Marine Safety Investigation Report

VERY SERIOUS MARINE CASUALTY | **November 2026**

The Bahamas Maritime Authority

Nightlife / SG Naav
Fatal man-overboard on 17 January 2026

Extract from The Bahamas Merchant Shipping (Marine Safety Investigations) Regulations, 2026 Regulation 4:

The purpose of a marine safety investigation is to prevent future events by establishing the facts of the marine casualty or marine incident and making safety, pollution prevention or emergency response recommendations as appropriate.

The purpose of a marine safety investigation shall not be to determine liability nor, except so far as is necessary to achieve its objective, to apportion blame.

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What happened

On the evening of 17 January 2026, The Bahamas flagged bulk carrier, Nightlife, was at anchor off Singapore. Whilst the ship's crew were preparing for diving operations and mooring a bunker barge alongside, a bunker surveyor was transferring to a service boat, SG Naav, using Nightlife's accommodation ladder.

During the transfer, the bunker surveyor fell, landing heavily on SG Naav's deck. The boat's two crew tried to pull him onboard but he fell into the sea. Despite in-water assistance from one of the boat's crew and a diver from a nearby workboat, it required assistance from a Singapore Police Coastguard vessel to retrieve him from the water.

Once recovered, he received cardio-pulmonary resuscitation whilst on passage to shore but was declared dead when he arrived at hospital. A post-mortem indicated that he drowned.

Why it happened

Nightlife's large freeboard, use of a forward-leading accommodation ladder and removal of the outboard stanchion increased complexity of the transfer. The rolling and pitching of SG Naav made it more difficult for the victim to safely complete the transfer.

As the victim's lifejacket was not effectively secured, it was lost and could not afford him any buoyancy. The combination of the design of SG Naav and unavailability of any man-overboard recovery equipment meant that the victim could not be recovered to SG Naav.

At the time of the casualty, there was significant time pressure on Nightlife's crew. Personnel on deck and on the bridge were tasked with several conflicting operations that affected the selection of transfer arrangements, reduced the available number of crew to facilitate the transfer and reduced the perceived importance of the personnel transfer. None of the operations were subject to effective assessment of the risks posed, either individually or collectively.

What we can learn

A significant number of personnel have been killed during transfer between ships and boats but the risks do not seem to be apparent to the industry. Much work has been done to improve the standards for pilot transfer arrangements: the industry would benefit from re-framing of the language used when referring to these arrangements to ensure that all personnel subject to the hazards present when transferring are offered the protections required by SOLAS Chapter V, Regulation 23.

The timing of the many operations being conducted at anchor was not under the influence of the crew. When planning calls at busy maritime hubs, charterers and ship managers need to identify what activities may clash or overstretch onboard resources and put measures in place to mitigate the potential additional risks created.

Broadcasting a 'Mayday' message on the appropriate channel using standard marine communication protocols increases the likelihood that near-by vessels are made aware of a situation where they may provide assistance.

Narrative

All times are local time (UTC +8)

On the morning of 17 January 2026, The Bahamas flagged bulk carrier, Nightlife, was approaching Singapore from the east and preparing for a brief stay at anchor to bunker fuel, take provisions, conduct a crew change and use divers to clean the hull. In preparation, the bosun and deck team rigged the port and starboard pilot transfer arrangements. As Nightlife was in ballast with a freeboard of approximately 14.8m, the pilot ladders were rigged in combination with accommodation ladders.

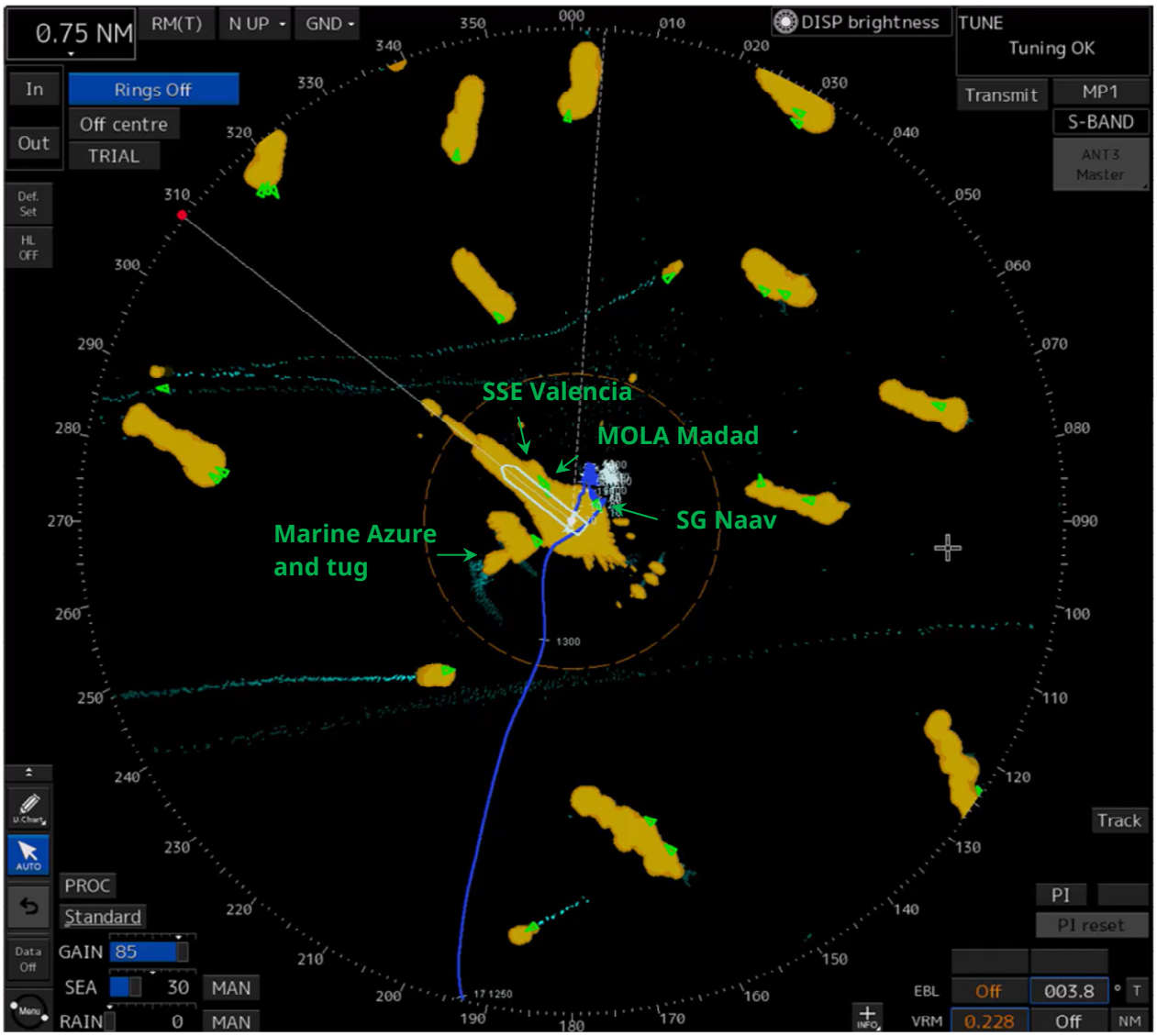
At 12:35, the pilot boarded and 25 minutes later Nightlife anchored at the Eastern Bunkering C anchorage. Shortly afterwards, dive barge SSE Valencia moored alongside Nightlife, forward of the starboard pilot ladder. Nightlife's crew stowed the pilot ladder to avoid entanglement with the barge's mooring lines. SSE Valencia was then joined by the dive workboat MOLA Madad with five divers onboard. After assessing the weather and tidal stream, the dive supervisor informed Nightlife's master that they would wait for more favourable tidal stream conditions and conduct their dives to clean the hull in the evening.

Over the course of the afternoon, the ship was boarded by the ship's agent, chandler, two dive supervisors, two on-signing crew and, at 16:05 and 16:13 two bunker surveyors. The bunker surveyors, accompanied by Nightlife's engineering team, sounded the fuel tanks and the survey was complete at around 17:10.

At 18:45 a service boat, SG Naav, was tasked with collecting Bunker Surveyor A (via the operator's mobile application). At around the same time, bunker barge Marine Azure was approaching Nightlife. At 18:56 Marine Azure called Nightlife on VHF radio and relayed that they would not come alongside on the starboard side as planned due to the presence of the dive barge and workboat. After a short discussion with the chief engineer, it was agreed that Marine Azure could moor on the port side.

