

YMN
TANKER

HSSEQ BULLETIN

Q1 2026 / ISSUE 25

MED ATLANTIC

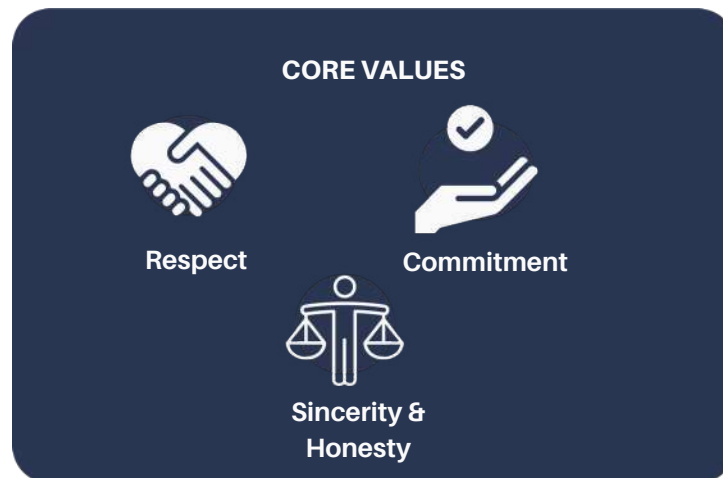
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About Us

YMN Tanker Marine Management Inc. (YMN Tanker Deniz İşletmeciliği A.Ş.) was founded in 2012 to provide technical and commercial management of 6 marine line Oil/Chemical tankers. The fleet was expanded in 2017 with an additional 4 vessels. There are 13 Chemical/Oil tankers under management at the moment.

The Company is focused on technical and crew Management and Chartering of vessels in the Specialty/Chemical tanker segment. The Company plans to strategically expand the fleet by continuing to offer quality ship management services to third party owners.



WE RESPECT FOR:

- Human life along with all other living beings' existence
- Multiculturalism Individual differences Our colleagues
- Our company values

WE ARE COMITTED TO:

- Self-examination and lifespan development
- Universal ethical values
- Being reliable and loyal
- Safety & environment
- Our customers
- Our crew friends

WE ARE SINCERE AND HONEST:

We are sincere & honest:

- To our affiliates
- About our values, visions & missions About keeping our promises
- About carrying on with upmost integrity

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Source: External information and news included in this magazine have been compiled from publicly accessible publications available on the internet.

Our Fleet



YMN TANKER
MARINE
MANAGEMENT INC.



MED NORDIC



MED ARCTIC



MED BALTIC



MED ATLANTIC



MED PACIFIC



MED ADRIATIC



MED ANTARCTIC



MED TUNCER



MED PAKIZE



MED EMRE



MED SERHAT



MED BLUE JAY



MED CANARY

2026 COMPANY RUN SEMINAR



YMN Tanker organized the 2026 Q1 Company Run Seminar with the participation of our General Manager, Yaman Şen during which each department shared its own operational statistics.

The departmental presentations related to the first quarter were presented in line with our company's transparency policy and provided an opportunity to analyze both ongoing and planned efforts aimed at achieving our corporate goals

2026 COMPANY RUN SEMINAR



The Company Run Seminar also hosted participants from outside the company. Presentations were delivered by Engin Koç on gas detectors and proper equipment usage, Banu Ökem Hepşen and Ali Özen on salvage operations, and Yaren Cemre Gülcek on maritime psychology.



BEST PRACTICE EXAMPLES FROM OUR FLEET

Best Practice Reported by MED TUNCER Crew

BAD PRACTICE



At the pilot access point, a lifebuoy equipped with a self-igniting light and a separate heaving line are available. However, the heaving line is attached directly to the lifebuoy instead of being stored separately.

GOOD PRACTICE



At the pilot access point, a lifebuoy equipped with a self-igniting light and a separate heaving line are readily available. The heaving line is stored separately from the lifebuoy in a ready-to-use condition, and NOT attached to the lifebuoy.





LESSONS LEARNED APPLICATIONS FROM OUR SHIPS

Lesson Learned, prepared based on the incident that occurred in MED ANTARCTIC:

EVENT:

During SIRE 2.0 Inspection in Amsterdam on 29.12.2025, Free Fall Lifeboat launching procedure was identified that ship-specific procedures and the SOLAS Training Manual did not include clear instructions for the release of grab lines after free fall launching.

ROOT CAUSES

- Inadequate implementation of procedure
- Inadequate assessment of needs and risks

LESSONS LEARNED

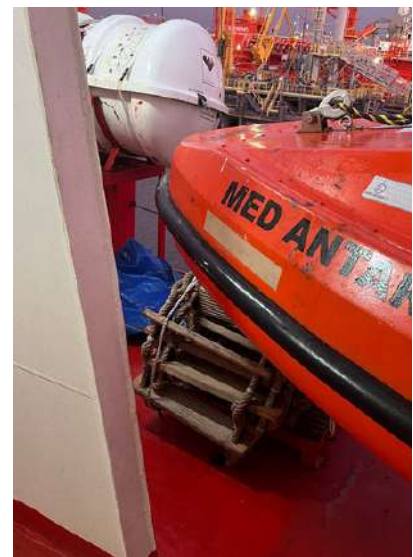
- Ship-specific procedures must clearly cover all critical post-launch actions, not only the launching phase.
- Small procedural gaps in emergency equipment operation can lead to serious life-threatening consequences
- Visual instructions and clear responsibility assignment are essential, especially for high-risk emergency systems such as free fall lifeboats

LESSONS LEARNED APPLICATIONS FROM OUR SHIPS

Lesson Learned, prepared based on the incident that occurred in MED ANTARCTIC:

EVENT:

During heavy weather and rough sea conditions, it was identified that the Rescue Boat was not sufficiently secured and moved from its position, blocking the access route to the liferaft embarkation area. The rescue boat was moved forward because the lashing arrangement did not have a ratchet buckle. This situation could delay or prevent access to the liferaft embarkation area during an emergency evacuation. Especially in severe weather conditions, this presents a significant risk of injury and loss of life to personnel.



