# Ist Edition,<br/>Apr 2025FUYO<br/>NEWSLETTER



Dear Crew Members,

#### Expo - Exhibition of Our Company's Fuyo Kaiun Flagship Model Ship

I am thrilled to announce that our company will be showcasing our flagship model ship, the biofuel-compatible bulk carrier "Kamsarmax," at the Japan Pavilion of the 2025 Osaka-Kansai Expo, which opens on April 13, 2025. The theme of the Japan Pavilion is "Between Lives," emphasizing the importance of "circulation" in connecting lives. In the Factory Area of the pavilion, alongside 10 partner companies of MATSURI, we will be part of the "Monomono by MATSURI" exhibit, which focuses on sustainable manufacturing using algae.

Our participation in the Japan Pavilion at the Expo is a groundbreaking and honorable opportunity. It allows us to showcase our innovative efforts on a global stage, enhancing our company's visibility both internally and externally. This event is expected to boost the motivation of our employees and crew members, fostering a sense of pride and loyalty towards our company.

I encourage all crew members to share this exciting news with your families and, if possible, visit the Expo together to see our flagship model ship and other exhibits. This is a unique opportunity to witness firsthand the advancements and contributions our company is making towards a sustainable future.

Thank you for your continued dedication and hard work and safe operation toward our goal.

#### Yasuki Noami Director, Fuyo



Towards a Brighter future for all



#### **Editor's Message**

Newsletter shall fulfil its goal when you can read, understand and implement it's content in your routine life onboard. Lets contribute your best for company sustainability.

Capt. Prerit Awasthi

Formatting and Content designing by Ms. Hiromi Ishikawa (HSSEQ)

### **Observations from External Inspections**



HUMAN Please carryout periodic and discussion to pre-							
CVIQ	Observed details	human related observations					
3.5.1	The required visitor familiarisation checklist was not completed for six shore personnel who boarded the vessel, and the responsible officer could not explain how or when their familiarisation was conducted						
5.1.1	The collision drill lacked documentation required by the operator's emergency checklist, including:						
9.1.3	OP, who was involved in mooring operations, was not familiar with content of Line Management Plan.						
4.1.1	The safety depth and contour alarms on the starboard ECDIS were incorrectly set to 17 m instead of the required 15 m. The officer attributed this oversight to being occupied with pilotage duties.						
4.2.6	Error on the speed indicator fitted to the starboard bridge wing was not checked through pre-arrival check list nor declared to pilot card on the day of the inspection.						
5.4	The officer incorrectly described the on-load lifeboat hook release procedure, omitting the necessary steps to access the release mechanism.						
	PROCESS	with QDMS and keep track of revisions					
CVIQ	Observed details						
2.8.1	Many discrepancies were identified in the HVPQ.	Recurring					
3.2.1 3.2.7	The assessor's qualifications and relevant seafaring experience were not detailed in the report; instead, a separate sheet outlining the assessor's qualifications was attached.						
4.2.2	The UKC (Under Keel Clearance) requirements under SBM/CBM conditions were not met. Furthermore, the procedures related to UKC requirements were not documented, and no UKC policy was defined for anchorage operations.						
4.3.1	The minimum required composition of the bridge team during drifting, offshore STS operations, and underway activities was not defined in the operator's navigation manual						
4.3.2	There was no procedure defining the company's expectations for operating the machinery space in either unattended or attended mode under various navigational conditions."						
2.4.2	There was a company procedure for reporting defects related to Class or Flag Administration, but there was none for reporting defects related to the cargo handling system to external stakeholders, such as notifying the terminal.						
4.1.2	According to the service report provided by the external agency, the usage of the radar Magnetrons did not follow the company procedure.						
4.2.1	There was no company procedure to include engine room status, i.e. manned mode or unmanned mode, in the passage plan.						

