



MARINER'S UPDATE

voice of seafarer

Voyage : 4

19 May 2026

INTERNATIONAL DAY FOR WOMEN IN MARITIME

18 MAY 2026



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MV DALI

\$5 BILLION LOSS

18K⁺

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Why is India Investing ₹51,000 Crore in 62 New Ships?

MARINER'S UPDATE

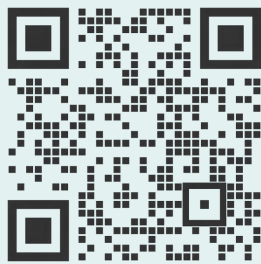
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EDITOR'S NOTE



This magazine delivers key maritime updates, insights, and visuals in one easy, reliable place.



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WELCOME TO THE 4TH EDITION

Dear Mariners,

We all know the DALI incident resulted in billions of dollars in losses for the operators.

But when we carefully analyze the case, it clearly shows how management negligence in correcting vibrations at the first reported case, which causes wire looseness which eventually lead to serious sequence of failures.

In the maritime industry, even a small failure can escalate into a major casualty.

A simple scupper plug can save the sea from pollution and act as our last barrier. Likewise, an anchor – though power not available remains a critical safety component that can save ships when needed. But humans were not ready for immediate action in this case.

This reminds us that no defect is “small” onboard a ship. Every issue, no matter how minor it appears, must be reported, investigated, and rectified immediately before it grows into a bigger problem.

On this International Maritime Women Day, we also extend our heartfelt wishes to all women sailing across the oceans with courage, professionalism, and dedication.

Capt. Philip

EMERGENCY SOURCE OF ELECTRICAL POWER



PSC FOCUS - WK 13

PSC FOCUS (CARGO SHIPS)

EMERGENCY SOURCE OF ELECTRICAL POWER

During Port State Control inspections, emergency source of electrical power arrangements are closely examined to verify the vessel's ability to maintain essential safety functions during a blackout or emergency situation. Inspectors frequently identify deficiencies related to poor maintenance, inadequate testing, fuel system leakage, defective starting arrangements, and improperly maintained emergency switchboards or battery rooms.

The emergency power system must be capable of supplying critical services such as emergency lighting, communication systems, navigation equipment, fire detection systems, steering gear, and emergency fire pumps within the required time frame. Failure of these systems can significantly affect vessel safety and may lead to detention.

1. EMERGENCY GENERATOR ROOM – PSC OBSERVATIONS

During inspection, the emergency generator room was found not maintained in a satisfactory condition. In several cases, access doors were defective, spaces were used for storage of spare parts or equipment, and housekeeping standards were poor with traces of oil, fuel, or water observed on deck plating.

Emergency operating instructions were either missing or not clearly displayed. Ventilation arrangements, lighting, and communication systems were not fully operational or adequately maintained. Fire extinguishing arrangements were also found overdue for servicing or not readily available for immediate use.

Common PSC Deficiencies

- Emergency generator room used for storage purposes
- Oil/fuel leakage inside compartment
- Poor cleanliness and housekeeping
- Defective lighting or ventilation
- Missing emergency operating instructions
- Communication equipment not operational
- Fire extinguishers not properly maintained



2. FUEL SYSTEM & FUEL LINE DEFICIENCIES

The emergency generator fuel system was inspected and deficiencies were identified relating to inadequate fuel quantity, leaking pipelines, temporary clamps fitted on fuel lines, and defective quick-closing arrangements.

Sight glasses used for fuel level indication were found without proper self-closing devices, while some fuel tank manholes showed evidence of leakage. Flexible hoses were also observed in deteriorated condition or unsuitable for marine service.

Common PSC Deficiencies

- Insufficient fuel quantity for emergency operation
- Leakage from fuel pipes or fittings
- Temporary repairs/clamps fitted on pipelines
- Defective quick-closing valves
- Fuel tank leakage around manhole covers
- Damaged or non-approved flexible hoses



3. EMERGENCY SWITCHBOARD DEFICIENCIES

PSC inspections identified emergency switchboards in unsatisfactory condition due to poor maintenance, missing labels, defective instrumentation, and inadequate insulation arrangements.

Switchboard lighting arrangements were occasionally inoperative, and insulating mats were missing in front of live electrical panels, presenting a potential safety hazard during emergency operation.

Common PSC Deficiencies

- Poorly maintained emergency switchboard
- Missing circuit identification labels
- Defective gauges or switches
- Missing insulating mat
- Inoperative switchboard lighting
- Signs of overheating or poor maintenance



4. DIESEL ENGINE & STARTING ARRANGEMENTS

Emergency generator diesel engines were frequently found with oil, fuel, or cooling water leakage. Exhaust piping insulation was damaged in some cases, exposing hot surfaces and creating fire hazards.