ROOT CAUSES:

- Inadequate implementation of procedure
- Failure to Secure
- Incorrect/Inadequate Tool/Equipment

LESSONS LEARNT:

- Rescue Boats and other lifesaving appliances require additional securing measures during heavy weather.
- Access routes to liferaft embarkation areas must always be kept clear, accessible, and unobstructed.
- Heavy weather preparation and securing checks are critical to ensure safe evacuation during emergencies.
- Lashing equipment shall be a Ratchet tie with buckle as shown in below picture



LESSONS LEARNED APPLICATIONS FROM OUR SHIPS

Lesson Learned, prepared based on the incident that occurred in MED BLUE JAY:

EVENT:

During a scheduled fire drill, it was observed that a member of "Fire Team 1" failed to properly don their BA (Breathing Apparatus) mask. Following this observation, the firefighter adjusted the internal nose and mouth cup before proceeding with the intervention. * Additionally, due to the rush of putting on firefighting gear quickly, the mask's tensioning straps were pulled with uncontrolled force, causing the buckles to snap suddenly. This rendered the mask unusable; it was subsequently replaced with a functional unit to continue the drill.

LESSONS LEARNT :

- The proper donning of a BA mask is critical during firefighting or enclosed space rescue operations;
- Any failure increases the risk of the rescuer becoming a casualty. Therefore, mask straps must be
- Tightened evenly and the inner nose cup must be perfectly centered on the face to ensure safety.
- While speed is essential during drills, rushed actions increase the margin of error and the risk of
- Equipment damage. To prevent such incidents, practical training should be intensified to improve the
- Muscle memory and technical proficiency of personnel during the donning process

ROOT CAUSES:

- Unintentional misuse (Incorrect donning technique).
- Lack of attention and excessive haste.
- Lack of training (Lack of familiarity with equipment limitations).



LESSONS LEARNED APPLICATIONS FROM OUR SHIPS

Lesson Learned, prepared based on the incident that occurred in MED NORDIC:

EVENT:

Shortly after a crew plugged the headlamp which had been assigned for his use into a charger in his cabin, the integrated battery of a headlamp exploded.

ROOT CAUSES :

- Improper operation of device
- Incorrect / inadequate tool / equipment
- Lack of situational awareness/risk perception/risk awareness



LESSONS LEARNT:

- The investigation revealed that there were two types of headlamps on board a vessel, one has 0,5 amper batteries and the other type with 2,5 amper batteries, and it was determined that the battery was exposed to a current over the capacity due to usage of an incorrect charger.
- The fact that the crew was in the cabin at the time of the incident and immediately unplugged the device and notified to Chief Officer, prevented a potential fire.
- If the crew had been in his cabin at the time of incident, he could have been injured as well.
- In the light of above three assessments, planned to install a battery charge station in order to minimize potential faults and the risks of injury and fire arise from.



INDUSTRY ACCIDENT REPORTS

INCIDENTS ARE A FREE LESSON - REPORT IT!

Accidents and incidents occurring within the maritime industry should always be regarded as valuable opportunities for “lessons learned.” Therefore, the incident experienced onboard MT Med Tuncer is presented below in this issue.

MED TUNCER - INVESTIGATION REPORT

The Vessel unberthed from Porto Marghera / ITALY on the 18th of March 2026 after loading of Soyabean oil at the installation of Cerealdocks terminal. The pilot for departure was booked at 14:00 LT on the 18th of March 2026. Pilot on board 13:30 Lt, M/E, steering and bow thruster tests were completed as per company/international regulations at 1324/1336 LT on 18th of March 2026 and the Vessel was ready to sail. 14:00 Lt Unmoored fm Cerealdocks with 2 tug boats, 14:39 tug boats let go (FORE & AFT). While the vessel was navigating with a pilot at in The Porto Marghera Channel / ITALY, the main engine was shutdowned automatically due to oil mist alarm arised at 14:44:20 LT on 18th of March 2026. Upon inspection, the detector cable was found loosened from its terminal connection. The connection was restored, system was checked for fault indication, and reset carried out. After confirming normal condition, main engine was put back into the service at 14:46:00 LT on 18th of March 2026. The team was ready to drop both anchors at the forecastle for an emergency, M/E was re-started at 14:46:00 LT , stbd anchor dropped 3 shackles on deck 14:47 LT, heavep up anchor and anchor cleared at 14:52 LT and the vessel was underway at 14:52 LT.

ROOT CAUSE:

- The main engine was shut down due to loosened of terminal connection of the oil mist detector sensor.
- Failure of signal due to disconnection of oil mist detector cable.
- Loss of communication between OMD unit and control system.



CORRECTIVE AND PREVENTATIVE ACTIONS :

- Once the alarm was occurred in alarm monitoring system, oil mist detector sensor has been checked.
- OMD cable was reconnected and secured to terminal connection immediately. Oil mist detector system was tested and verified as functioning correctly.
- After oil mist alarm was removed from the Alarm Monitoring System, Main Engine was restarted safely within 2 minutes.
- Class surveyor attended to the vessel and further checks and surveys completed on the same day of the incident after vessel re-berthed. The Main Engine has been satisfactorily tested and the ship is able to continue her voyage safely as stated in the class survey report.
- All Oil Mist Detector and critical sensor cable connections have been checked and tightened on board.
- Additional securing arrangements (proper fastening) have been applied to prevent loosening due to vibration.
- Engine room personnel have been briefed importance of sensor integrity.