At the same time, SG Naav was approaching Nightlife's port side. Marine Azure then called Nightlife requesting that they inform the "crew boat" (SG Naav) to stay clear of the port side. SG Naav then repositioned to Nightlife's starboard side. Onboard Nightlife, the bosun started re-rigging the starboard combination ladder but the dive barge's mooring lines obstructed deployment. After asking permission from the bridge, he then went aft to rig the starboard accommodation ladder.

With the duty able seafarer on the accommodation ladder's hoist control and the accommodation ladder at deck level, the bosun rigged the rails, set the lower platform and added stanchions, removing the outboard stanchion at the request of Bunker Surveyor A. Following hand signals from the deckhand on SG Naav, the duty able seafarer lowered the accommodation ladder to facilitate the transfer.



Screenshot from Nightlife's VDR: Radar at 19:20.
Marine Azure, SG Naav, SSE Valencia and MOLA Madad labelled

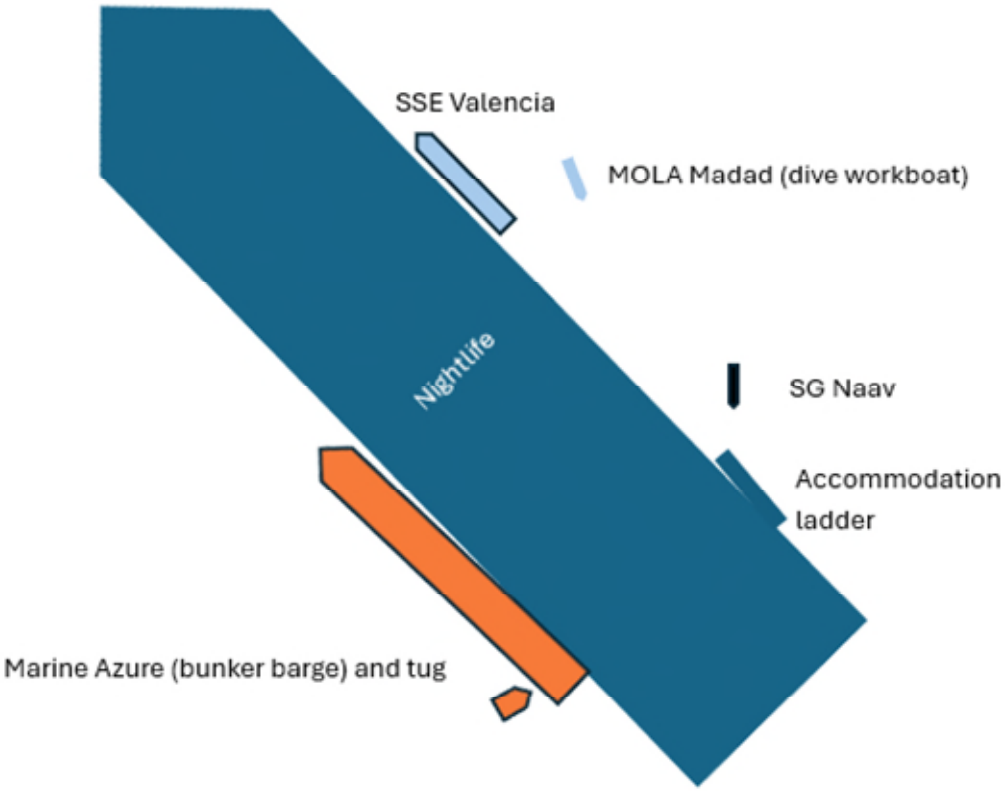
Whilst the accommodation ladder was being rigged, divers onboard MOLA Madad were preparing for their dive and, at 19:25, Nightlife notified Singapore's Marine Safety Control Centre of the commencement of diving operations and were told to proceed. At the same time, Marine Azure was coming alongside on the port side, assisted by a tug.

With the accommodation ladder rigged, Bunker Surveyor A made his was down, wearing a lifejacket and a backpack. SG Naav was rolling and pitching as the coxswain brought the vessel towards the gangway, perpendicular to Nightlife. The deckhand, who was standing-by on the fore deck, gestured for Bunker Surveyor A to wait. Moments later, Bunker Surveyor A stepped across to SG Naav and fell. He was left holding the hand of the deckhand and the tyre fenders on SG Naav's bow.

Onboard SG Naav, the coxswain came forward to assist. Together they removed Bunker Surveyor A's backpack but were unable to pull him onto the deck whilst the service boat continued to pitch and roll, close to the accommodation ladder. The coxswain returned to the controls and manoeuvred astern to increase clearance. From Nightlife, SG Naav was quickly out of sight and lost in the dark[1]. Unaware of the seriousness of the situation, the Bosun and Duty AB were called to the port side to assist with the mooring of Marine Azure.

[1] Sunset was at 19:16

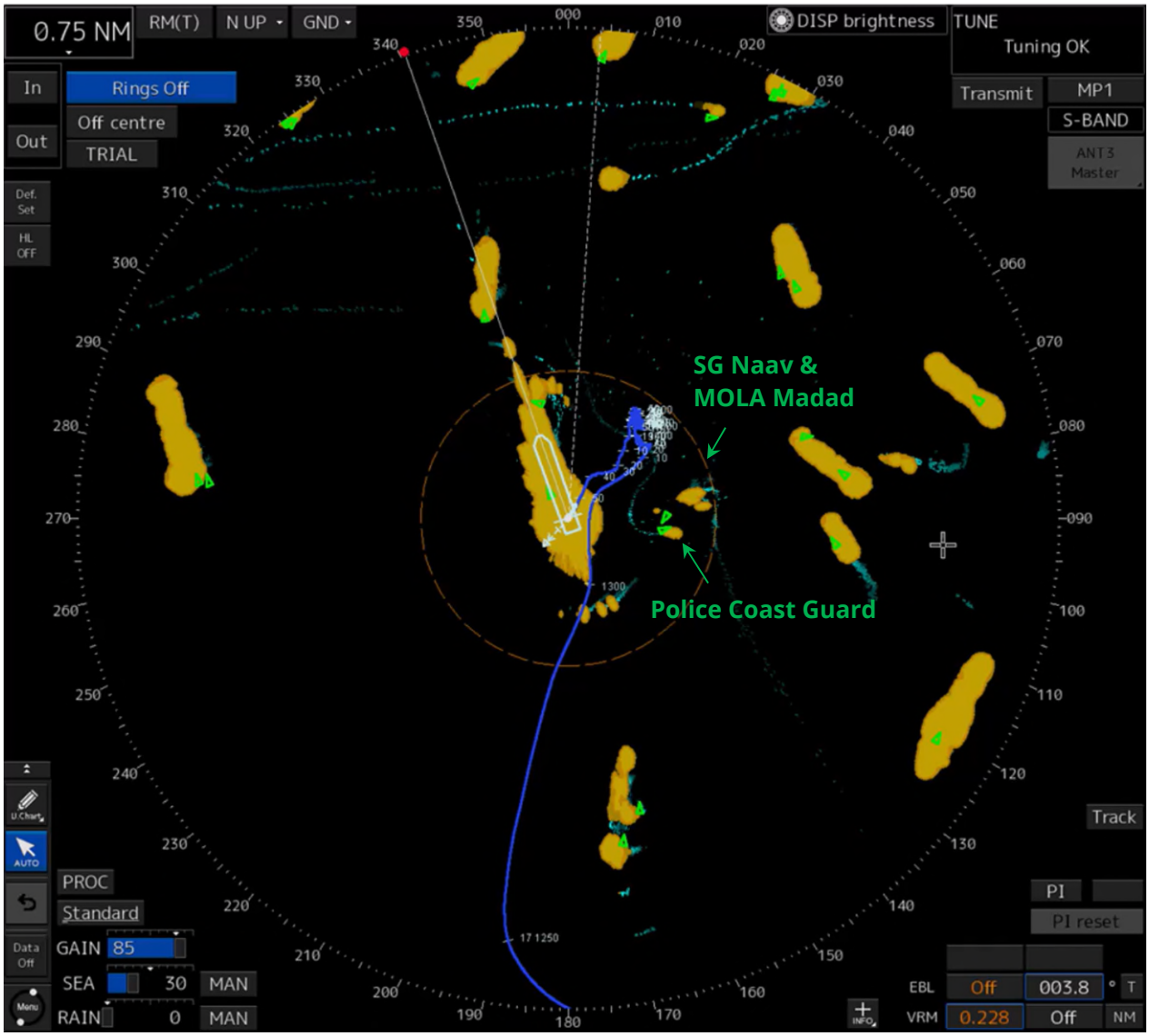
Onboard SG Naav, Bunker Surveyor A lost his grip and fell into the sea. His lifejacket inflated but was not effectively secured and was lost. SG Naav's deckhand, wearing a lifejacket, jumped into the sea to try and keep Bunker Surveyor A afloat with his head above water. The coxswain shouted "man-overboard" towards Nightlife but was not heard. He threw a lifebuoy and called port operations using his mobile phone. At 19:38 a call was also made on VHF: "man-overboard, man-overboard, man-overboard" but this was overspoken and had no identifying callsign or location. SG Naav's coxswain then manoeuvred toward MOLA Madad to seek help.