Starting arrangements were also examined carefully. Deficiencies included poorly secured batteries, defective battery chargers, inadequate maintenance records, air starting system leakage, and malfunctioning secondary starting arrangements.

Common PSC Deficiencies

- Oil/fuel/water leakage from engine
- Damaged exhaust insulation or hot spots
- Defective battery charging arrangements
- Poorly maintained starting batteries
- Air starting system leakage
- Emergency starting arrangements not operational

5. BATTERY ROOM DEFICIENCIES

Battery compartments were inspected for ventilation, cleanliness, securing arrangements, and electrical safety. Several deficiencies were noted where batteries were improperly secured, ventilation was inadequate, warning signs were missing, or electrical fittings were not explosion-proof.

Loose battery cables and poorly maintained charging systems were also identified during inspection.

Common PSC Deficiencies

- Inadequate ventilation inside battery room
- Batteries not properly secured
- Missing warning signs
- Loose or damaged battery cables
- Defective charging equipment
- Non-explosion-proof electrical fittings



6. TESTING & OPERATIONAL READINESS

Routine inspection and testing records were reviewed during PSC inspection. In several cases, records were incomplete or unavailable. Functional tests revealed failures in automatic starting and automatic connection to the emergency switchboard within the required time.

Some emergency generators failed to supply essential emergency services during prolonged running tests, indicating inadequate maintenance and testing procedures onboard.

Common PSC Deficiencies

- Incomplete maintenance and testing records
- Failure of automatic generator starting
- Delayed connection to emergency switchboard
- Emergency loads not supplied correctly
- Unsatisfactory prolonged running test
- Ship staff unfamiliar with testing procedures

KEY PSC FOCUS AREAS

PSC inspectors typically verify:

- Automatic starting capability of emergency generator
- Availability of sufficient fuel supply
- Condition of switchboard and electrical systems
- Proper maintenance of batteries and charging systems
- Readiness of emergency lighting and communication systems
- Routine testing and maintenance records
- Crew familiarity with emergency procedures

CONCLUSION

Emergency source of electrical power remains one of the critical areas assessed during Port State Control inspections due to its direct impact on vessel safety during blackout conditions. Deficiencies associated with poor maintenance, ineffective testing, and defective starting arrangements continue to be among the most frequently observed PSC findings onboard cargo ships.

Ship operators and crew should ensure that emergency power systems are maintained in operational readiness at all times, with regular testing, proper housekeeping, and complete maintenance records available for inspection.

...



NEWSLETTER

PSC FOCUS

PORT STATE CONTROL MANAGEMENT FOR MARINERS



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DETECTING LEAKAGE



WEEK 54

WK 54: SIRE 2.0 : DETECTING LEAKAGE

Ch 2.3.4

Were the Master and deck officers familiar with the company procedures for detecting leakage of liquids between cargo, bunker, ballast, void and cofferdam spaces which included inspecting the surface of ballast water prior to discharge, and were records available to show that the necessary checks had been performed?

Applies to: OIL TANKER / CHEMICAL TANKER / LNG / LPG

POTENTIAL GROUND FOR NEGATIVE OBS:

- There was no company procedure to periodically check empty spaces for ingress of liquids from adjoining spaces or pipeline leakage or, to check the surface of ballast water for contamination prior to discharge.
- The accompanying deck officer was unfamiliar with the company procedure for periodically checking empty spaces for liquid ingress or monitoring the levels of full or partially full tanks for migration of liquid between spaces.
- The accompanying officer was unfamiliar with the company procedure for inspecting the surface of ballast water prior to discharge when a ballast tank adjoined a cargo or bunker tank or had piping containing oil passing through it.
- Records determined that periodic checks to identify the ingress of liquids into empty spaces had not been conducted as required by the company procedures.
- Records determined that the surface of ballast water contained in tanks adjacent to cargo or bunker tanks, or which had pipes containing oil passing through them, had not been inspected prior to discharge.
- Records determined that ballast lines had not been tested where they passed through cargo tanks or fuel tanks.

- Inspection of the ballast tank sighting arrangements determined that numerous bolts were required to be removed from the inspection hatch or, an enclosed space entry was needed to be made, to inspect the surface of the ballast water within a full tank.
- Records determined that liquid leakage was detected in an empty space as a result of structural or pipeline failure during the previous twelve months.
- Records determined that ballast water or a ballast tank was contaminated by oil from an adjacent space or pipeline leakage during the previous twelve months.