### **Observations from External Inspections**



	PROCESS							
CVIQ	Observed details							
5.1.1	The company did not provide sufficient flowcharts as the onboard emergency response plan for the vessel.							
5.8.1 5.8.2 5.8.6	The checklist used for safety inspection of the main deck and mooring areas lacked many items listed in the guidance.							
5.8.3	There was no company procedure for safety inspection of cargo pump room							
4.3.3	The operator did not have procedure to record times of the transfer of the conn between the Master and pilot, between pilots and between the Pilot and Master							
5.1	The operator's drill report form did not include the required details							
5.5	The company procedures did not require the completion of an enclosed space entry permit when entering the ballast water treatment plant room, nor were the necessary alternative procedures followed prior to entry.							
5.7	The accident report of the total loss of main propulsion at open sea was not recorded in PIQ.							
	HARDWARE Senior officers must							
CVIQ	Observed details E/R to prevent Hardware							
4.2.6	Speed indicator fitted to starboard bridge wing showed a speed of 6 knots ahead while the speed log in wheel house showed 0. 1 knots ahead. Crew knocked the glass and the needle was changed to 2. 5							
5.3	EEBD provided to the engine room bottom deck near the main engine shaft was lack of pressure (indicating red range). Crew replaced the EEBD with spare one during the inspection.							
	PSC							
CODE	Observed details No PSC Deficiencies let it happen on your vessel							
16- 14615	Responsible crew not familiar with bunker change over procedure.							
17/10- 11103	Life boat (port side) not stowed & managed as follows: a) FWD side suspension block not fully loaded to davit horn. b) one safety belt not contrast with the belt for immediately adjacent							







Thumb Injury by Grinder in Engine Room Workshop (Industry sharing , not from Fuyo Fleet)

#### What happened?

While fabricating an "F" type spanner, the No. 1 Oiler was using a bench grinder to shape a bent rod. His left thumb got caught between the rotating grinding wheel and the side protection plate. The Bosun, who was nearby, quickly responded and rescued him by dismantling the grinder cover and wheel.









#### **Direct Cause**

Thumb got caught between the grinding wheel and the workpiece.

#### **Root Cause**

- •Poor condition of grinder wheel
- Improper handling and technique while grinding



#### <u>Lesson learnt</u>

High-speed rotating tools can cause serious injuries if not handled properly. Awareness and correct use are critical

### REMEMBER

SAFETY FIRST, SAFETY ALWAYS



### Lessons Learnt from Incidents

Defect Reporting and Repair Plan for Hermetic UTI Meter

#### What happened?

On January 18, 2025, during the cleaning of the Hermetic UTI meter, a portable gas-tight measuring device on the vessel ," the UTI display unit showed a "No MSG" error alarm when powered on. According to the manufacturer's manual, this issue is usually caused by tape damage or sensor malfunction. Further investigation revealed suspected damage at the end of the tape (the sensor was confirmed to be functioning normally).

#### **Direct Cause**

The tape is suspected to be damaged.



#### **Root Cause**

The UTI tape defect occurred due to the product's lifespan and improper handling.



#### <u>Lesson learnt</u>

To prevent recurrence, the UTI tape must be handled carefully. A warning to operate the tape slowly and carefully is posted near the UTI storage area.

Recently, Lot of cases observed due to mishandling of equipment. Good familiarization and supervision required

### Learning from Near Miss Reports -Analysis



Encourage junior and rating for participation

- (One from each).
- Report good quality NM
- Include areas such as Mooring, Navigation, bunker



Immediate Root cause



Sub standard practices
Sub standard condition

- Vessel MUST report NM if event has potential of injury or health consequences
- Identify Environment related NM and report.



NM with cause as people

Train and mentor crew and juniors at all opportunity e.g. drill, TBM, Meeting

box meeting and Safety meeting.
Identify barriers (PMS, Design, Best practice) to prevent such

Discuss such practices in Tool

conditions





NM with cause as Job factors



Follow company campaign for good maintenance onboard



### Learning from Near Miss Reports-Sub Standard Practices



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Rescue Boat Left Unchecked After Rain – Risk of Electrical Damage

#### Outline:

During deck maintenance, Crew noticed the water did not drain properly after the previous rainfall

#### What should have been done?

Remind PIC to inspect and maintain drains regularly to prevent clogs, water buildup, and equipment damage.

#### **Preventive Action:**

Weekly and post use checks to include drain check monitored by senior officer

All checks of lifeboat to be done for securing after use/drill.



the light buoy improperly stored in the midship store

#### Outline:

During a routine inspection, Crew noticed the light buoy in the midship store was activated and the battery drained.

