with the ISM Code. For defects which cannot be promptly rectified, ship masters are requested to promptly report to MPA (shipping@mpa.gov.sg) and the ship's Classification Society. Masters should also promptly report the deficiency to the relevant competent authority when the vessel is calling at a port.

Dialogue with SRS Operators calling Australia's ports and ports in Paris MOU region

As part of MPA's continual efforts to maintain the SRS as a quality flag, the Flag State Control Department organised two dialogue sessions for operators with SRS frequent calls at ports of Australia and the Paris MOU region on 26 February and 7 March 2025, respectively.

The session provided insights into the Port State Control (PSC) performance of SRS in Australia and Paris MOU ports, including addressing common deficiencies found on SRS vessels.

The dialogue session also provides an additional information on procedures which MPA would take following a detention of an SRS, including necessary conditions for securing a vessel's release from the port of detention.

The dialogue session served as a valuable platform for knowledge sharing, strengthening compliance, and fostering a culture of safety and quality in maritime operations. The active involvement and sharing among participants demonstrated a strong dedication of SRS operators to uphold the standards of excellence and safety in ship operations.



Port State Control Committee Introduces New Performance Recognition Scheme for Shipping Companies

Tokyo MOU Port State Control (PSC) Committee Introduces New Performance Recognition Scheme for Shipping Companies

As a member of the Tokyo MOU PSC Committee, Singapore participated in a recent Committee Meeting where a new performance recognition scheme was adopted to reward and recognise high-performing companies. This scheme, developed by an intersessional working group, would see performance lists being published on the Tokyo MOU website, on a trial basis.



Under the scheme, companies would be classified as “High Performance Companies” upon fulfilling certain specific criteria – including completing a minimum of 30 PSC inspections over a 36-month period and achieving a “High” performance category rating. This initiative forms part of broader measures aimed at encouraging vessels to improve on overall compliance when operating within the region.

Singapore, along with other member authorities, supports this programme which demonstrates a collective commitment to promoting safety excellence in maritime operations while maintaining transparency in the industry.

The lists of high-performing and under-performing companies may be accessed at: <https://www.tokyo-mou.org/inspections-detentions/performance-lists/>. Performance data would be updated quarterly and maintained for reference.

MPA Appreciation Dinner for Seafarers and Partners in Seafarers' Welfare

Seafarers play a vital role in the efficacy and sustainability of the maritime industry. In recognition of their hard work and dedication, MPA hosted an annual year-end appreciation dinner for seafarers and shipping community's partners at Club@52, The Seacare Hotel in December 2024.

MPA's Chief Executive, Mr. Teo Eng Dih, together with Singapore Maritime Officers' Union's (SMOU) General Secretary, Ms. Mary Liew, attended the event together with some 120 guests. The lucky draw saw seafarers walking away with prizes graciously sponsored by the SMOU, Ocean Network Express (ONE), Jurong Port, NYK Shipmanagement and PSA Singapore, while beverages were kindly sponsored by the Singapore Organisation of Seamen (SOS).



Celebration held at The Mission to Seafarers Singapore's (MtSS) Drop-in Centre at Jurong Port

Over the past months, MPA, together with SMOU, the Mission to Seafarers Singapore (MtSS) and other key partners, hosted several seafarers' groups for various visiting ships encompasses of different nationalities to festivities and celebrations at the MtSS drop-in Centre in Jurong Port. These included Christmas celebrations on 23 December 2024, Lunar New Year celebrations on 13 February 2025, and Hari Raya celebrations on 14 April 2025.

During each of these sessions, seafarers from various visiting ships which called at Jurong Port were treated to a spread of seasonal delights and festive cheer – through interactive games, lucky draws, distribution of goodie bags and birthday celebrations. In addition, the Hari Raya event also featured an informative session by Bigyellowfish which discussed seafarers' wellbeing and mental wellness.

These activities were organised to promote a sense of community for visiting seafarers in Singapore, and also recognise their unwavering dedication, professionalism and sacrifices to keep maritime trade and supply chains flowing.



Christmas Celebrations on 23 December 2024



Lunar New Year Celebrations on 13 February 2025



Hari Raya Celebrations on 14 April 2025

Crew member struck by rescue boat crank handle during maintenance

What happened?

While using the crank handle to manually slack the Rescue Boat davit's wire rope, the handle suddenly rotated violently, dislodging from its hoisting slot, and striking both the Able Seaman (AB) and Electro-Technical Officer (ETO), resulting in injuries.

How did it happen?

The Bosun and AB attempted to slack the wire from the storage drum using the remote-control unit (see Figure 1). However, contrary to their intention, the wire began hoisting in the opposite direction. They requested ETO to examine the remote control for potential malfunctions.