CHECKLIST FOR YOU :

1. Are all deck officers familiar with the company procedure for sighting the surface of ballast water prior to discharge where the ballast tanks are adjacent to a cargo/bunker tank or where oil pipes and/or hydraulic lines pass through the tanks?
2. Are all deck officers familiar with the company procedure for periodically checking empty spaces for liquid ingress or for monitoring the levels of full or partially full tanks for migration of liquid between spaces?
3. Are the records of periodic monitoring of empty spaces for liquid ingress available?
4. Are the records of ballast water surface inspection before discharging available?
5. Are the records of testing of ballast lines available where they passed through cargo tanks or fuel tanks?
6. Do numerous bolts need to be removed from the inspection hatch or, is enclosed space entry needed, to inspect the surface of the ballast water within a full tank?
7. Do the records indicate that liquid leakage was detected in an empty space as result of structural or pipeline failure during the previous 12 months?
8. Do the records indicate that ballast water or a ballast tank was contaminated by oil from an adjacent space or pipeline leakage during the previous twelve months?

GUIDELINES:**Human Guidelines:**

The accompanying Deck Officer must be familiar with the company procedure for periodically checking empty spaces for liquid ingress or monitoring the levels of full or partially full tanks to detect any migration of liquid between spaces.

The accompanying Officer must also be familiar with the company procedure for inspecting the surface of ballast water prior to discharge, especially when a ballast tank adjoins a cargo or bunker tank or contains piping with oil passing through it.

Process Guidelines:

The vessel operator should ensure that there are procedures in place for leakage detection, covering the following areas:

- Inspecting the surface of ballast water in tanks adjacent to cargo or bunker tanks and areas where oil pipes, such as hydraulic lines, run through, before discharging ballast overboard.
- Periodically sounding empty tanks and spaces to detect any migration of liquids from other spaces in the event of structural failure or pipeline leakage.
- Periodic monitoring of the contents level in full or partially full tanks to detect migration of liquids between adjacent or interconnected spaces.
- Testing of ballast lines that pass through cargo tanks or fuel tanks.
- Taking mitigating actions when contaminated ballast water is found or when there is evidence of cross-contamination of contents between different spaces.

The Inspector is expected to sight these procedures and verify the following:

- Sounding records and records of ballast water inspections prior to discharge, ballast line tests, as per company procedures.
- Periodic soundings of empty tanks have been conducted.

- The ballast tank sighting arrangements are readily accessible to inspect the surface of ballast water prior to discharge.
- Whether tanks adjacent to cargo or bunker tanks can be easily inspected without the removal of numerous bolts to access inspection hatches or make an enclosed space entry.
- Whether liquid leakage or cross-contamination was detected in an empty space or ballast tank due to structural or pipeline failure in the past 12 months.
- Records of ballast line tests passing through cargo or fuel tanks.

Hardware Guidelines:

Ensure the availability of the Cargo/ballast tanks/ void space/ FW tanks reports.

REFERENCE:


TMSA KPI 4.2.2 requires that cargo, void and ballast spaces are inspected to ensure their integrity is maintained.

IMO: ISM Code / 7.

OCIMF: International Safety Guide for Oil Tankers and Terminals. Sixth Edition

11.3.4 Monitoring of Void and Ballast Spaces


12.6.5 Discharging Segregated Ballast



NEWSLETTER

SIRE 2.0

EVERYTHING YOU WANT TO KNOW ABOUT SIRE 2.0
PROCEDURES AND OBSERVATIONS



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FOR SHIP SENIOR OFFICERS & SUPERINTENDENTS

Behavioural Competency Assessment & Verification

For Compliance with OCIMF SIRE 2.0 Requirement

NEXT COURSE PLANNED ON

MAY 2026

23RD

SATURDAY



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RISQ

INSPECTION FRAMEWORK EVOLUTION

A JOURNEY THROUGH
SAFETY, COMPLIANCE &
MODERN MARITIME STANDARDS



“ Follow us and stay tuned as we explore the latest RISQ updates, inspection insights, PSC trends, and practical onboard guidance in our weekly RightShip newsletter series.