LESSON LEARNED:

- Even a minor connection issue in critical safety systems (such as OMD) can lead to a main engine shutdown and directly affect vessel operations.
- During critical operations such as port departure, not only system testing but also the integrity and reliability of physical connections are of utmost importance.
- The prompt response of the crew and correct decisions (e.g., anchor readiness and system checks) helped prevent escalation of the incident.
- Alarms generated by safety systems must always be treated seriously; however, the possibility of false alarms should also be technically evaluated.
- This incident once again highlights the importance of proactive maintenance and thorough visual/physical inspections.



VESSEL TAKEOVER: WHAT REALLY MATTERS BEYOND THE CHECKLIST

- Based on my experience at sea and ashore, vessel takeovers are never just a simple handover.
- They are often handled as a standard process - go through the list, check what's there, and move on. In practice, this is where many future issues either get noticed or missed.
- A takeover is not only about documents or compliance. It's about seeing how the vessel actually works - usually in a short time and sometimes under pressure.
- Even if there has been a pre-purchase inspection before delivery, you still need to see the vessel yourself. The real condition becomes clear when you walk through it.
- One thing becomes clear very quickly: not everything is written down. Even if the paperwork looks complete, the real situation shows itself in small details:
 - minor leakages
 - temporary fixes that stayed longer than expected
 - recurring alarms that people got used to
- These are part of normal operations.
- Having a structure helps, but you also need to stay practical. Every vessel is different.
- From my side, I usually focus on a few key areas:
 1. Technical Reality vs Documentation
- Reports and PMS records are a good starting point, but they don't always reflect the actual condition onboard. Walking the vessel and asking the right questions often gives a much clearer picture.
 2. Critical Systems and Standby Equipment
- Main engine and auxiliaries come first, but standby equipment is just as important. Stand by pumps/compressors/separators - these need to be ready when required, not just listed as available.
 3. Spare Parts & Inventory
- This is often underestimated, yet it directly affects operations after takeover.

It's not only about system records, but what is physically onboard:

 - differences between records and actual stock
 - missing critical spares
 - unusable or oversized spares

Having a clear picture early on helps avoid unnecessary issues later.

VESSEL TAKEOVER: WHAT REALLY MATTERS BEYOND THE CHECKLIST

4. Safety-Critical Systems

- Safety systems should never be taken for granted. They need to be checked properly and, where possible, tested.
- Emergency fire pump, emergency generator, water mist system, quick closing valves, fan dampers etc. - these are not just items on a list. They are essential in real situations.
- A system that looks fine on paper but does not work when needed is a serious risk.

5. Whole Vessel Perspective

- A vessel should be assessed as a complete system, not in isolated parts.
- Deck equipment such as winches and cranes, cargo and ballast systems, and overall tank condition give a clear indication of how the vessel has been operated and maintained. Cargo and ballast tanks, together with visible hull areas, often reveal early signs of corrosion, coating breakdown, or recurring maintenance issues.
- Bridge equipment is critical for safe navigation and must be treated with the same level of attention as any major machinery onboard.
- If available, pre-purchase inspection findings should be reviewed carefully, as they give useful background on the vessel's condition. However, they should be seen only as a reference, not a substitute for onboard checks.
- Underwater inspection is a key element that should not be overlooked. Hull condition below the waterline, propeller condition, possible damage, fouling, or any abnormal findings directly affect vessel performance, fuel consumption, and overall efficiency. These are not areas that can be assessed during a standard walkthrough and need to be verified through proper inspection.
- Looking at all these elements together gives a more accurate and realistic picture of the vessel.

‘Source: Technical Superintendent/Aytaç Çalışkaner LinkedIn April 2026’

VESSEL TAKEOVER: WHAT REALLY MATTERS BEYOND THE CHECKLIST

6. Inspections After Takeover

- In many cases, inspections follow shortly after takeover - class, flag, port state, or industry inspections such as SIRE, CDI, or RightShip.
- This is where the quality of the takeover becomes clear very quickly. Any gap missed during handover tends to surface during these inspections.
- Being prepared from day one makes a real difference, both for the crew and for avoiding unnecessary findings.

7. Communication with the Crew

- Crew members often know the vessel better than any report. A short conversation can reveal things that are not documented.
- In the end, it comes down to mindset. A takeover is not about finding faults - it's about understanding the vessel as it is.
- When done properly, it makes everything that follows much easier.
- It is not just a handover. It is the beginning of responsibility.
- Note: This article reflects general observations and personal experience. It is not intended to refer to or evaluate any specific company, vessel or organization.



‘Source: Technical Superintendent/Aytaç Çalışkaner LinkedIn April 2026’

Health of Seaman: Food Poisoning

Ensuring that crew members on board maintain a regular and healthy diet is an important matter, while the hygiene and freshness of food supplies are also of vital importance, as they may lead to food poisoning. Proper transportation and storage of provisions delivered to vessels play a critical role in protecting the health of seafarers.

Food poisoning can briefly be defined as an illness caused by the human body reacting to toxins or microorganisms present in contaminated food. Onboard food poisoning may occur due to various reasons such as improper heating and cooling practices, incorrectly stored provisions, or unhygienic food preparation areas. According to Merchant Ships and Fishing Vessels, some of the main causes of food poisoning are listed below:

- Raw or undercooked food
- Storing cooked meals under unsuitable hygienic or temperature conditions
- Unpasteurized milk and dairy products
- Food preparation in unclean environments
- Food stored in humid conditions without adequate refrigeration



PREVENTING FOOD POISONING AT VESSELS

The best way to prevent food poisoning is to keep both food and food preparation areas clean at all times. Certain food products are more likely to cause food poisoning than others. These include:

Meat products

Eggs

Shellfish

Milk and dairy products

Some of the key measures that should be taken in order to prevent food poisoning are listed below.