#### What should have been done?

Third Officer to ensure LSA/FFA readiness at all times, verified by Chief Officer.

#### **Preventive Action:**

• Educate the crew to

maintain the safety equipment

Check proper stowage of spare LSA/FFA items



#### Unsecured Mooring winch operating Lever

#### Outline:

During port operation, after turning on the hydraulic motor system, Crew noticed one of the winches was already running. It turned out that the handle was not in the idle position.

#### What should have been done?

Remind deck crew to check equipment properly when securing to avoid accidents or damage.

**Preventive Action:** 

• Explain crew for good practice and consequences

Always lock lever of mooring winch after use



Securing Pin Missing on F.O. Hose Davit

#### Outline:

F.O. hose davit securing pin was missing, risking the davit swinging in rough seas.

#### What should have been done?

After using, put pin in place for securing at sea.

#### Preventive Action:

• Discuss with crew equipment after use and risks from poor practices during the toolbox meeting.





### Learning from Near Miss Reports-Sub Standard Conditions



#### Improper use of drain pipes

#### Outline:

During line draining,Crew removed hose without closing valve—pressure caused it to whip near his face.

#### What should have been done?

Remind PIC to inspect and maintain drains regularly to prevent clogs, water buildup, and equipment damage.

#### **Preventive Action:**

Safety meeting: remind crew to stay alert around Life Saving Appliances.





Forget to war Harness for Working aloft permit related jobs

#### Outline:

During maintenance on deck ,Crew was painting in strong wind without a harness.

#### What should have been done?

The crew should promptly execute a stop work attitude.

#### **Preventive Action:**

• Weather conditions to be ascertained before commencing work





# Holdiing Tug Line without taking rope stopper

**Outline:** During mooring, crew attempted to hold the tug line with his body instead of using a rope stopper.

#### What should have been

Discuss in the next meeting and remind of tug and mooring rope dangers to prevent recurrence.

#### **Preventive Action:**

- Practical training for rope handling
- Tool box meeting before mooring



#### Inadequate closing of E/R skylight

#### Outline:

Ocean water entered the engine room skylight, risking damage to nearby switchboards and transformers.

#### What should have been done?

All skylights and doors must be securely closed as a heavy weather precaution. **Preventive Action:** 

## • Daily check the surroundings for issues and fix them immediately if possible.

Failure to securely close all openings cause serious damage

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### **Sharing of Best Practices from Fleet**



#### RHV-Radar Use & Virtual Aids for Safe Navigation

#### Outline:

During transit to anchorage, effective use of Xband and S-band radars, along with long-range scanning, improved early detection of nearby objects. A Virtual Aid to Navigation marking a submerged pipeline provided clearer situational awareness than the ECDIS display.



#### SSE - Reducing Plastic Bottle Volume Onboard

#### **Outline:**

To reduce plastic waste volume, bottles are cut and wrapped together into compact bundles. This method can compress up to 30 bottles. Cutters are provided in the messroom to make it easy for crew to follow the practice.





### Have you Implemented??



#### RRB - Introducing Digital Safety Manuals via SMART PAL

#### Outline:

As part of the company's shift to a digital safety management system using MariApps (SMART PAL), crew members are being trained to access manuals, checklists, and forms through their personal PAL accounts. This encourages familiarity with the system, supports skill development, and promotes awareness of the company's digital transformation efforts.





# CAR- Reliable working bench for G/E F.O. pump maintenance.

#### Outline:

Fabricated G/E F.O pump working bench for easy maintenance to hold it tight and to prevent from accidental falling of heavy object that <u>may cause injury during maintenance</u>









### Safety Culture and Self-Discipline

### By Capt. Devasish Bhaumik, DPA EAM/QAM

**Safety culture** refers to the collective values, attitudes, and behaviors within an organization that prioritize the well-being of employees and stakeholders. A strong safety culture ensures that safety is not just a set of rules but a deeply ingrained mindset where individuals actively identify and mitigate risks. It is built on leadership commitment, employee involvement, and continuous learning to prevent accidents and create a secure work environment.