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SAFETY
FOCUS**



**ENHANCED
COMPLIANCE
REQUIREMENTS**



**OPERATIONAL
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RISQ INSPECTION FRAMEWORK EVOLUTION

A JOURNEY THROUGH SAFETY, COMPLIANCE &
MODERN MARITIME STANDARDS



MARINERS UPDATE

MAY
2021



VERSION 0 – ORIGINAL RELEASE

Laying the Foundation

- Cargo hold ladder access using Australian ladder
- Lifeboat, life buoys & fire control plan updates
- Ballast control panel & working access updates
- Sounding pipes, deck lines & steering system added
- Walkways, ladders & inspection guides improved

OCT
2021



VERSION 1 – 18 OCT 2021

Safety & Access Enhancements

- Life-saving appliances & pyrotechnics checks added
- Fire control & lifeboat/raft launching guides updated
- Ballast, working access & inspection requirements revised
- Steam lines, walkways & ladders added
- Inspection guide for multiple sections updated

JUN
2022



VERSION 2.0 – 01 JUN 2022

Operational Risk Focus

- Emergency overrides & operational control checks
- Confined space, lockout/tagout & emergency power
- Hatch cover practices & cargo damage checks
- MLC/ILO standards & industry recommendations
- Onboarding new personnel guidelines added

VOYAGE 4 - 19 MAY 2026

FEB
2023

VERSION 3.0 – 28 FEB 2023

Compliance & Human Factors

- Code of Conduct to reduce bribery; "Finding" introduced
- Enclosed space, hot work & gas detector checks updated
- Coal temperature, towing & crane inspection added
- Biofuel management, asbestos reporting & ITF requirements
- Potable water checks & reference list updated

MAY
2024

VERSION 3.1 – 01 MAY 2024

Alternative Fuel & Modern Operations

- New sections: Methanol (7C), Ammonia (7D) & Ship-to-Ship Operations (17)
- EEDI/EEXI reporting & OCIMF alignment
- Enclosed space register, fall protection & comms clarity
- Battery-powered vehicles, conveyor & skirt monitoring
- Deck cargo securing & hatch cover training updates

NOV
2025

VERSION 3.2 – 01 NOV 2025

Latest RISQ Enhancements

- New revisions introduced under Annex A
- Enhanced inspection expectations
- Updated operational compliance focus

RISQ 3.2, RightShip's newest major inspection update, came into effect on **25 February 2026**. Stay tuned for weekly insights and detailed breakdowns.



RIGHTSHIP INSPECTION

Stay updated with our weekly RightShip Inspection featuring bulk carrier inspection insights, safety observation.



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COMPLIANCES, AND OPERATIONAL EXCELLENCE.”

USER-FRIENDLY DIGITAL COMPLIANCE FOR MODERN MARITIME OPERATIONS

MARITIME SOFTWARE

USER-FRIENDLY DIGITAL COMPLIANCE

- ▶ WRH : Work Rest Hours Software
- ▶ e-Training : Self Learning Monthly Safety Videos
- ▶ PSC-Q : Port State Control Questionnaire (port specific)
- ▶ EXIT EXAM : All Competency, Proficiency, Modular Exit Exams



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MARINER'S UPDATE
COMPLIANCE WITH SIMPLICITY

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LOST COMMUNICATION, RESTRICTED ESCAPE, SERIOUS CONSEQUENCES



Small communication gaps can create major risks inside enclosed spaces.

MISCOMMUNICATION DURING ENCLOSED SPACE INSPECTION INJURES CREW MEMBER

INTRODUCTION

A routine enclosed space inspection onboard a vessel resulted in a crew member suffering a head injury after confusion developed during exit procedures inside a void space. Despite proper permits and safety checks being completed, a missed radio communication and multiple simultaneous tasks contributed to the incident.

The case highlights how quickly enclosed space operations can become dangerous when communication and coordination break down.

ROUTINE INSPECTION OPERATIONS

The vessel's crew had scheduled six-monthly inspections of several void spaces, including bilge suction and alarm testing. Due to operational schedules, the inspections were carried out during non-service hours.

A company technical manager joined the inspection team, and all enclosed space entry procedures were completed beforehand, including:

- Gas testing
- Permit-to-work checks
- Emergency arrangements
- Assigned crew responsibilities

The inspection team included the supervising officer, technical manager, and several ABs assigned to monitoring and safety duties.

HOW THE INCIDENT OCCURRED

The first two void spaces were inspected without problems. During inspection of the third space, the supervising officer and technical manager exited while the duty AB remained inside to continue bilge testing and communicate with the engine room.

To reduce radio traffic, the AB switched to a different communication channel. Unaware of this, the supervising officer informed him that the starboard hatch would be closed and instructed him to exit later through the port-side opening. The message was never received.

Shortly afterward, the AB's gas detector activated a low battery warning. Mistaking it for a gas alarm, he immediately used an Emergency Escape Breathing Device (EEBD).

DURING EVACUATION:

- The EEBD hood fogged up
- The AB dropped his radio
- Communication was lost
- Visibility became restricted

Disoriented, the AB attempted to exit through the starboard hatch, not knowing it had already been secured. While climbing the ladder, he struck his head against the closed hatch cover before the team reopened it for emergency exit.