PACKAGED FOOD

Packaged food stored in dry provision rooms should be inspected regularly for insects, larvae, or infestation. Broken jars or damaged packages may attract insects and flies; therefore, all food packages should be properly checked and stored in suitable dry storage areas.

PROVISION SUPPLY

When provisions are delivered on board, the responsible ship personnel should inspect all products using a checklist, including expiry dates, package conditions (tears, holes, etc.), and thawing conditions for frozen products. All vessels should have adequate dry provision rooms and Meat & Fish Rooms meeting operational requirements. Provisions should be arranged according to the “first expiry, first use” principle



PREVENTING FOOD POISONING AT VESSELS

MEAT & FISH ROOM

The Meat & Fish Room should be maintained regularly. Inspections should include door insulation effectiveness, proper operation of thermometers, and ensuring that cooling fans are not blocked, allowing proper cold air circulation. The smell and color of frozen or thawed food should also be carefully monitored.



STORAGE OF RAW AND COOKED FOOD

To prevent cross-contamination, meaning the transfer of bacteria from one food item to another, raw and cooked foods must be stored separately. Cutting boards and knives used for raw food should always be separated from those used for cooked food. If raw and cooked foods must be stored together, raw food should always be placed on the lower shelves.



PERSONAL HYGIENE

Special attention should be given to personal hygiene, particularly by the chief cook and galley staff. Hands should be washed thoroughly with soap and water before and after handling raw food. Clean clothing and aprons should always be worn. In addition, all personnel involved in food handling should be knowledgeable about legal regulations, the use of protective equipment, personal hygiene, and workplace sanitation practices.



WHAT SHOULD WE DO

1. Hands should be washed with soap for at least 20 seconds before and after food preparation.
2. Raw meat, poultry, and seafood should be stored separately from other food items.
3. The cold chain must be maintained, and perishable foods should be stored at appropriate temperatures.
4. Meals should be cooked at sufficient temperatures, especially meat products, which must be fully cooked.
5. Kitchen equipment, cutting boards, and work areas should be cleaned and disinfected regularly.
6. Expired food or food with suspicious odor or appearance should not be used.
7. Drinking and domestic water tanks should be inspected regularly, and hygienic conditions must be maintained.
8. Crew members should receive regular hygiene and food safety training.



RECURRING INSPECTION OBSERVATIONS



We also share the topics of recurring CDI and SIRE inspection observations reported during audits in our bulletin in order to prevent these issues from reoccurring on our vessels and to ensure extra attention is given to them

CDI

Section 8 - Health and Safety

8.1.44: The gangway / accommodation ladder is available and maintained in accordance with appropriate requirements.

In the first quarter of 2026, 4 of our vessels were inspected under CDI, resulting in 10 recorded observations. Among these, 2 were categorized under section 8.1.44.

SIRE

Section 5 - Safety Management

5.8.1. Were the Master and officers familiar with the company procedure for safety inspections of the main deck areas, and had inspections been effective in identifying hazards to health, safety and the environment?

Section 2- Certification and Documentation

2.4.1. Were the senior officers familiar with the company procedure for reporting defects to vessel structure, machinery and equipment to shore-based management through the company defect reporting system and was evidence available to demonstrate that all defects had been reported accordingly?

Section 3- Crew Familiarisation

3.5.1. Had the company developed an effective familiarisation programme that covered the personal safety and professional responsibilities of all onboard personnel, including visitors and contractors, and were records available to demonstrate that the familiarisation had been completed as required?

In the first quarter of 2026, 8 of our vessels were inspected under SIRE 2.0, resulting in 17 recorded observations. It was noted that two observations were recorded from the same sections mentioned above.

2026 Q1 YMN TANKER VESSELS USAGE/PRODUCTION STATISTICS

Garbage Consumption Total 1st Quarter
292,35 ltrs

Med Arctic	26,16 cbm
Med Baltic	22,49 cbm
Med Atlantic	17,04 cbm
Med Pacific	35,85 cbm
Med Adriatic	13,29 cbm
Med Antarctic	13,56 cbm
Med Tuncer	24,08 cbm
Med Pakize	12,46 cbm
Med Emre	32,1 cbm
Med Serhat	24,89 cbm
Med Blue Jay	23,69 cbm
Med Nordic	26,81 cbm
Med Canary	19,93 cbm

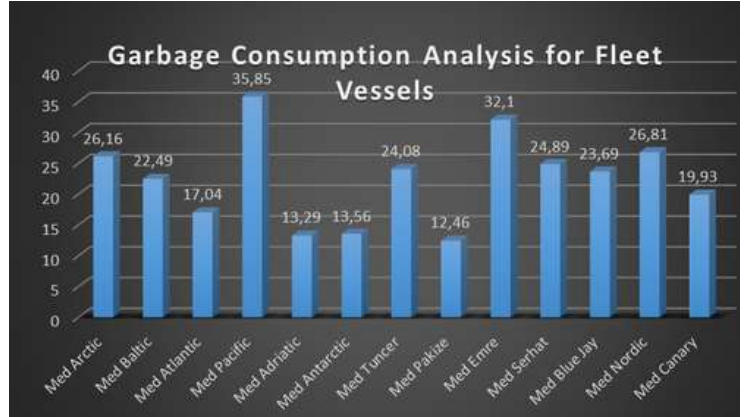


CHART 1 : GARBAGE CONSUMPTION ANALYSIS FOR FLEET VESSELS

Paint Consumption Total 1st Quarter
1939 ltrs

Med Arctic	135 ltrs
Med Baltic	140 ltrs
Med Atlantic	810 ltrs
Med Pacific	315 ltrs
Med Adriatic	95 ltrs
Med Antarctic	50 ltrs
Med Tuncer	122 ltrs
Med Pakize	40 ltrs
Med Emre	0 ltrs
Med Serhat	92 ltrs
Med Blue Jay	40 ltrs
Med Nordic	15 ltrs
Med Canary	85 ltrs