During the ETO's inspection and testing the remote control, the AB decided to slack the wire manually using the hand crank. Without warning, the motor began rotating violently without load due to the slack wire, causing the hand crank to slip before striking both AB and ETO. The incident resulted in the AB sustaining a fractured forearm and the ETO suffering a head injury.



Figure 1

Improper Method for Laying Out Rescue Boat Wire Rope

The electric motor of the rescue boat davit is designed for hoisting operations, not for lowering the lifeboat. Instead, rescue boat davits employ a gravity-based lowering system, whereby the rescue boat descends under its own weight, regulated by a brake mechanism. This design specification is clearly documented in the manufacturer's instruction manual.

The incident revealed that the team lacked the requisite seamanship skills, knowledge and experience in operating this mechanism. Furthermore, the preliminary toolbox meeting proved inadequate of risk assessment in establishing and communicating the correct procedure and task to be carried out.

Wrong Type of Remote Control

The remote-control unit in operation featured "Up" and "Down" buttons, which was inappropriate for this system and potentially misleading. This unsuitable control device appears to have been inherited during the management transition, during which time its inherent safety risks went unidentified.

Faulty Limit Switch

Investigation revealed that the limit switch had malfunctioned, failing to perform its critical safety function of interrupting the electrical power supply when the hand crank was engaged with the cranking post.

Improper Work Procedure

Rather than waiting for the ETO's resolution of the remote control, the AB initiated manual cranking operations. This simultaneous execution of conflicting work processes failed to trigger any safety concerns among the three team members present. This incident highlights a lack of safety awareness within the team.

Conclusion and recommendations

This incident resulted from a combination of technical failures and human factors. The primary contributing factors included improper equipment, mechanical failure (faulty limit switch), inadequate procedural knowledge, and poor safety awareness. The absence of proper safety protocols and insufficient team communication significantly elevated the risk of injury. Most critically, the fundamental misunderstanding of the davit's designed operating principle—using gravity-based lowering rather than motor-powered descent—underpinned the entire sequence of events leading to the accident.

To prevent future incidents, a structured programme of crew training and competency assessment should be established, supported by enhanced safety protocols linked to the machinery / equipment to be used, proper documentation, and regular maintenance schedules, with particular emphasis on the gravity-based lowering system's correct operation.

Collision Incident in the Singapore Strait Traffic Separation Scheme (TSS)

What happened?

Vessel A departed from Singapore Eastern Petroleum “A” anchorage (AEPA) intending to join the eastbound lane of the TSS at the precautionary area. Meanwhile, Vessel B was proceeding in the westbound lane of the TSS, following the general traffic flow towards Pilot Eastern Boarding Ground “C” (PEBGC). Despite VTIS (Vessel Traffic Information Service) advising Vessel A to cross the westbound lane only after Vessel B had passed, Vessel A made a significant starboard alteration of course whilst approaching Vessel B, resulting in a collision.

Why did it happen?

Vessel B reduced speed to adjust its Estimated Time of Arrival (ETA) at PEBGC, during which Vessel C overtook it on the port side. At this time, Vessel A’s intention was to follow Vessel B’s stern, adjusting its heading for crossing the TSS. However, as Vessel A drew closer to Vessel B, it made a significant starboard alteration.

Analysis suggests that Vessel A's bridge team mistakenly tracked Vessel C's path to cross the TSS instead of Vessel B. When Vessel C completed its overtaking of Vessel B and became visible to Vessel A, the bridge team lost situational awareness of Vessel B's position and shifted attention from monitoring Vessel B to following Vessel C's stern for the TSS crossing (see Figure 1).