Several days later, the crew member reported ongoing headaches linked to the impact.



KEY FINDINGS FROM THE INCIDENT

Communication Failure

The main contributing factor was the missed instruction caused by the radio channel change. No confirmation was received to ensure the message had been understood.

Task Overload

The AB was simultaneously handling:

- Bilge testing
- Engine room communication
- Alarm monitoring
- Emergency equipment

This increased stress and reduced situational awareness inside the confined space.



Alarm Misinterpretation

The gas detector's low battery warning was mistaken for a gas emergency, triggering panic and confusion.

Poor Team Coordination

One of the most serious failures was the closure of an exit hatch while a crew member was still inside the enclosed space.

Exit routes should never be blocked until all personnel have safely exited.

SAFETY LESSONS FOR THE MARITIME INDUSTRY

For Seafarers

- Always confirm safety-critical instructions during enclosed space operations. Assumptions and routine habits can lead to serious incidents.

For Ship Managers

- Work planning should consider human factors, communication backup systems, and operational workload during high-risk activities.

For Regulators

- Safety procedures should address real onboard challenges, including communication failures, emergency escape difficulties, and equipment usability under stress.

CONCLUSION

This incident highlights that even well-planned enclosed space operations can quickly become dangerous when communication, coordination, and situational awareness fail during execution. Confined spaces onboard vessels remain high-risk environments where even small misunderstandings or delayed responses can lead to serious injuries.

The case reinforces the importance of clear communication, effective teamwork, proper supervision, and keeping escape routes accessible at all times. Reducing task overload, conducting proper toolbox meetings, and ensuring all crew members fully understand their roles are essential steps in preventing similar incidents during enclosed space operations onboard.

INDIA EXPANDS ITS SHIPPING POWER

Why is India Investing ₹51,000 Crore in 62 New Ships?



India plans to add 62 new vessels by 2027 with a ₹51,383 crore investment to strengthen maritime trade, energy security, and reduce dependence on foreign shipping companies.

The project includes new tankers, container vessels, and LNG carriers to boost national shipping capacity.

The move comes amid rising global trade and supply chain concerns.

India is set to strengthen its maritime future with a massive ₹51,383 crore investment to add 62 new vessels by 2027. The expansion includes tankers, LNG carriers, container ships, and dredging vessels aimed at boosting trade security, energy transportation, and reducing dependence on foreign shipping companies.

The move comes amid growing global shipping disruptions and rising concerns over critical trade routes such as the Red Sea and Strait of Hormuz.

M/V DALI DISASTER ESCALATES

BILLION-DOLLAR SETTLEMENT AND CRIMINAL CHARGES SHAKE GLOBAL MARITIME INDUSTRY

OPERATOR AND TECHNICAL SUPERINTENDENT OF **M/V DALI** CHARGED FOR ROLES IN KEY BRIDGE CRASH

\$5 BILLION LOSS

12 MAY 2026



6 LIVES LOST
SIX CONSTRUCTION
WORKERS KILLED



CRITICAL INFRASTRUCTURE
ICONIC FRANCIS SCOTT KEY
BRIDGE COLLAPSED



ECONOMIC IMPACT
LOSSES EXCEEDING
\$5 BILLION



ENVIRONMENTAL DAMAGE
OIL, CONTAINERS & DEBRIS
INTO PATAPSCO RIVER

The legal fallout from the collapse of the Francis Scott Key Bridge involving the Singapore-flagged M/V Dali has escalated significantly, with both major civil settlements and criminal indictments now reshaping the case.

The U.S. Department of Justice has formally indicted vessel operators Synergy Marine Pte Ltd and Synergy Maritime Pte Ltd, along with Indian national Radhakrishnan Karthik Nair, the vessel's Technical Superintendent, in connection with the March 2024 disaster that claimed the lives of six construction workers in Baltimore.

According to federal prosecutors, the Dali suffered two power blackouts within four minutes while departing the Port of Baltimore before striking the bridge. Investigators allege that a loose wire in the vessel's high-voltage switchboard triggered the initial failure, while subsequent machinery arrangements and reliance on a flushing pump configuration prevented power from being restored in time to safely navigate beneath the bridge.

The indictment accuses the companies and superintendent of conspiracy to defraud the United States, obstruction of an agency proceeding, failure to report hazardous conditions to the U.S. Coast Guard, providing false statements to investigators, and environmental violations linked to oil, debris, and cargo pollution in the Patapsco River and Chesapeake Bay.