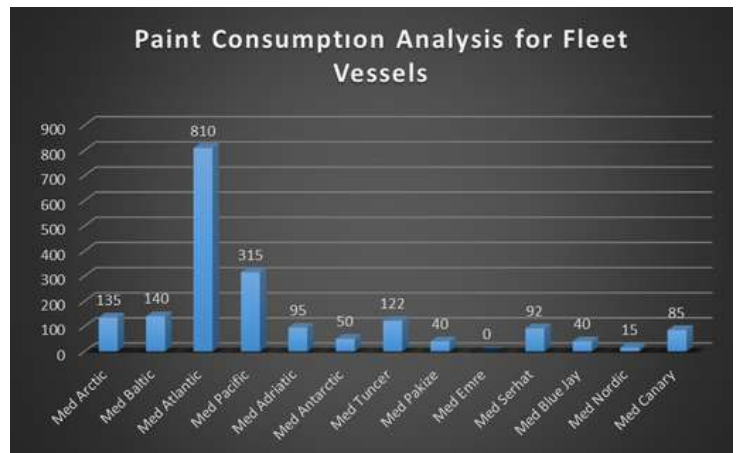


CHART 2 : PAINT CONSUMPTION ANALYSIS FOR FLEET VESSELS

Cartridge Consumption Total 1st Quarter
39 Pcs

Med Arctic	0 pcs
Med Baltic	0 pcs
Med Atlantic	0 pcs
Med Pacific	0 pcs
Med Adriatic	0 pcs
Med Antarctic	2 pcs
Med Tuncer	27 pcs
Med Pakize	0 pcs
Med Emre	5 pcs
Med Serhat	5 pcs
Med Blue Jay	0 pcs
Med Nordic	0 pcs
Med Canary	0 pcs

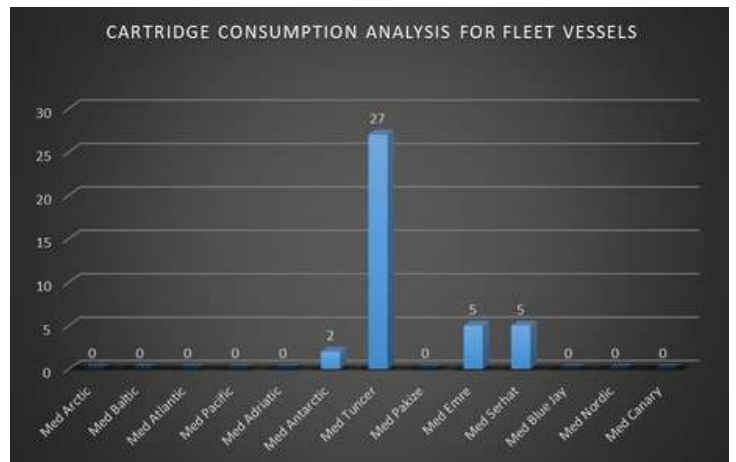


CHART 3 : CARTRIDGE CONSUMPTION ANALYSIS FOR FLEET VESSELS

SOURCE:COMPANY INTERNAL DATA

2026 Q1 YMN TANKER VESSELS USAGE/PRODUCTION STATISTICS

Paper Consumption Total 1st Quarter
58050 Pcs

Med Arctic	0 pcs
Med Baltic	5000 cbm
Med Atlantic	6000 cbm
Med Pacific	100 cbm
Med Adriatic	1500 cbm
Med Antarctic	1600 cbm
Med Tuncer	6500 cbm
Med Pakize	8000 cbm
Med Emre	5000 cbm
Med Serhat	12100 cbm
Med Blue Jay	7000 cbm
Med Nordic	3500 cbm
Med Canary	4250 cbm

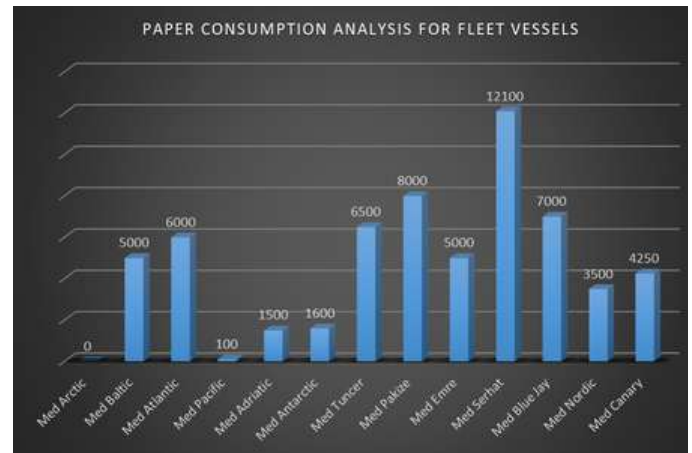


CHART 4 : PAPER CONSUMPTION ANALYSIS FOR FLEET VESSELS

Battery Consumption Total 1st Quarter
461 Pcs

Med Arctic	0 pcs
Med Baltic	0 cbm
Med Atlantic	0 cbm
Med Pacific	0 cbm
Med Adriatic	70 cbm
Med Antarctic	30 cbm
Med Tuncer	90 cbm
Med Pakize	82 cbm
Med Emre	0 cbm
Med Serhat	40 cbm
Med Blue Jay	0 cbm
Med Nordic	100 cbm
Med Canary	49 cbm