Self-discipline plays a crucial role in maintaining and strengthening safety culture. It involves personal responsibility, adherence to safety protocols, and making conscious choices that promote well-being. Employees with self-discipline consistently follow safety procedures, report hazards, and avoid shortcuts, even when no one is watching. This sense of accountability reduces workplace accidents and fosters a proactive approach to risk management.

Organizations that encourage self-discipline through training, clear communication, and positive reinforcement see long-term improvements in safety outcomes. When individuals internalize safety as a personal value rather than an obligation, they contribute to a culture where safety becomes second nature. Ultimately, the combination of a strong safety culture and self-discipline leads to a healthier, more productive workplace, reducing costs associated with accidents and increasing overall organizational efficiency.

We recently had senior officers breaching the alcohol policy and an incident where 3 shore personnel were injured (though not because of ship's fault). But these indicate that we have to ourselves inculcate the habits of following procedures and also use stop work for anyone deemed unsafe including shore personnel. Always remember Safety starts with us.



### Project Smart Fuyo - Convenience to Compliance

### By Capt. Prerit Awasthi, Project Leader



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0	8	Near Miss Number 🛛 🖓	Near Miss Date	Title	Vessel Name	
Q	6	FRE/NMIS/2025/515	29-Apr-2025	Safety goggies.	FLORA EXPRESS	
Q		FRE/NMIS/2025/S16	28-Apr-2025	Using unauthorized USB in bridge working PC	FLORA EXPRESS	
Q		FRE/NMIS/2025/514	26-Apr-2025	Garbage stored outside of a designated waste co	FLORA EXPRESS	
Q		CAR/NMI5/2025/53	26-Apr-2025	Loosen fixing bolts (U-Bolts)	CHEMWAY ARROW	
Q		CAR/NMIS/2025/S2	25-Apr-2025	Wet Cloth keep to dry in Engine Room	CHEMWAY ARROW	
Q		FDM/NMIS/2025/510	23-Apr-2025	Visitor left toilet faucet open and left.	FEDERAL MASAMUNE	
Q		EDM/NMIS/2025/59	22-Apr-2025	Foreman caught smoking inside accommodation	FEDERAL MASAMUNE	

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FUYO KAIUN



### Case Report: Off-Spec Gas Oil (10ppm) Due to Shore Tank Issues

### By Mr. Ogawa, GL Operation Group

### Summary of the Incident

The vessel loaded three CPP grades—Gas Oil (10ppm),95R, and UMS 91R—at Ulsan, Korea, for discharge at multiple New Zealand ports.

At the first discharge port, the Gas Oil sample failed due to a high FBT value (>1.30) and visible white particles.

Discharge ports were subsequently changed, and a joint survey by Idemitsu (charterer), Ampol (receiver), and Fuyo (owner) traced the issue to the shore tank. No formal claim was filed, and the case is now closed.

#### Why It Happened

- White particles were detected in the shore tank sample during the joint inspection.
- The exact chemical origin remains unclear, but a chemical specialist suggested it may be due to reaction with additives in the tank.
- The shipboard cargo sample passed at the load port, but failed at the discharge port, indicating possible settling of particles at the bottom of the tank during the long voyage.

#### **Preventive Measures**

#### Description

Take samples immediately at the beginning of loading (first flow), not 5–10 minutes later.

If multiple manifolds are used, take a sample at each manifold.

Take a new manifold sample whenever

a shore tank is switched.

Check the color and clarity of the cargo. If particles or discoloration are observed, report immediately to the CCR, then the Master and Fuyo OPS with photos.

Retain both shore and ship samples onboard for at least one year with proper records, as the claim period extends up to 12 months.





### Environmental Compliance -NZ Hull Clean - Full Regulation

### By CE Subir , GL Technical



/essel diagram provided by the Department of Agriculture and Water Resources

Before vessel's arrival, NZ ministry of Primary industries (MPI) will ask to see evidence that bio-fouling prevention measurements were applied. Evidence must be verified and may include:

Vessel's Biofouling Management Plan and record book dates and reports of dry docking current antifouling system certificates vessel operational history

evidence of independent inspections and ongoing maintenance (such as cleaning or treatment) by suitably qualified people.