At the same time, the State of Maryland announced a massive USD 2.25 billion settlement with the vessel’s owner Grace Ocean and operator Synergy Marine, making it one of the largest maritime-related settlements in recent history. The agreement is particularly significant as the companies had previously attempted to limit liability to approximately USD 44 million under an 1851 U.S. maritime law.

What initially appeared to be a marine casualty involving technical failures and vessel blackout scenarios has now evolved into a much broader case centered on operational decision-making, alleged unsafe modifications, corporate accountability, and accusations of concealment.

The DOJ estimates total economic losses from the disaster at more than USD 5 billion, while U.S. authorities continue to describe the incident as a preventable tragedy with serious implications for maritime safety, maintenance standards, and corporate compliance across the global shipping industry.

In response, Synergy Marine stated it was “deeply disappointed” by the criminal charges and maintained that findings from the National Transportation Safety Board (NTSB) do not support allegations of wrongdoing by the vessel’s crew.



DALI 2.0 – ROOT CAUSE ANALYSIS

Click the link below or scan the QR code to find out more.



[WATCH VIDEO NOW](#)

INDIAN CARGO VESSEL 'HAJI ALI' SINKS AFTER SUSPECTED DRONE OR MISSILE STRIKE NEAR OMAN COAST

An Indian- flagged cargo vessel, MV Haji Ali, sank near Oman after a suspected drone or missile strike triggered a massive onboard fire while en route to Sharjah with livestock cargo. Thankfully, all 14 Indian crew members were rescued safely by the Oman Coast Guard.

The incident has once again highlighted growing security concerns in Gulf shipping lanes and the risks faced by seafarers operating in high-tension waters.

INDIAN CARGO VESSEL 'MV HAJI ALI' IN FLAMES

SUSPECTED DRONE OR MISSILE STRIKE NEAR OMAN COAST





QUICK SEA NEWS
GLOBAL MARITIME INTELLIGENCE

Indian cargo vessel MV Haji Ali caught fire after a suspected drone or missile strike while sailing from Somalia to Sharjah.

The vessel later sank near Oman, while all 14 Indian crew members were rescued safely by the Oman Coast Guard.

EX-MERCHANT NAVY CAPTAIN ARRESTED IN CYBER TRAFFICKING CASE

FROM JOB PROMISES TO DIGITAL CAPTIVITY

CYBER SLAVERY RACKET BUSTED:

EX-MERCHANT NAVY CAPTAIN HELD



Indian youths were allegedly trafficked to cyber scam hubs in Cambodia and Laos through fake overseas job offers.

Police arrested an ex-merchant navy captain accused of running the cross-border cyber slavery network linked to online fraud operations targeting Indian citizens.

FOLLOW US FOR MORE MARITIME UPDATES



A shocking case highlighting the growing threat of cyber slavery and fake overseas job scams has emerged, where Indian youths were allegedly trafficked to Southeast Asian cyber scam hubs under false employment promises.

Authorities have arrested an ex-merchant navy captain identified as Nagesh Kumar alias "Captain Chauhan," accused of operating the racket and forcing victims into online fraud operations.