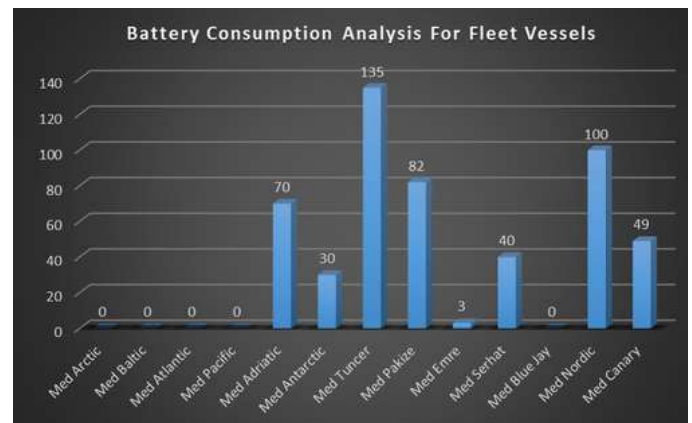


CHART 5 : BATTERY CONSUMPTION ANALYSIS FOR FLEET VESSELS

SOURCE:COMPANY INTERNAL DATA

RECAAP 2026 REPORT OF FIRST QUARTER

SUMMARY OF PIRACY AND ARMED ROBBERY INCIDENTS AGAINST SHIPS IN ASIA DURING Q1 2026



16 Case reported

**16 - Occurred
0 - Attempt**

Severity of Incidents



- **CAT 1 - Nil**
- **CAT 2 - 1**
- **CAT 3 - 6**
- **CAT 4 - 9**

**0 Piracy Incident
16 Armed Robbery**



6 At anchor or At Port

10 Underway



Recommendations



- **Remain vigilant, maintain the highest level of watchkeeping, and raise the alarm when necessary.**
- **Report all incidents witnessed to the nearest coastal state authority.**
- **Strengthen coordination and encourage information sharing among personnel.**
- **Increase the number of lookouts in high-risk and dangerous areas.**

SOURCE:RECAAP INFORMATION SHARING CENTRE

RECAAP 2026 REPORT OF FIRST QUARTER

In the first quarter of 2026, a 63.6% decrease was observed compared to the same period in 2025. While 44 incidents were reported between January and March 2025, this figure dropped to 16 incidents in the same period of 2026. Of the 44 reports submitted in Q1 2025, 37 were confirmed incidents, while 7 were attempted incidents.

The chart below illustrates the total number of incidents reported to the ReCAAP ISC between 2021 and 2026, along with the average number of incidents per quarter for each year.

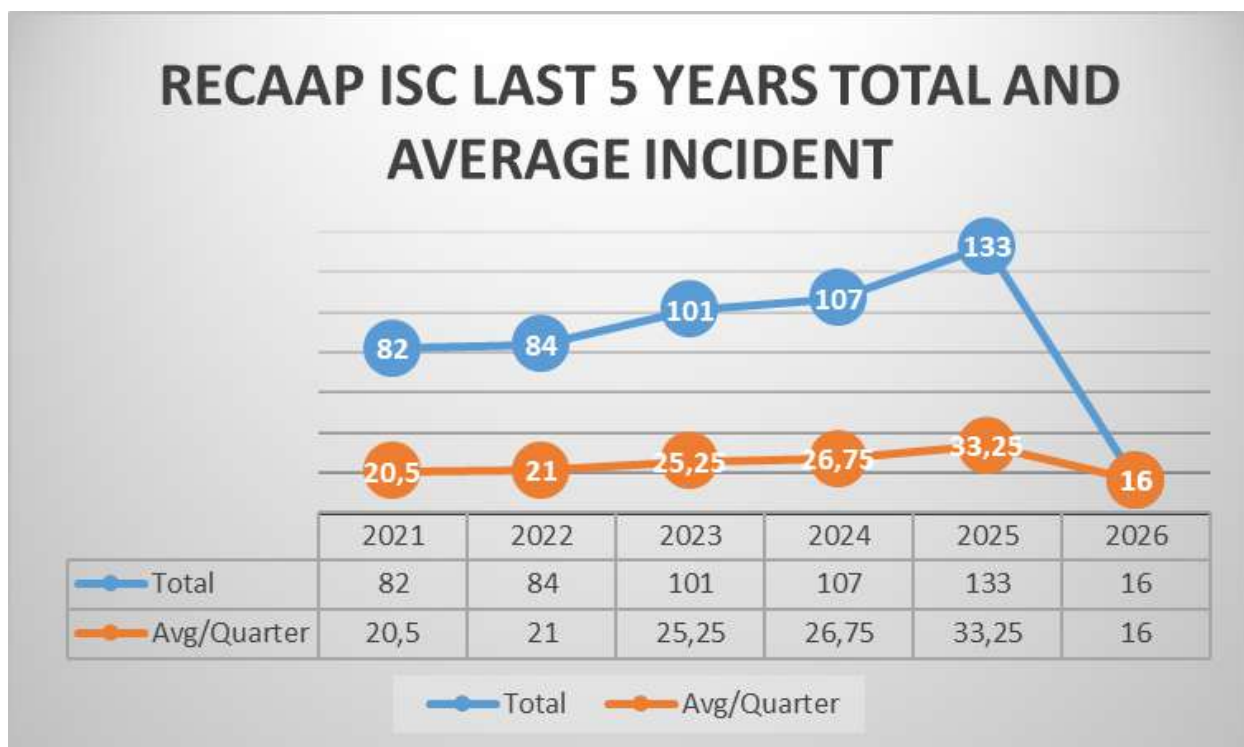


CHART 6 : RECAAP ISC LAST 5 YEARS TOTAL AND AVERAGE INCIDENT

SOURCE:RECAAP INFORMATION SHARING CENTRE

Comparison of ReCAAP ISC Reported Incidents in Each Quarter (2021–2026)