Representation of vessel positions at 19:40

On MOLA Madad, the skipper started the engine and manoeuvred to the two persons in the water; divers onboard then threw a lifebuoy with line to SG Naav's deckhand to facilitate retrieval. As visibility was reducing and the deckhand appeared to be exhausted, one diver entered the water and positioned the lifebuoy under the arms of the now unresponsive Bunker Surveyor A. The diver instructed the deckhand to board MOLA Madad. The assisting diver held onto Bunker Surveyor A while the remaining divers on board pulled them towards the workboat using the lifebuoy's line.

At 19:48 there was a further "man-overboard" call on VHF, which included an attempt to hail "Nightlife" but this was not heard by the crew on Nightlife's bridge and no further calls were transmitted.



**Screenshot from Nightlife's VDR: Radar at 19:58.
SG Naav, MOLA Madad and Police Coastguard boat labelled**

At 19:58, a Police Coastguard boat, followed by a Singapore Maritime and Port Authority boat, arrived at the scene. The assisting diver handed the lifebuoy line to the Police Coastguard officers and, at around 20:00, the Police Coastguard officers retrieved both the unresponsive Bunker Surveyor A and the assisting diver onto the Police Coastguard boat.

Whilst officers commenced cardio-pulmonary resuscitation, the Police Coastguard boat proceeded at speed to the Tanah Merah Ferry Terminal, where an ambulance was waiting. At 21:13, Bunker Surveyor A was pronounced dead at Changi General Hospital. The post-mortem indicated Bunker Surveyor A drowned.

Background to the investigation

Following the casualty, Singapore authorities conducted initial inquiries to establish the circumstances. Once it was established that the man-overboard involved the transfer operation from the Bahamas-flagged vessel Nightlife, the Transport Safety Investigation Bureau of Singapore (TSIB) notified the Bahamas Maritime Authority on 20 January 2026 (three days after the casualty).

In the days between the man-overboard and the notification, Nightlife was boarded by insurance interests, officers from Singapore Police Coastguard and an officer from Singapore's Ministry of Manpower. Singapore Police Coastguard conducted a re-enactment of the circumstances of the casualty with SG Naav. Nightlife was then released and started passage.

On the basis that the casualty involved the transfer operation from a Bahamas-flagged vessel, Singapore's Transport Safety Investigation Bureau did not commence its own marine safety investigation but subsequently assisted the investigation by facilitating evidence gathering as a Substantially Interested State (SIS).

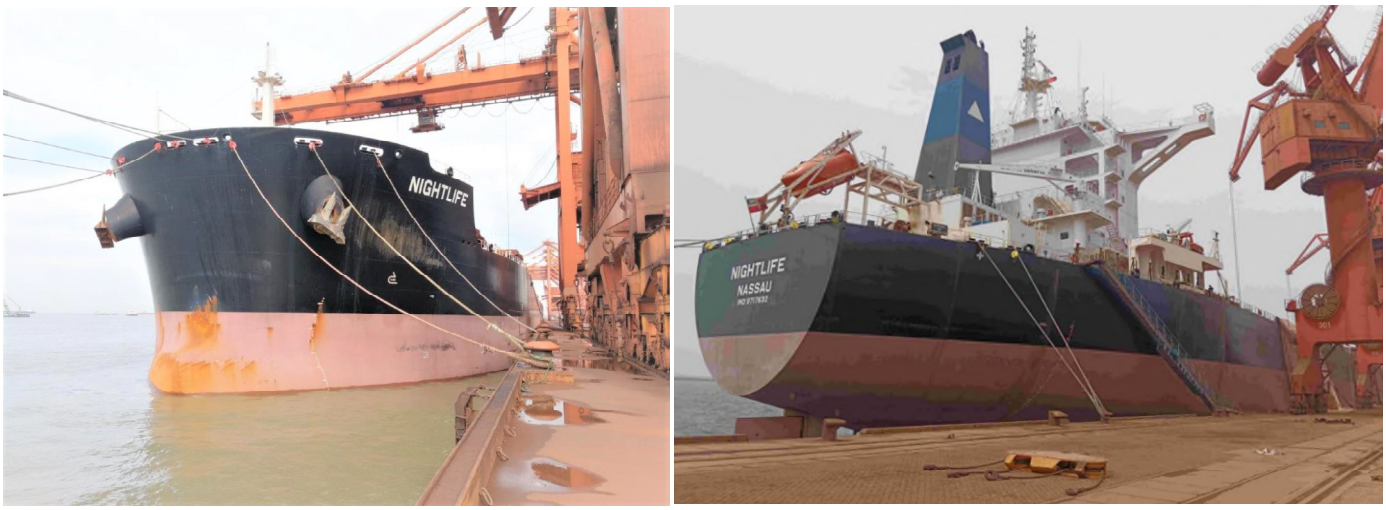
Nightlife's operators did not report this casualty to the Bahamas Maritime Authority on the basis that the incident did not occur onboard the vessel. The operators did however facilitate provision of the voyage data recorder download, access to witnesses for remote interviews and other requested evidence.

Oldendorff Carriers GmbH & Co KG was the time charterers of the vessel at the time of the incident. The victim was engaged by a separate company within the Oldendorff Group, Egon Oldendorff Management GmbH.

Vessels and victim

Nightlife was a nine hold bulk carrier with a deadweight of 179,455 tonnes. It was built in 2015. The accommodation ladder was of aluminium construction, with 60 steps (21m long). Its construction certificate stated it had an operational range of 0°-55°. Nightlife had a freeboard of approximately 14.8m on arrival at Singapore.

Nightlife was last subject to a port State control inspection on 15 December 2025 and a flag State annual inspection on 12 May 2025. Neither identified any deficiencies.



Nightlife, at a similar draught condition, during flag State annual inspection

SG Naav was a fibreglass hulled, domestic registered, supply vessel. It was authorised by the Maritime and Port Authority of Singapore to carry up to 12 passengers. Its engines delivered 390 kW to two propellors. It was last surveyed by the Maritime and Port Authority on 01 August 2025.



SG Naav, photos courtesy of Singapore TSIB

The victim was a 65 year old Greek national who worked as a freelance surveyor. He was a master mariner and had provided survey services since 2006. He was appointed to conduct the bunker survey by Nightlife's Charterers, Oldendorff Carriers GmbH & Co. KG. He mobilised for the bunker survey from Greece[2] on 2 January 2026.

Legislation and guidance

The Bahamas Maritime Authority's Marine Notice 36: Management of Occupational Health & Safety describes the general duties of employers and employees in relation to health and safety, in line with Merchant Shipping (Health and Safety – General Duties) Regulations 1984.

Marine Notice 36 does not provide specific guidance on working safely onboard ships but states that the shipowner shall comply fully with the International Labour Organization's Code of Practice "Accident prevention on board ship at sea and in port" or other recognised Codes of Practice including the United Kingdom's Maritime & Coastguard Agency's "Code of Safe Working Practices for Merchant Seafarers".

Both *Accident prevention on board ship at sea and in port* and the *Code of Safe Working Practices for Merchant Seafarers* provide guidance on safe access to ships. Neither provide detailed guidance on provision of safe access for personnel transferring from boats to ships except in the case of access for pilots.

The *Code of Safe Working Practices for Merchant Seafarers* offers the following guidance for crew when there is a risk of falling into the water during a transfer to a vessel or structure that is not alongside in Chapter 22.7.7:

> Crew should wear working lifejackets and, where necessary in particularly cold water, anti-exposure suits (see section 8.3), when there is a risk of falling into the water during a transfer to a vessel or structure that is not alongside. Baggage and other items should be transferred by the crews of the vessels and not by those boarding.