UNKNOWN FACTS

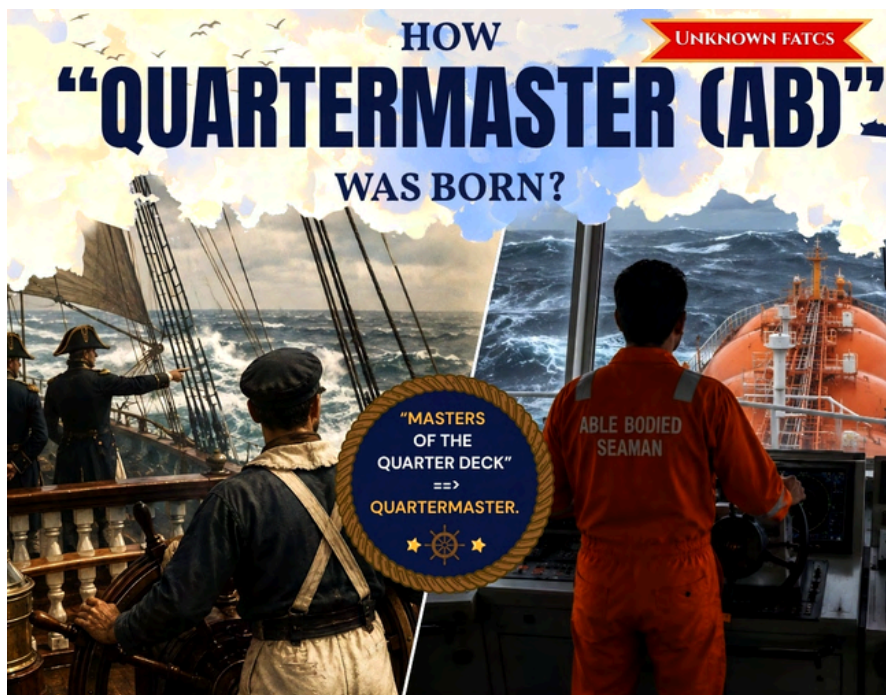
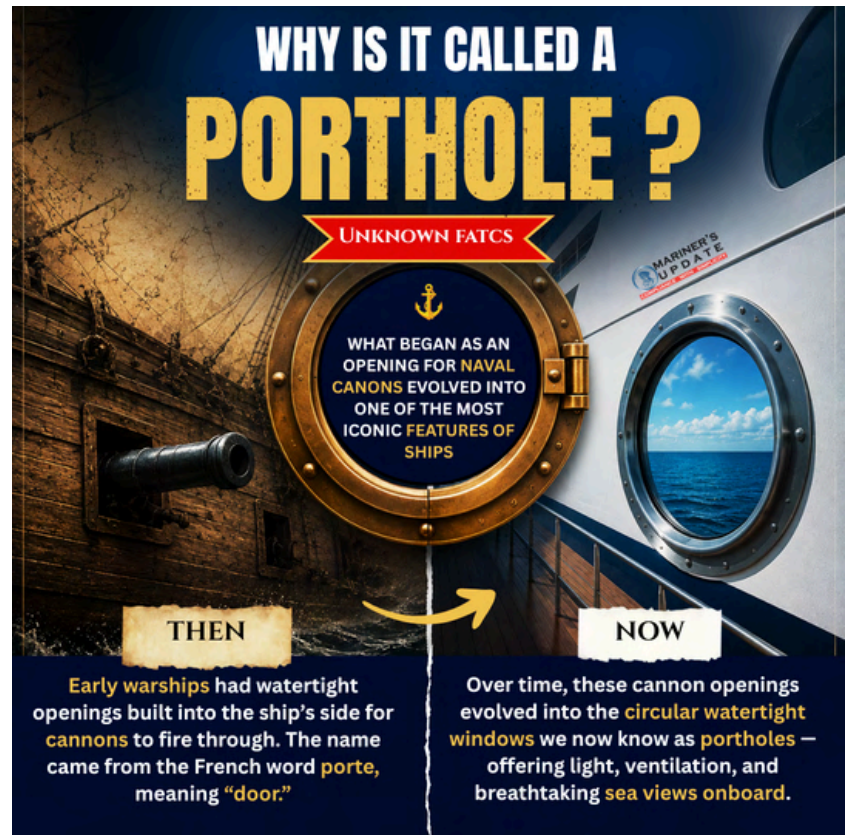
DID YOU KNOW?

MARINERS UPDATE

HOW CANNON PORTS BECAME PORTHOLES ?

In modern maritime terms, a porthole is a watertight circular window on a ship's side.

Its origins trace back to naval warships during King Henry VII's era, when special watertight openings were created to fire heavy cannons through the hull. Derived from the French word *porte* meaning "door," these cannon openings eventually evolved into the iconic portholes seen on ships today.



★ In the age of British sailing ships, the **quarterdeck** was reserved for officers, not all officer experts in practical seamanship. So **Skilled sailors (AB)** were therefore allowed onto the **quarterdeck for steering** ★

ORIGIN OF THE QUARtermaster

In today's merchant navy, a Quartermaster is responsible for steering the ship and assisting on the bridge.

The title dates back to British sailing ships, where skilled sailors were allowed onto the quarterdeck to help officers with navigation and ship handling.

These experienced seamen became known as the "Masters of the Quarter Deck" — later shortened to Quartermaster.

VOYAGE 4 - 19 MAY 2026

X [WATCH VIDEO NOW](#)