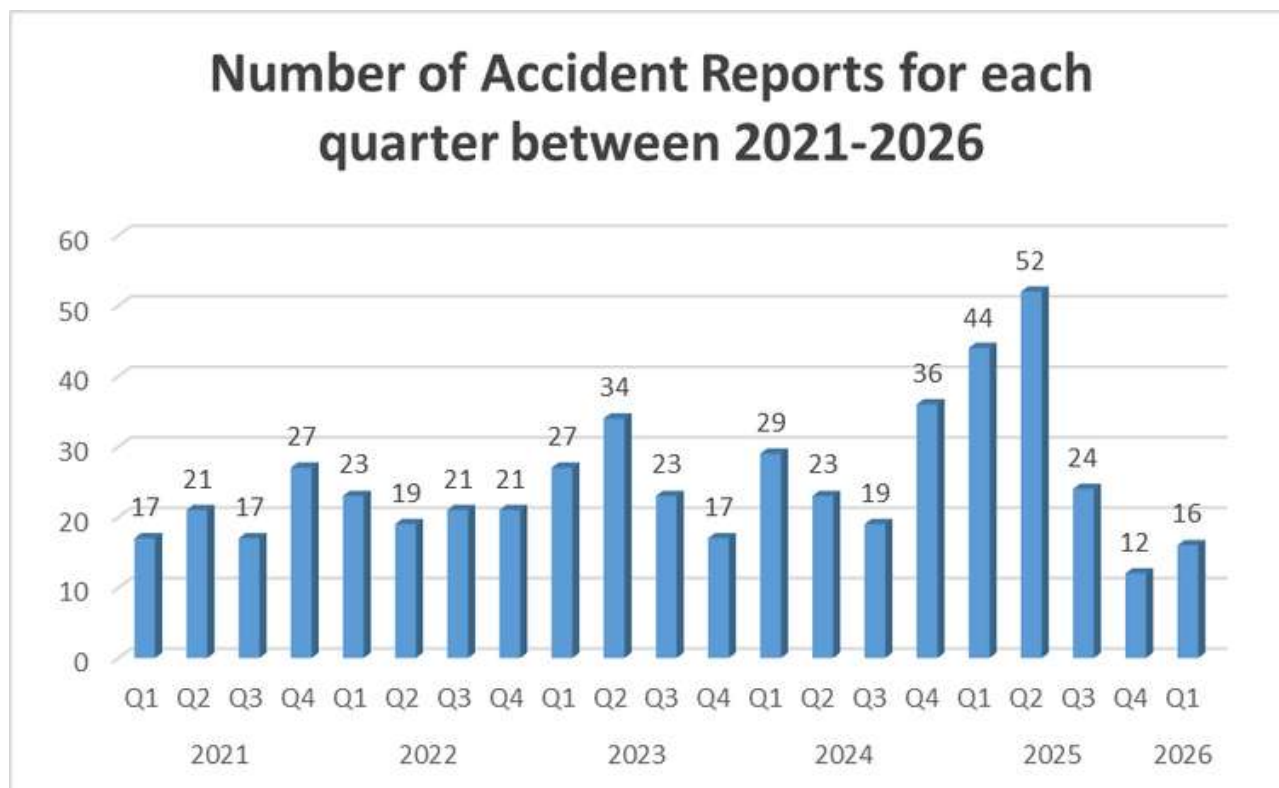


CHART 7 : NUMBER OF ACCIDENT REPORTS FOR EACH QUARTER BETWEEN 2021-2026

The number of incidents in Q1 2026 shows a decrease compared to the same period in 2025; however, it indicates an increase when compared to the last quarter of 2025.

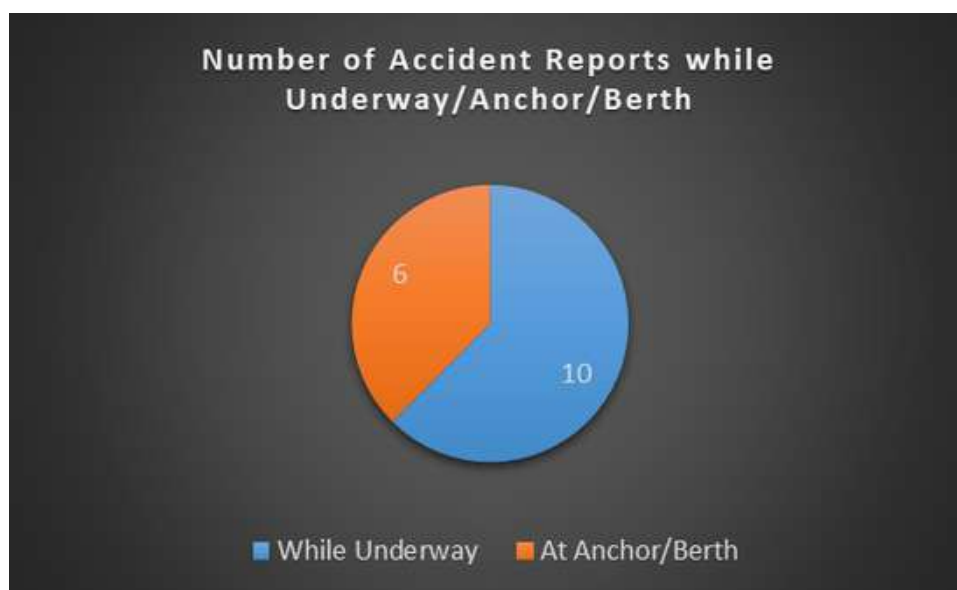


CHART 8 : NUMBER OF ACCIDENT REPORTS WHILE UNDERWAY/ANCHOR/BERTH

Of the 16 incidents reported between January and March 2026, 10 incidents (62.5%) occurred while vessels were underway. The remaining 6 incidents (37.5%) took place while vessels were at anchor or in port. The chart alongside illustrates the distribution of incidents based on vessel status (underway, at port, or at anchor).