#### For any voyage planned for New Zealand, please consult asap with OPS/Tech group.

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FUYO KAIUN

### "Onboard Drinking Culture: Responsibility and Limits"



### By Capt. Song , GL Crewing Group

#### 1. Alcohol is a Major Cause of Maritime Accidents

Even moderate impairment can lead to critical errors during navigation, maintenance, or emergency response. A single lapse in judgment due to intoxication or a hangover can result in serious injuries, environmental damage, or loss of life.

#### 2. Excessive Drinking Can End Your Career

What once might have resulted in a simple warning now often leads to formal disciplinary action or even dismissal. Regulatory bodies like the IMO and national maritime authorities enforce strict alcohol policies, and violations can be career-ending.

### Redefining Alcohol Use at Sea: A Shift Toward Responsibility and Safety



For decades, alcohol was seen as a natural part of life at sea —a way to unwind after long, exhausting shifts. But as the maritime industry evolves, so too does our understanding of safety and professionalism. Today, excessive alcohol consumption is no longer tolerated onboard, and policies are becoming stricter to reflect the serious risks involved.

#### **Building a New Safety Culture**

We must move beyond outdated attitudes and create a culture that prioritizes responsibility:

#### **Outdated Mindset**

- Life at sea is tough, so excessive drinking is understandable.
  - Excessive drinking is tradition.
- Just ignore it.

Safer Alternative

- Life at sea is tough, so staying sharp is essential.
- Responsible drinking is acceptable; excessive drinking is a risk.
- We must enforce moderation for everyone's safety.

#### **Clear Boundaries for a Safer Future**

- Maximum of one beer per day, if permitted by company policy.
- No alcohol consumption during shore leave while assigned to a vessel.

The ocean doesn't forgive mistakes. By committing to responsible behavior and holding ourselves and each other—accountable, we can build a safer, more professional environment for everyoneonboard.

Safety starts with us. Let's choose responsibility.

#### 3. Would You Trust an Impaired Colleague with Your Life?

Safety at sea relies on every crew member being alert and responsible. An impaired crew member puts everyone at risk—not just themselves. Trust and teamwork break down when alcohol gets in the way.



Yangoon

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### Opportunities of engagement between ship & shore staff - Ship visit

Capt. Noami in SSE Mr. Kim (OJTI) in HSL Kensington **OJTI Mykola** in SSE MSI Delo & TSI Singh RICH HARVEST in RHV YO SAFETY SEMI **DPA Dev & TSI** Zhang at **Crew Seminar in** 

Seafarer Page -Practices of Team Building onbord



# Introducing OUR Team









JAPAN



### PH LIPPINES



Ohoy! Kumusta na?

### Myanmar



Ming-Gah-Lah-Bahr

### KOREA



### UKURAINE

Greet your friend in his langauage next time!!

Fuyo has 5 nationalities, Japan, Myanmar, Korea, Ukraine, and Philippines.

Hi – Casual

ПриветPronunciation: Privet

### Seafarer Page

M/V HSL KENSINGTON

2025

The Art of "Self-Care" Expressing Yourself

Through Camaraderie

E/CDT GRAIG M. BALAGTAS



Making an impact Happiness extends beyond the confines of the ship; by enjoying the views of the various cities we visit, we forge connections and bring light into our experiences, making it easier to navigate the ever-changing life at sea.







#### <u>Join us in Newsletter</u>



**FUYO NEWSLETTER** 



#### How Self-Care Reflect and Influence Individuality and Being a Team-player

Self-care enhances individuality by fostering self-awareness and personal growth, while also supporting teamwork by ensuring that people are mentally and physically prepared to make positive contributions to a healthy work-environment.



Mind and Body Prioritizing physical activity and social connections not only enhances self-esteem and overall well-being but also fosters resilience and confidence, enabling us to tackle life's challenges and cultivate a more fulfilling and joyful existence.

#### The Beauty in Unity

The Synergy of

The beauty in unity is exemplified through the celebration of diverse cultures thru food, as it fosters connections, harmony, and enhances the morale of crew members by bringing them together to share stories and experiences around a communal meal.

If you want to see your name and photo, Do send us Article related to shipboard working orHealth. Max 1000 characters with 1 or 2 Photos. >>hsseqgroup@fuyokkk.co.jp<<<