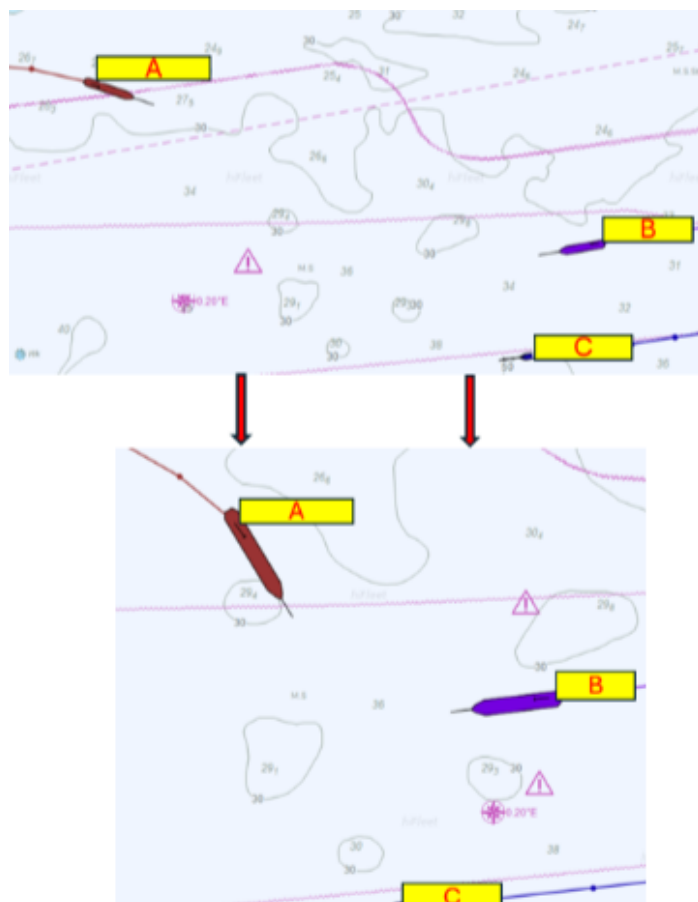


Figure 1

Collision Incident in the Singapore Strait Traffic Separation Scheme (TSS)

Bridge Watch Level

The bridge team on Vessel A consisted of the Master, Officer of Watch (OOW/Second Officer), and Helmsman, which was at manning level 3. During the pilot disembarkation, the Second Officer escorted the pilot to the ladder, temporarily reducing the bridge team to level 2, with no dedicated lookout maintained.

Look Out

The collision's primary cause was attributed to the absence of a proper lookout on both vessels. The Masters and OOWs failed to maintain adequate situation awareness of the developing close-quarter situation. The master of Vessel A, without conducting a comprehensive assessment, attempted to cross the TSS while following an incorrectly identified vessel. Simultaneously, Vessel B's bridge team failed to properly evaluate the crossing situation and did not detect Vessel A's change in aspect at close range. Critically, there was no monitoring or assessment of Vessel A's movement.

Conclusion and recommendations

The collision between Vessel A and Vessel B resulted from a combination of poor bridge team management and inadequate situational awareness. The temporary reduction in bridge manning during pilot disembarkation, coupled with the failure to maintain proper lookout, led to critical errors in vessel identification and traffic assessment for Vessel A. Vessel A's bridge team's misidentification of the vessel to follow, and Vessel B's failure to monitor the developing situation, ultimately resulted in the collision.

To prevent recurrence, it is recommended that:

- Bridge teams maintain minimum safe manning levels at all times (in accordance with its safety management system), particularly during critical operations
- Proper lookout be maintained through dedicated personnel and effective use of all available means
- Bridge teams verify target vessel identification before executing course alterations
- VTIS advice be acknowledged and followed, especially during TSS crossings
- Regular training be conducted on maintaining situational awareness in dense traffic situations

Loss of life

What happened?

Before starting work in the morning in engine room, the deceased told his peer that he could not sleep the previous night because his mind was ‘full of matters’. The said peer told the deceased that “it is alright. Relax. Take it easy.”

That evening, the deceased and other two deck ratings, D1 and D2 cooked and dined together. During the meal, the deceased shared his sleeping difficulties to them. When asked about the cause, he expressed uncertainty about his inability to sleep. After dining, all of them retired to their respective cabins for the night.

D1 felt uneasy in his cabin thinking of the deceased’s sharing. After a while, he initiated to knock on the deceased locked cabin to check on him but received no response. D1 then went to the bridge to report the situation to the duty officer, who promptly alerted the Chief Officer. Using the master key, the Chief Officer opened the deceased cabin only to find it vacant. The Chief Officer immediately informed the Master and a search for the deceased ensued.

During the search, the deceased was found hanging by his neck, on a nylon snorter that was secured through an overhead monorail track in the engine room workshop.

Why did it happen?

Investigation ruled out foul play in the above incident.

Conclusion and recommendations

Company

Companies should implement a comprehensive mental health support framework that includes:

- Clear reporting protocols for crew members showing signs of distress
- Confidential counselling services accessible at sea
- Mental health first aid training for senior officers
- Regular crew welfare checks and support systems
- Established intervention procedures for at-risk personnel
- 24/7 emergency support hotlines for crew members

These preventive measures are crucial for safeguarding crew welfare and preventing incidents of self-harm or disappearance at sea.

On board

Masters and crew members should maintain heightened awareness of potential warning signs concerning the wellbeing of colleagues, including:

- Sleep disturbances
- Social withdrawal or isolation
- Selective sharing of personal difficulties
- Changes in normal behaviour patterns

When such signs are observed, immediate escalation to senior management is essential. Early intervention may prevent tragic outcomes.

Total loss of Utility Vessel

What happened?

A vessel was transferring an old main engine liner to a utility vessel (UV) at Singapore anchorage. Prior to the transfer, the UV provided 14 lifting straps and four slings with hooks to the vessel to be used for the transfer operation. The vessel's crew secured the liner with the equipment before undertaking the transfer operations to UV using the vessel's provision crane.