ROTATIONAL & LINEAR MOTIONS ON SHIP

PITCHING



MARINER'S UPDATE
COMPLIANCE WITH SIMPLICITY

SHIP MOORING ROPE USES

Rotational & Linear Motions of a Ship Explained

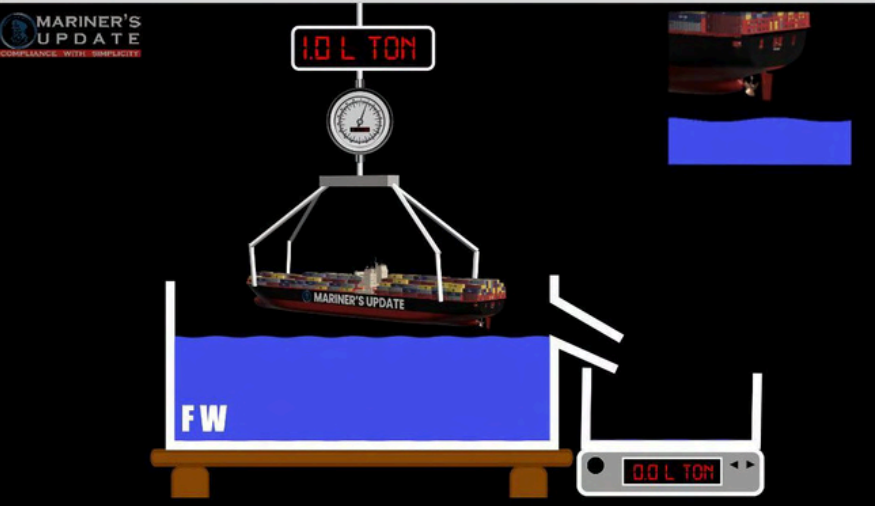
Understand how ships move at sea during rough weather with simple and practical explanations of all ship motions.

Click the link on the image or scan the QR code to watch the video.



X [WATCH VIDEO NOW](#)

HOW SHIP FLOATS ?



MARINER'S UPDATE
COMPLIANCE WITH SIMPLICITY

FW

0.0 L TON

HOW SHIP DISPLACEMENT CALCULATED ?

Ever wondered how a massive steel ship floats?

This video explains the basic science of ship flotation and how displacement is calculated using simple maritime principles.

Click the link on the image or scan the QR code to watch the video.



WEEKLY WEALTH PLAN
FOR SAILORS

WEEK 3

THE \$24,926.90 SUV MISTAKE

SMART CHOICES TODAY,
FINANCIAL FREEDOM TOMORROW.



IMPULSE TODAY
REGRET TOMORROW



PLAN TODAY
ENJOY FOREVER



FINANCIAL
SECURITY



WEALTH
GROWTH



ASSET
CREATION



GOALS &
FREEDOM



DISCIPLINE
AT SEA, WEALTH
ON SHORE



DISCIPLINE AT SEA. WEALTH ON SHORE.
A SEAFARER'S JOURNEY TO FINANCIAL INDEPENDENCE

THE \$24,926.90 SUV MISTAKE

A young 3rd Officer completed his contract and returned home with nearly USD 24,926.90 in savings. Excited to enjoy the reward of his hard work, he used almost his entire salary to buy a brand-new SUV worth **\$24,926.90**.

The purchase felt great at first. Friends admired it, family felt proud, and social media attention followed.

But financially, it was a poor decision.

The moment the SUV left the showroom, its value started decreasing. Within 5 years, the vehicle could be worth only **USD 13,000–15,000**, while maintenance, fuel, insurance, and servicing costs continue increasing.

Instead of using all his savings on a **depreciating asset**, he could have made a smarter move.

SMARTER WEALTH ALLOCATION :

Allocation	Initial Amount	Estimated Value After 5 Years
Emergency Fund / Fixed Deposit	\$10,000	\$ 13,000+
Property or Land Investment	\$9,000	\$ 16,000–20,000
SUV Down Payment	\$5,926.90	SUV still usable while assets continue growing

With this approach:

- He could still own the same SUV through manageable EMI.
- His emergency savings would remain secure.
- His property investment could appreciate significantly over time.
- He would build long-term financial stability instead of temporary lifestyle satisfaction.

The Real Lesson

Many seafarers earn good money at a young age, but wealth is not built by salary alone — it is built by **smart allocation**.

Cars lose value.
Assets grow value.

The goal is not to avoid enjoying life, but to **make your money work for you** before spending everything on liabilities.





MARITIME FUNCORNER

FUN CORNER: LIFE AT SEA

A CAPTAIN'S JOURNEY

- 1** I used to be **Cadet**, and I knew loat
- 2** Then I become **Third Mate**, and I knew Everything
- 3** Then I upgraded to **Second Mate**, and soon realized I was not as Clever
- 4** Then I got promoted to **Chief Officer**, And I knew I had much to learn
- 5** Then I became **Captain**, and I realized how much knowledge still left to aquire

But it didn't matter because my **Third Mate** knew Everything!

FINAL THOUGHTS

**LONG VOYAGES BUILD STRONG MINDS,
SKILLED HANDS, AND UNFORGETTABLE
STORIES.**

**STAY VIGILANT, STAY MOTIVATED, AND SAIL
SAFELY.**

UNTIL THE NEXT EDITION.

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