[2] The victim's precise movements, work and rest prior to boarding Nightlife are unknown so no assessment of potential effects of fatigue was possible.

Singapore's Workplace Safety and Health Act imposes a general duty on employers to take such measures as are necessary to ensure the safety and health of their employees at work. This includes providing a safe work environment, implementing appropriate safety measures, managing workplace risks, developing emergency procedures, and ensuring that workers receive adequate instruction, information, training, and supervision.

Workplace Safety and Health (General Provisions) Regulations s23 (11) provides:

> 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.

Maritime and Port Authority of Singapore issued Guidelines for Safe Transfer of Persons Between Vessels at Anchorages in August 2020 (Port Marine Circular No. 34 of 2020). The guidelines are applicable to "persons who are exposed to risk of falling into the water during transfers between vessels at the anchorage". Such persons explicitly includes ships' crew, harbour pilots, boarding officers of shipping agencies, marine surveyors, marine superintendents, repair crew and other service personnel that board ships at the anchorages.

The guidelines stipulate:

> 5. Suitable boarding arrangements, such as accommodation ladder, pilot ladder and/or combination ladder, are to be properly rigged and assessed to be safe for use, by an authorised person from the vessel providing the boarding arrangements.
> a) A safely rigged pilot ladder might be the most appropriate means for boarding a vessel from a service boat. However, where the vessel's freeboard exceeds 9 meters, a combination of pilot ladder and accommodation ladder should be used.
> b) Where pilot ladders are used for embarkation and disembarkation, they should conform to the requirements of IMO Resolution A.1045(27).
> c) Steep angled accommodation ladders (>55 degrees to horizontal) should not be used for embarking or disembarking at anchorages into or from a service boat.

The International Convention for the Safety of Life at Sea (SOLAS) applies to ships over 500GT and to passenger ships on international voyages. Chapter V - Safety of navigation - Regulation 23 covers pilot transfer arrangements and applies to all ships on which pilots may be employed. They apply exclusively to arrangements used to transfer pilots. New standards were adopted in June 2025 but are not in force until 1 January 2028.

The International Safety Management (ISM) Code provides an international standard for the safe management of operation of (SOLAS) ships and for pollution prevention. The ISM Code requires shipping companies to implement and maintain a Safety Management System.

Safety management

As required by the ISM Code, the managers of Nightlife, Alcyon Shipping Co. Ltd, had a safety management system. It did not include any policy or procedure for safe transfer of personnel and there was no formal assessment of the associated risks.

As a domestic vessel under 500GT, SG Naav was not required to operate a safety management system under the ISM Code. Its operator, SeaCabbie, provided standard operating procedures which included an Operations Procedure for Safe Transfer of passengers and briefing cards for passengers.

Oldendorff Carriers GmbH & Co. KG had no risk assessments, policies or procedures for appointing independent contractors.

Previous similar cases

The BMA has identified 10 recent similar cases from the data available in the International Maritime Organization's marine casualty and incidents database in their Global Integrated Shipping Information System[3]. Surveyors, technicians, superintendents and ship's crew have fallen into the sea whilst attempting to transfer between ships and boats. Details are included at Appendix 1.

In almost all cases the victim was not wearing a lifejacket. In many cases the victim was wearing a backpack. In all the cases the service/transfer boat was unable to rescue the person in the water.

SRS Proteus Harvonne (2024) Singapore
A Singapore flagged tanker was at anchor in ballast off Ulsan. After completing a handover the off-signing master was climbing down the combination ladder to a service boat when he fell into the sea. He could not be recovered by the service boat and the weather conditions hampered the ship's attempts. He was recovered by Korean Coastguard but declared dead on arrival. He was wearing a backpack. He was not wearing a lifejacket.
https://isomer-user-content.by.gov.sg/287/a82157a8-5ee7-44e0-acbf-7bdf60104b44/cas-168---death-due-to-mob-involving-srs-ph-at-ulsan-anchorage-24-may-24.pdf

Enki/ Hürkuş (2022) Türkiye
A St Kitts and Nevis flagged chemical tanker was anchored at the Southern entrance to the Istanbul Strait. Whilst climbing a 2m pilot ladder an on-signing cook fell into the sea. She could not be recovered by the service boat and it took 25 minutes to recover her to the ship's rescue boat. She was wearing a backpack. She was not wearing a lifejacket.
https://ulasimemniyeti.uab.gov.tr/uploads/pages/safety-investigation-reports/enki-final-marine-safety-investigation-report-06-06-2023.pdf

Agios Nikolas / LEO 38 (2022) Singapore
A Malta flagged tanker was at anchor in Singapore for bunkering and maintenance, utilising three local technicians. Whilst the technicians were disembarking to a service boat via the accommodation ladder, the service boat rolled and one technician fell from the deck into the sea. The service boat could not recover the victim. He was wearing a backpack that weighed approximately 10kg. He was wearing a lifejacket that required manual inflation but did not pull the activation cord.
https://isomer-user-content.by.gov.sg/287/d9f743e7-8979-4d89-baa7-1082d8a6f431/tib-mai-cas-125_final-report-of-mob-involving-service-boat-leo-38-and-tanker-agios-nikolas6d916087da324dd49e1f1c0520a0ec03.pdf

VS Salome / Portunus (2022) Malta
A Malta flagged tanker was at anchor off Hartlepool, UK. The off-signing master, wearing an inflatable lifejacket provided by the transfer boat, fell whilst climbing down the pilot ladder. The lifejacket inflated but the crotch strap was not secured. The backpack could not be removed as its straps were underneath the lifejacket. The presence of the backpack complicated the service boat's attempts to rescue the victim using the permanently fixed rescue cradle.
https://msiu.gov.mt/wp-content/uploads/2023/09/MT-VS-Salome_Final-Safety-Investigation-Report.pdf

[3] If a tight definition is applied, the victim fell overboard from SG Naav: a non-SOLAS vessel. The victim was not a member of Nightlife's crew and could be considered outside the control of the vessel's operation. It is wholly conceivable that similar casualties occur may not be subject to a marine safety investigation in line with the Casualty Investigation Code.

Analysis

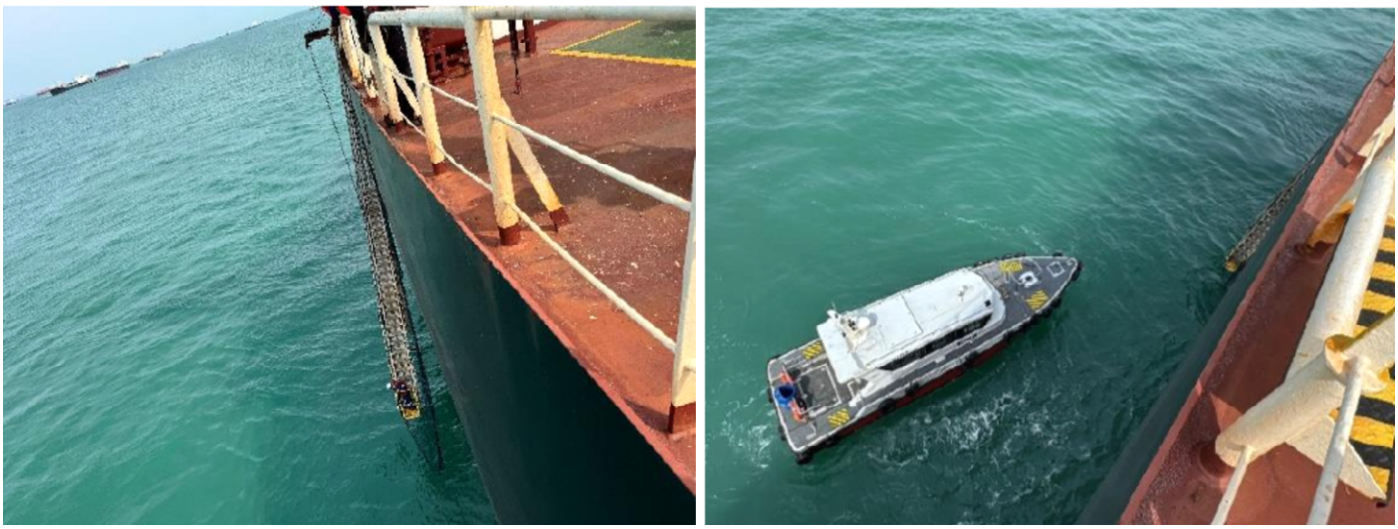
The purpose of the analysis is to determine the contributory causes and circumstances of the casualty as a basis for making recommendations to prevent similar casualties occurring in the future.