The UV's crew did not secure the liner properly when it landed on UV's deck. Moderate swells caused UV to roll, which in turn caused the liner to shift to another end of the deck. This resulted in the UV capsizing and sinking. No reported injury and pollution resulted from the incident.

Why did it happen?

When the liner was landed on UV's deck, it was not properly secured (i.e. no precautions were taken to ensure that it would not move at all). Despite not securing the liner properly to prevent movement, UV's crew released the lifting equipment (see below Figure 1).

Note:

UV's crew prematurely removed the slings from hooks 'A', 'B' or 'C and D' before the liner was properly secured on deck to prevent movement.

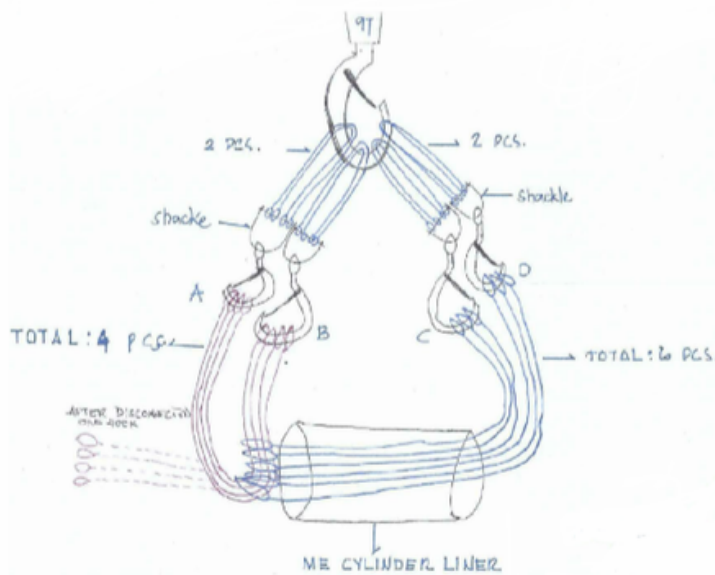


Figure 1

Conclusion

Based on the information gathered, it was deduced that UV's crew had not carried out correct procedure in relation to securing heavy load on deck.

Unauthorised boarding leading to injury of crew

What happened?

A vessel was boarded by around seven intruders while transiting the Singapore Straits. The intruders entered the vessel's steering gear room and the bottom floor through engine room escape trunk. They went to the engine room store and took some of the engine stores. While fleeing, one intruder caused a vessel's crew to suffer eye injury.

The injured crew was standing at the engine room incinerator platform, which was at the same level as the Engine Control Room; see image below:



Why did it happen?

The vessel had failed to implement security measures as required by the Ship's Security Plan (SSP) and Company's Security Circulars. The steering gear door was left open (see Figures 1, 2, 3 and 4 below).

Figure 1:
Steering gear room access door
was left opened

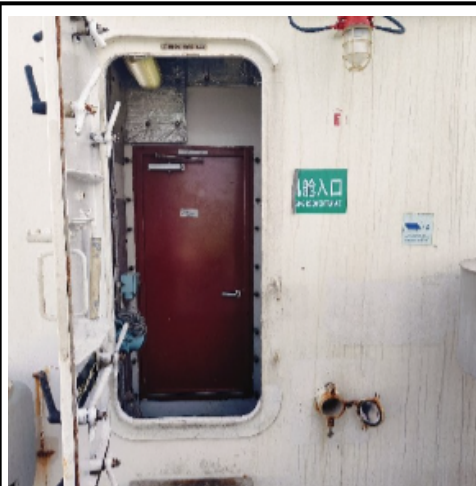


Figure 2:
The engine room escape trunk
used by the intruders.



Figure 3:
Engine Room Store where engine
parts were taken by the intruders.



Figure 4:
Intruders' footprints on starboard
quarter.
Note: Razor wire was rigged only
after the incident.



Conclusion

MPA had issued an advisory following the incident to all Singapore-registered ship owners, managers, operators, Company Security Officers, Ship Security Officer and masters on 11 March 2025, titled “Advisory for Singapore Registered Ships (SRS) Transiting the Singapore Strait – Security Precautions”.

The shipping community is reminded to ensure shipboard compliance of the SSP and consider heighten precautionary measures at identified risk areas where occurrences of unauthorised boarding are known.

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Seafarers Policy, Development & Welfare Department (SPDW):
(Select option 1, followed by option 2)

**Flag/Port State Control, Ship Regulatory, Design and Standards
Department (FSC/PSC/SRDS):**
(Select option 1, followed by option 3)

**Seafarers Skills Upgrading, Certification and Accreditation Department
(SSCA):**
(Select option 1, followed by option 4)



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