The transfer

Witness accounts differ on the precise mechanism and timing of the fall but the post-mortem identified fractures to the victim's left and right second to seventh anterior ribs, as well as bruising on the midline of the chest, indicating a heavy forward fall on to a solid object.

With the absence of hydrodynamic interaction and the inability of the ship to provide an effective lee, manoeuvring service boats to facilitate transfer from ships at anchor is technically challenging. The use of a forward facing accommodation ladder to facilitate transfer increased complexity. Both Nightlife and SG Naav's crew indicate that SG Naav was rolling and pitching heavily as the surveyor descended the accommodation ladder but the transfer arrangements made the transfer complex.

With the estimated freeboard and clearance above the waterline, Nightlife's accommodation ladder is calculated to have been at an angle of 41 degrees (below horizontal) at the time of the casualty. Whilst this is within its stated operation range, it was steep. The crew of SG Naav reported that the lower platform was not horizontal – making transfer more difficult. The large freeboard also meant that the lower platform was at a significant distance from the hull. The removal of the outboard stanchion, albeit at the victim's request to help him move more easily, may have made it more challenging.



**Singapore Police Coastguard's re-enactment with SG Naav.
Photos courtesy of Alcyon Shipping Co. Ltd. and Skuld P&I Club.**

Anecdotal evidence, supported by a review of previous similar cases, indicates that the arrangements above are not unusual for transfer of surveyors, technicians, superintendents and ship's crew. There are currently no international standards in force that prescribe requirements for transfer of personnel that are not pilots. These arrangements however would not be acceptable for a pilot transfer under the current requirements of SOLAS Chapter V Regulation 23.

SOLAS Chapter V Regulation 23

SOLAS Chapter V covers safety of navigation. Regulation 23 describes standards for the design, manufacture, construction, rigging (including lighting), installation, operational readiness, onboard inspection and maintenance of pilot transfer arrangements.

The Regulation also mandates that the rigging of the pilot transfer arrangements and the embarkation of a pilot be supervised by a responsible officer having means of communication with the navigation bridge and the need to have a lifebuoy with light and a heaving line at hand, ready for immediate use.

The current Regulation applies exclusively to arrangements used to transfer pilots. New standards, adopted in June 2025, but not in force until 1 January 2028, include the following:

> 2. Pilot transfer arrangements shall enable pilots and other personnel to embark and disembark safely in all seagoing conditions of draught and trim.

Singapore's Guidelines for Safe Transfer of Persons Between Vessels at Anchorages are intended to provide operational safety guidance specifically for shore-based personnel and ship's crew embarking and disembarking ships. Because the current SOLAS Chapter V Regulation 23 applies exclusively to marine pilots, these Guidelines serve to bridge the safety gap for non-pilot transfers by offering advisory recommendations. It does not require service boats to enforce the requirements where transfer arrangements are suspected to be unsafe, only to report unsafe practices.

Singapore's Workplace Safety and Health (General Provisions) Regulation 23 puts responsibility to provide suitable lifejackets on the employer of a person who is exposed to the risk of falling into water. Regulation 23 also places the responsibility to provide equipment and means of rescuing and resuscitating drowning persons on the employer of the person at risk - difficult to put into practice, when considering the transfer of ship's agents, chandlers, third party surveyors and other service personnel not employed by the ship or boat.

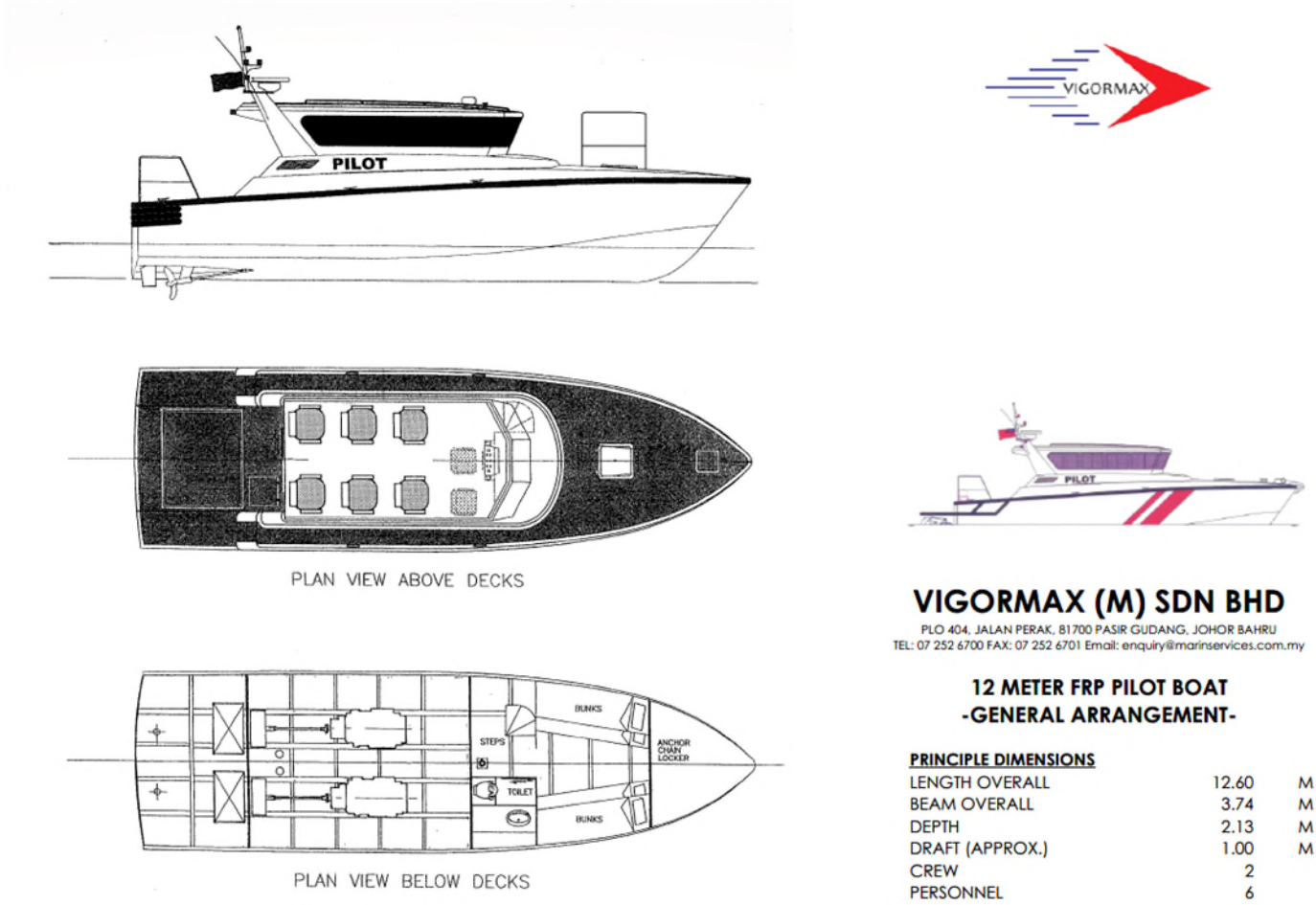
Casualty recovery

Nightlife's crew were unaware of the seriousness of the situation and were quickly called away to deal with the mooring of the bunker barge. There was no responsible officer monitoring the transfer and resources on the bridge and elsewhere onboard were focused on the arrival of the bunker barge and start of diving operations. Verbal calls from SG Naav were not heard by those on deck and two transmissions on VHF radio were not heard[4] on the bridge. Nightlife therefore did not deploy any lifesaving equipment to assist the victim or his recovery from the water.

Onboard SG Naav the deckhand and coxswain did their best to keep the victim onboard and removed his backpack as part of their efforts to help. When the victim's strength ebbed and he fell into the sea, there was no man-overboard recovery equipment available to facilitate recovery other than the boat's four lifebuoys. On seeing that the victim's lifejacket had "come off" the deckhand felt compelled to enter the water to help keep the victim afloat but SG Naav's relatively high freeboard and absence of a rescue area meant that the victim could not be recovered. The victim was eventually recovered to a Singapore Police Coastguard vessel with a low freeboard.

SG Naav was constructed to a standard pilot boat design with its internal arrangement adapted to enable transport of additional passengers.

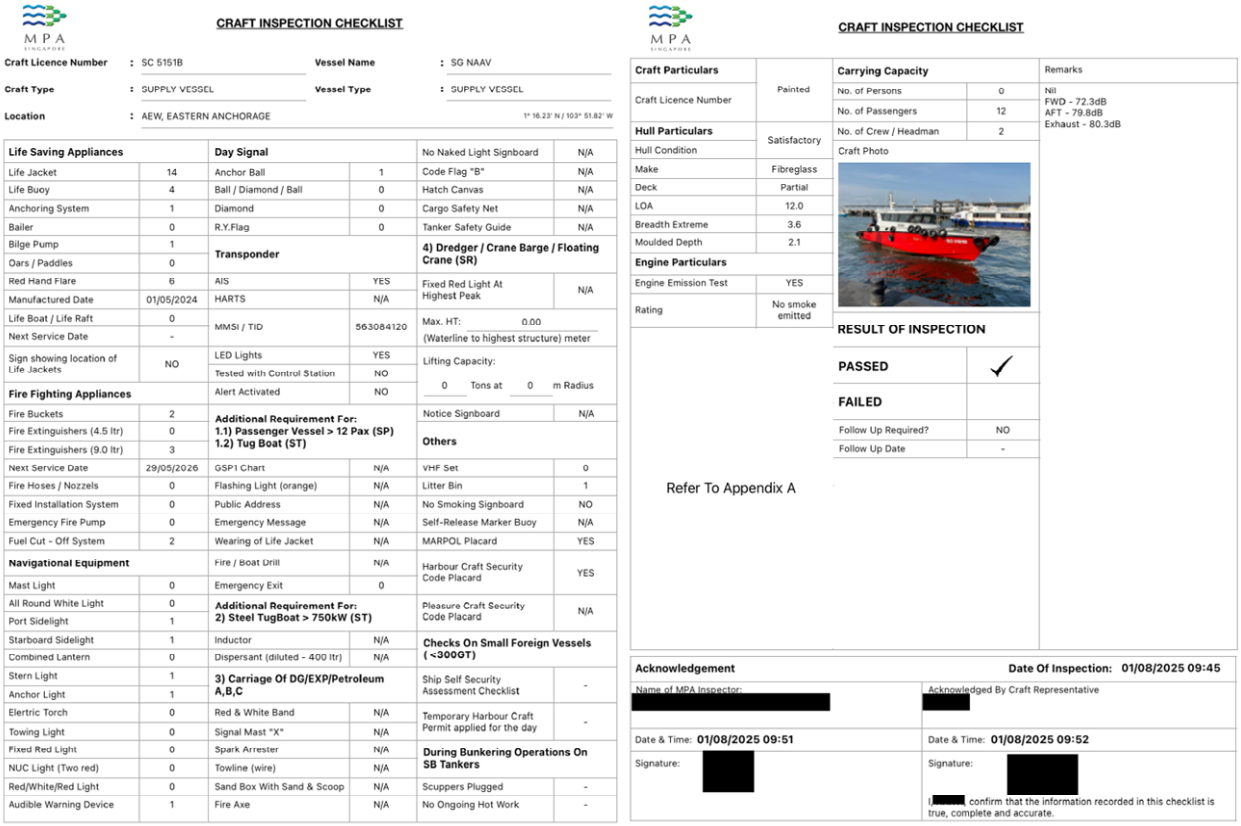
[4] The man-overboard calls did not follow the protocol of a distress call or include any detail on the location of the man-overboard. Whilst they were clear on VDR recordings of the VHF channels, they were unintelligible when listening to Nightlife's ambient bridge audio recordings.



SG Naav – manufacturer's general arrangement included in marketing material

SG Naav's sole use was for the transport of passengers and small amounts of packaged cargo. It was subject to licencing and inspection under the Maritime and Port Authority of Singapore (harbour craft) Regulations which included requirements for an annual inspection.

As the vessel was licenced to carry up to 12 passengers, it was not subject to additional requirements for passenger vessels. It had a minimum manning level of a single "steersman". Maritime and Port Authority of Singapore's craft inspection checklist did not require assessment of man-overboard recovery arrangements, emergency procedures or the completion of any drills as part of the annual inspection. As such it was not equipped to deal with a man-overboard situation without external assistance.



MPA

CRAFT INSPECTION CHECKLIST

Craft Licence Number	: SC 5151B	Vessel Name	: SG NAAV
Craft Type	: SUPPLY VESSEL	Vessel Type	: SUPPLY VESSEL
Location	: AEW, EASTERN ANCHORAGE		1° 16.23' N / 103° 51.82' W

Life Saving Appliances		Day Signal		No Naked Light Signboard	N/A
Life Jacket	14	Anchor Ball	1	Code Flag "B"	N/A
Life Buoy	4	Ball / Diamond / Ball	0	Hatch Canvas	N/A
Anchoring System	1	Diamond	0	Cargo Safety Net	N/A
Bailer	0	R.Y.Flag	0	Tanker Safety Guide	N/A
Bilge Pump	1	**Transponder**		**4) Dredger / Crane Barge / Floating Crane (SR)**	
Oars / Paddles	0				
Red Hand Flare	6	AIS	YES	Fixed Red Light At Highest Peak	N/A
Manufactured Date	01/05/2024	HARTS	N/A		
Life Boat / Life Raft	0	MMSI / TID	563084120	Max. HT: 0.00 (Waterline to highest structure) meter	
Next Service Date	-				
Sign showing location of Life Jackets	NO	LED Lights	YES	Lifting Capacity:	
		Tested with Control Station	NO	0 Tons at 0 m Radius	
Fire Fighting Appliances		Alert Activated	NO		
Fire Buckets	2	**Additional Requirement For: 1.1) Passenger Vessel > 12 Pax (SP) 1.2) Tug Boat (ST)**		Notice Signboard	N/A
Fire Extinguishers (4.5 ltr)	0			**Others**	
Fire Extinguishers (9.0 ltr)	3				
Next Service Date	29/05/2026	GSP1 Chart	N/A	VHF Set	0
Fire Hoses / Nozzels	0	Flashing Light (orange)	N/A	Litter Bin	1
Fixed Installation System	0	Public Address	N/A	No Smoking Signboard	NO
Emergency Fire Pump	0	Emergency Message	N/A	Self-Release Marker Buoy	N/A
Fuel Cut - Off System	2	Wearing of Life Jacket	N/A	MARPOL Placard	YES
Navigational Equipment		Fire / Boat Drill	N/A	Harbour Craft Security Code Placard	YES
Mast Light	0	Emergency Exit	0		
All Round White Light	0	**Additional Requirement For: 2) Steel TugBoat > 750kW (ST)**		Pleasure Craft Security Code Placard	N/A
Port Sidelight	1				
Starboard Sidelight	1	Inductor	N/A	**Checks On Small Foreign Vessels (<300GT)**	
Combined Lantern	0	Dispersant (diluted - 400 ltr)	N/A		
Stern Light	1	**3) Carriage Of DG/EXP/Petroleum A,B,C**		Ship Self Security Assessment Checklist	-
Anchor Light	1				
Elertric Torch	0	Red & White Band	N/A	Temporary Harbour Craft Permit applied for the day	-
Towing Light	0	Signal Mast "X"	N/A		
Fixed Red Light	0	Spark Arrester	N/A	**During Bunkering Operations On SB Tankers**	
NUC Light (Two red)	0	Towline (wire)	N/A		
Red/White/Red Light	0	Sand Box With Sand & Scoop	N/A	Scuppers Plugged	-
Audible Warning Device	1	Fire Axe	N/A	No Ongoing Hot Work	-

MPA

CRAFT INSPECTION CHECKLIST

Craft Particulars		Carrying Capacity		Remarks
Craft Licence Number	Painted	No. of Persons	0	Nil FWD - 72.3dB AFT - 79.8dB Exhaust - 80.3dB
Hull Particulars		No. of Passengers	12	
Hull Condition	Satisfactory	No. of Crew / Headman	2	
Make	Fibreglass	Craft Photo		
Deck	Partial			
LOA	12.0			
Breadth Extreme	3.6			
Moulded Depth	2.1			
Engine Particulars				
Engine Emission Test	YES			
Rating	No smoke emitted			

RESULT OF INSPECTION

PASSED	✓
FAILED	
Follow Up Required?	NO
Follow Up Date	-

Refer To Appendix A

Acknowledgement	Date Of Inspection: 01/08/2025 09:45
Name of MPA Inspector: [redacted]	Acknowledged By Craft Representative [redacted]
Date & Time: 01/08/2025 09:51	Date & Time: 01/08/2025 09:52
Signature: [redacted]	Signature: [redacted]
	I [redacted] confirm that the information recorded in this checklist is true, complete and accurate.

MPA Craft inspection checklist

The victim's lifejacket was not recovered. It was not supplied by Egon Oldendorff Management GmbH / Oldendorff Carriers GmbH & Co KG and its specification is unknown. It is not known if the cause of the lifejacket "coming off" was due to a defect with the lifejacket's securing straps, if the waistbelt was not fastened or if it was ineffectively donned.

Nightlife's call at Singapore

Nightlife's planned call at Singapore was busy. The call required the ship to be boarded by pilots, the ship's agent and chandler, two on-signing crew, two personnel associated with the hull cleaning operation and two bunker surveyors.

It required crew to rig and stow the pilot transfer arrangements multiple times, drop anchor and take provisions. Two crew were required to handover to their reliefs and prepare to go home. Oncoming crew were required to familiarise themselves with the ship and adapt to the ongoing operations and schedule. Crew were required to moor the dive barge (SSE Valencia) and bunker barge (Marine Azure), liaise with those vessels and the Singapore authorities to ensure requirements were met, prepare for and be available to tend to the requirements of both operations. They also had to facilitate the bunker survey and maintain the anchor watch.

In the minutes leading up to the casualty, Nightlife's crew were tasked with seeking permission for the diving operations to start and then tending to the dive barge, liaising with and then preparing to moor the bunker barge and adjusting the pilot transfer arrangements (and then the accommodation ladder) for the transfer of Bunker Surveyor A to SG Naav.

In the offshore industry, these diverse but time synchronised activities that directly affect each other would be classed as Simultaneous Operations (SIMOPS): the potential clash of activities which could bring about an undesired event or set of circumstances. SIMOPS often involve multiple companies (owners, contractors, subcontractors) and a large workforce carrying out various activities concurrently.

To manage simultaneous operations, work needs to be effectively planned to minimize the number of simultaneous operations, risks created by overlapping activities need to be identified and controls set prior to the work starting, boundaries established to ensure that work does creep to reintroduce risks that are managed on paper and the plans need to be effectively communicated to those doing or potentially affected by the work.

Neither the Bahamas Maritime Authority, "Accident prevention on board ship at sea and in port" nor the "Code of Safe Working Practices for Merchant Seafarers[5]" provides any guidance on simultaneous operations. Nightlife's safety management system did not account for the management of simultaneous operations.

Conclusions

The victim drowned after falling into the sea whilst transferring from Nightlife to SG Naav. Nightlife's large freeboard, use of a forward-leading accommodation ladder and removal of the outboard stanchion increased complexity of the transfer. The movement of SG Naav made it more difficult.

As the victim's lifejacket was not effectively secured, it was lost and did not afford him any buoyancy. The combination of the design of SG Naav and unavailability of effective man-overboard recovery equipment meant that the victim could not be recovered to SG Naav, even with in-water assistance. The absence of supervision of the transfer from Nightlife meant that the ship's resources were not made available to assist recovery.

At the time of the casualty, Nightlife's crew were tasked with several conflicting operations. The nature of the other operations not only affected the selection of transfer arrangements (the combination ladders being rendered unusable) but also reduced the available number of crew to facilitate and oversee the transfer. This may have also reduced the perceived importance of the personnel transfer. There was significant time pressure on the crew to complete the evolution so they could move on to the next pressing matter.

The timing of the simultaneous operations of personnel transfer, arrival of the bunker barge and start of underwater operation were not under the influence of Nightlife's crew. Whilst it may not have been foreseeable that these three events would occur at the same time when planned by the ship's charterer and operator, none of the operations were subject to effective assessment of the risks the posed individually or collectively. The busyness of Nightlife's brief stay at anchor was designed into the program, as it is with many calls at maritime hubs.

Singapore's Workplace Safety and Health (General Provisions) Regulations 23(11) puts the duty to provide equipment and means of rescuing and resuscitating drowning persons on that person's employer, not the vessels between which they are transferring. Maritime and Port Authority of Singapore's craft inspection checklist did not require assessment of SG Naav's man-overboard recovery arrangements, emergency procedures or the completion of any drills as part of the annual inspection despite its function. As such, it was not equipped to deal with a man-overboard situation without external assistance.

There have been a significant number of deaths of surveyors, technicians, superintendents and ship's crew during transfer between ships and boats but the risks do not seem to be apparent to the industry. Much work has been done to improve awareness of requirements and implement universal standards for pilot transfer arrangements but this has not extended to others that face the same hazards.

[5] CoSWP defines simultaneous operations as "Work activities that involve more than one vessel, or a vessel and an installation."

Action taken

As a result of the casualty, the Bahamas Maritime Authority has issued new guidance on pilot transfer arrangements. Information Notice 18 now highlights that the requirement to provide equipment to transfer safely applies to any person who needs to board or leave the ship using the pilot transfer arrangements including ship's crew, inspectors, technicians, surveyors and other personnel.

As a result of the casualty, SeaCabbie PTE Ltd (operator of SG Naav) has:

- conducted a Safety Stand-Down for all boat crew to reinforce safe crew transfer practices, man-overboard prevention, and the exercise of Stop Work Authority;
- reinforced operational requirements relating to freeboard limits, the mandatory use of SOLAS-compliant combination ladders, and the suspension of transfers where safety concerns exist; and
- implemented a Launch Boat Emergency Response & Notification Framework as part of the Company's Safety Management System, providing structured emergency response, notification procedures, and reinforcing the principle that safety takes precedence over operational and commercial considerations.

As a result of the casualty[6], Alcyon Shipping Co. Ltd. has:

- circulated the Company's investigation and lessons learned throughout their fleet. Masters and responsible officers have been instructed to use the case as a practical lesson learned, with particular emphasis on third-party personnel transfers, the individual characteristics and mobility of the person being transferred, appropriate PPE and baggage arrangements.
- enhanced its controls for embarking/disembarking pilots and other persons. Controls include consideration of the individual's mobility and physical characteristics, PPE, baggage, small-craft movement and the need for any additional protective or fall-prevention measures before the transfer is permitted.

Recommendations

The investigation found that SG Naav was not equipped to recover a person from the water without external assistance. It is therefore recommended that:

SeaCabbie PTE Ltd:

- Ensures its vessels carry suitable equipment to enable recovery of a person from the water, taking account of vessel design and crewing levels.

Maritime and Port Authority of Singapore:

- Incorporates verification of a vessel's ability to recover a person from the water into its licensing and annual craft inspection protocols.

The investigation found that neither the Bahamas Maritime Authority, the International Labour Organization's Code of Practice "Accident prevention on board ship at sea and in port" or other Bahamas recognised Codes of Practice provide specific guidance on the risks or safe conduct of multiple activities carried out at the same time, in a single location, in close proximity to one another. It is therefore recommended that:

The Bahamas Maritime Authority work with interested parties to make guidance on simultaneous operations available to industry.

[6] These measures are preventive enhancements arising from the Company's review and should not be interpreted as indicating that the vessel's transfer arrangement caused or contributed to the subsequent casualty.

Vessel particulars		
Vessel name	Nightlife	SG Naav
Vessel type	Bulk carrier	Supply vessel (personnel transfer)
Flag / IMO number	Bahamas / 9717632	Singapore / Licence No. SC 5151 B
Registered owner	Nightlife Marine Ltd.	SeaCabbie PTE Ltd
Manager	Alcyon Shipping Co. Ltd.	SeaCabbie PTE Ltd
Classification Society	Nippon Kaiji Kyokai	N/A
Built	2015, Sungdong, South Korea	
Length / breadth / moulded depth	292m / 45m / 24.8m	11.1m / 3.6m / 2.1m
Gross / net tonnage	93,511 / 59,338	27 / N/A
Minimum safe manning	14	1
Authorised cargo	Dry bulk	12 passengers, dry or packaged general cargo

Voyage Particulars		
Departure port	Dung Qat, Vietnam	Changi, Singapore
Arrival port	Singapore	South Marine Pier, Singapore
Distance / duration		
Cargo information	In ballast	N/A
Crew	24	2

Marine Casualty Information	
Severity of casualty	Very Serious Marine Casualty
Date / time	17 January 2026 19:30LT
Geographical location	Eastern Bunkering Anchorage “C”, Singapore
Injuries / fatalities	0 / 1
Damage / environmental impact	None
Ship operation	Transferring personnel / mooring bunker barge / underwater operations
Stage of passage	At anchor
External environment	Clear skies. Wind: north easterly Force 5. Moderate sea, 1.5m swell. Tidal stream 056°T, 0.3 knots. Sea temperature approx. 27°C

Appendix 1 - Recent similar casualties

Year	Vessel	Flag	Coastal State	Investigating State	Summary	Investigation report	Lifejacket worn?	Backpack worn?	Reg 23 compliant arrangements?	Hit launch during fall?	Transfer at anchor	Service boat recovery issue?
2019	Angelic Glory / LES Swift	Greece	Singapore	TSIB	A Greek flagged tanker was at anchor in Singapore for bunkering and other activities including the servicing of the air conditioning by four technicians. Whilst the technicians were disembarking to a service via an accommodation ladder, the service boat made contact, the accommodation ladder's lower platform tipped and one technician fell into the sea. The service boat's lone coxswain could not recover the victim. He was not wearing a lifejacket.	https://isomer-user-content.by.gov.sg/287/65bc7b93-24e6-4950-8bb1-f0cba35c427b/mib-mai-cas-074---angelic-glory_23-oct-19---final-report_completea18a8ccc06e74f5b8345dc7a43a031ab.pdf	No	Yes	No	No	Yes	Yes
2021	Formosabulk Clement	Liberia	Australia	ATSB	Crew change at anchor during COVID. Departing C/O was waiting on ladder when struck by service boat. Died of injuries.	https://www.atsb.gov.au/investigations/mo-2021-004	Yes	No	Yes	No	Yes	No
2021	Venus / Amal	Singapore	Singapore	TSIB	Singapore registered bunker tanker, Venus, was alongside the Saudi Arabia registered chemical tanker NCC Amal anchored at the Eastern Special Purpose Alpha anchorage in Singapore. A shore technician after completing servicing of the oily water separator onboard Amal crossed over to Venus for disembarking to a supply boat. While descending from the pilot ladder of Venus, the ST fell into the water. Efforts to bring the ST out of the water by a bunker surveyor and the skipper of the supply boat were to no avail. The victim was eventually brought out of the water by a port authority patrol boat. The ST was unconscious when rescued from the water and subsequently passed away. The investigation deduced that the ST had either lost his balance or felt dizzy while descending the pilot ladder. The lifejacket worn by the ST was only suitable for sheltered or calm water and was not meant for a non-swimmer. The ST was a non-swimmer and the weather condition at the time occurrence was Force 3 with swell of less than 2m. While the ST was in the water, sea swells were seen covering his face resulting in sea water entering his airway and eventually being swallowed. The investigation noted that the crew of Amal and Venus did not object to the ST's request to cross over from Amal to Venus using an unsafe means of transfer. The transfer from Amal to Venus involved rigging a pilot ladder at a non-designated location onboard Amal and landing on the safety railing of Venus both of which were deemed as unsafe work practices.	https://isomer-user-content.by.gov.sg/287/60e48e7a-ebea-40b3-89d2-0ac677a595fb/final-report---man-overboard-from-the-bunker-tanker-venus-at-aespa-on-16feb21.pdf	Yes	Yes	No	No	Yes	Yes
2022	Enki / Hürkuş	St Kitts and Nevis	Turkiye	Turkiye	A St Kitts and Nevis flagged chemical tanker was anchored at the Southern entrance to the Istanbul Strait. An on-signing cook. Whilst climbing a 2m pilot ladder she fell into the sea. She could not be recovered by the service boat and it took 25 minutes to recover her to the ship's rescue boat. She was wearing a backpack. She was not wearing a lifejacket.	https://ulasimemniyeti.uab.gov.tr/uploads/pages/safety-investigation-reports/enki-final-marine-safety-investigation-report-06-06-2023.pdf	No	Yes	Yes	No	Yes	Yes
2022	Agios Nikolas / LEO 38	Malta	Singapore	TSIB	A Malta flagged tanker was at anchor in Singapore for bunkering and maintenance, utilising three local technicians. Whilst the technicians were disembarking to a service boat via the accommodation ladder, the service boat rolled and one technician fell from the deck into the sea. The service boat could not recover the victim. He was wearing a backpack that weighed approximately 10kg. He was wearing a lifejacket that required manual inflation but the technician did not pull the activation cord.	https://isomer-user-content.by.gov.sg/287/d9f743e7-8979-4d89-baa7-1082d8a6f431/tib-mai-cas-125_final-report-of-mob-involving-service-boat-leo-38-and-tanker-agios-nikolas6d916087da324dd49e1f1c0520a0ec03.pdf	Yes	Yes	No	No	Yes	Yes
2022	VS Salome / Portunus	Malta	UK	Malta	A Malta flagged tanker was at anchor off Hartlepool, UK. The off-signing master, wearing an inflatable lifejacket provided by the transfer boat, fell whilst climbing down the port pilot ladder. The lifejacket inflated but the crotch strap was not secured and the backpack could not be removed as its straps were underneath the lifejacket. The presence of the backpack complicated the service boat's attempts to rescue the victim using the permanently fixed rescue cradle.	https://msiu.gov.mt/wp-content/uploads/2023/09/MT-VS-Salome_Final-Safety-Investigation-Report.pdf	Yes	Yes	Yes	No	Yes	Yes*
2023	Ince Northwind	Singapore	Turkiye	TSIB	Singapore registered bulk carrier was anchored at Istanbul, changing crew and taking provisions. Nine on-signers took a launch and arrived at the anchorage for joining. After eight of them boarded the vessel via the pilot ladder, the last on-signer, fell from the pilot ladder when he was about 2-3m from the deck level and landed on deck of the launch. The OS suffered serious injuries and was declared dead at hospital on the next day. The onsigning crew boarded by pilot ladder despite the freeboard being more than 9m. The OS also boarded INW with only the pilot ladder, although the accommodation ladder had already been ready for use then. The OS appeared to be nervous prior to climbing the ladder and was seen tired and exhausted in the midst of climbing. The investigation also revealed that the Company's procedures were not implemented onboard INW effectively. There was no personal floatation device or lifejacket prepared for the on-signers. The launch was secured to INW by a mooring rope and did not move away when on-signers crossed onto the pilot ladder and started climbing.	https://isomer-user-content.by.gov.sg/287/37ab2b88-6773-43db-aee0-73c6df24fd4d/fatality-of-crew-after-falling-overboard-from-ince-northwind_final-report.pdf	No	No	No	Yes	Yes	No
2023	Erguvan S	Marshall Islands	Mexico	Marshall Islands	ERGUVAN S was anchored off Altamira, Mexico, undergoing a full change of crew following a change of ownership. The weather was good with calm seas. The freeboard amidships was approximately 11-12 m. Whilst climbing the combination ladder, the on-signing Master, who was not wearing a lifejacket, reported to say he could not climb any further. He then appeared to lose his grip on the pilot ladder and fell, hitting the launch before falling into the sea. He could not be recovered despite in-water assistance and died.	https://www.register-iri.com/wp-content/uploads/Republic-of-the-Marshall-Islands-Office-of-the-Maritime-Administrator-ERGUVAN-S-Casualty-Investigation-Report.pdf	No	No	No	Yes	Yes	Yes
2024	SRS Proteus Harvonne	Singapore	Korea	TSIB	A Singapore flagged tanker was at anchor in ballast off Ulsan. After completing a handover the off-signing master was climbing down the combination ladder to a service boat when he fell into the sea. He could not be recovered by the service boat and the weather conditions hampered the ship's attempts. He was recovered by Korean Coastguard but declared dead on arrival. He was wearing a backpack. He was not wearing a lifejacket.	https://isomer-user-content.by.gov.sg/287/a82157a8-5ee7-44e0-acbf-7bdf60104b44/cas-168---death-due-to-mob-involving-srs-ph-at-ulsan-anchorage-24-may-24.pdf	No	Yes	Yes	No	Yes	Yes
2024	STI Jermyn	Marshall Islands	USA	NTSB	A mooring master suffered a fatal accident while transferring between the Marshall Islands-registered STI Jermyn and the US-registered Mallard via a pilot ladder The transfer took place approximately 50 nautical miles south of Galveston, Texas, in the Gulf of Mexico.	Investigation ongoing.						