SOURCE: RECAAP INFORMATION SHARING CENTRE

The accompanying chart shows the locations where the incidents occurred.



CHART 9 : LOCATION OF ACCIDENT REPORTS

INCIDENT LOCATIONS

The map below presents the geographical distribution of reported incidents between January and March 2026

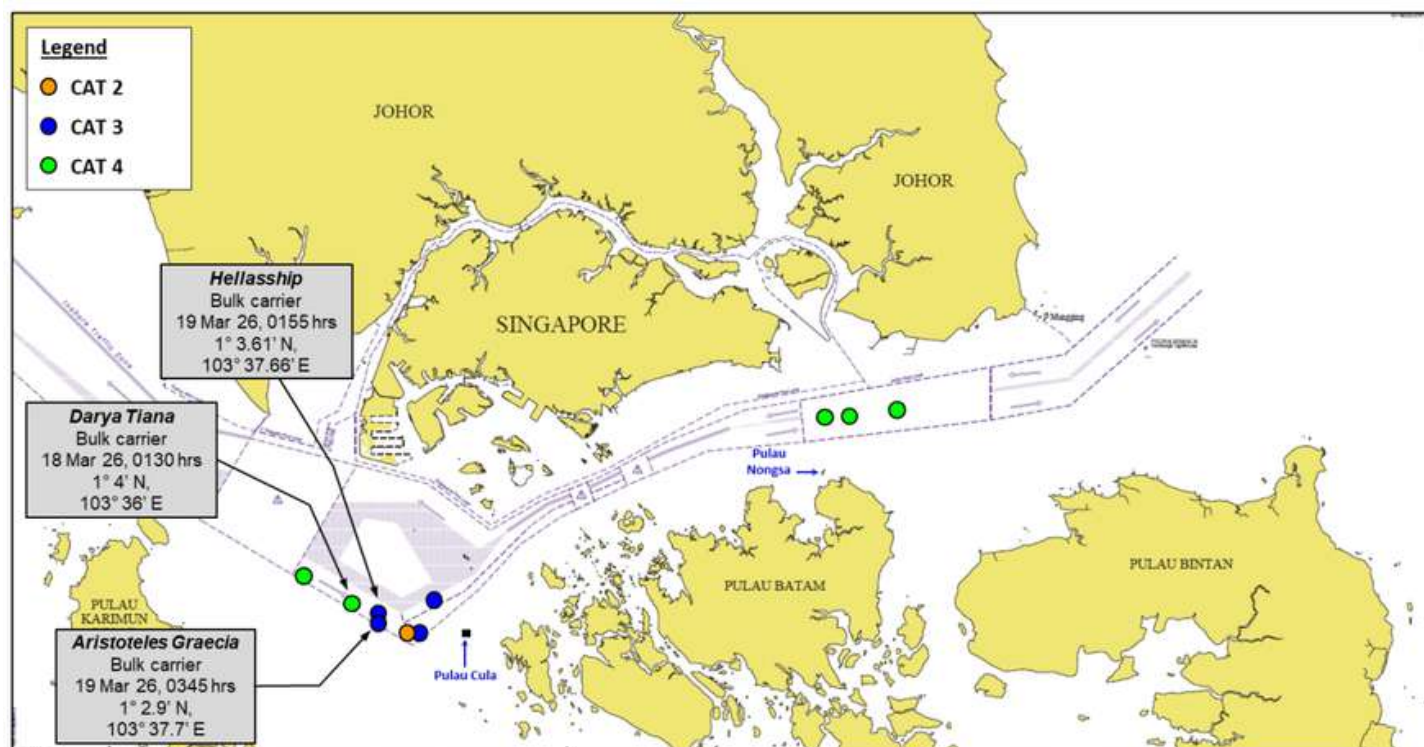


CHART 10 : LOCATION OF THE INCIDENTS IN SOMS (1 JANUARY 2026 - 19 MARCH 2026)

SOURCE: RECAAP INFORMATION SHARING CENTRE

INCIDENT LOCATIONS

The table below shows the locations and number of incidents reported in Asia over the last 10 years.

Act: Actual incidents

Att: Attempted incidents

January -December																					
		2017		2018		2019		2020		2021		2022		2023		2024		2025		2026	
		Act	Att	Act	Att	Act	Att	Act	Att	Act	Att	Act	Att	Act	Att	Act	Att	Act	Att	Act	Att
North Asia																					
China		2				3															
Sub Total		2				3															
South Asia																					
Arabian Sea			1																		
Bangladesh		11		9	2			5													
India		4		3	1	4	1	9		5											
Sub Total		15	1	12	3	4	1	14		5											
Southeast Asia																					
Andaman Sea																					
Indonesia		30	3	21	6	18	5	21	1	12	1	10		17		17	5	9	1	10	
Malaysia		1	1	6		8		3		1		1	1	1		1		1			
Pacific Ocean							1														
Philippines		19		8	1	5	2	13		10	1	4		10		3		2		6	
SOMS		7	2	6	2	29	2	34		47	3	54	1	62	1	59	3	104	4		
South China Sea		11	1	3	1	1		3	1			1				2		2			
Sulu-Celebes Seas		3	4	2	1	2		1													
Thailand														1							
Vietnam		2		4		2		6		2		2		3		2		2			
Sub Total		73	11	50	11	65	10	81	2	72	5	72	2	94	1	84	8	120	5	16	
Overall Total		90	12	62	14	72	11	95	2	77	5	80	4	100	1	96	11	127	5	16	

CHART 11 : LOCATION OF THE INCIDENTS BETWEEN 2017-2026

SOURCE:RECAAP INFORMATION SHARING CENTRE

INCIDENT NEARMISS ANALYSIS

The analysis of nearmiss, unsafe acts, and unsafe conditions for the period January–March 2026 is presented below.

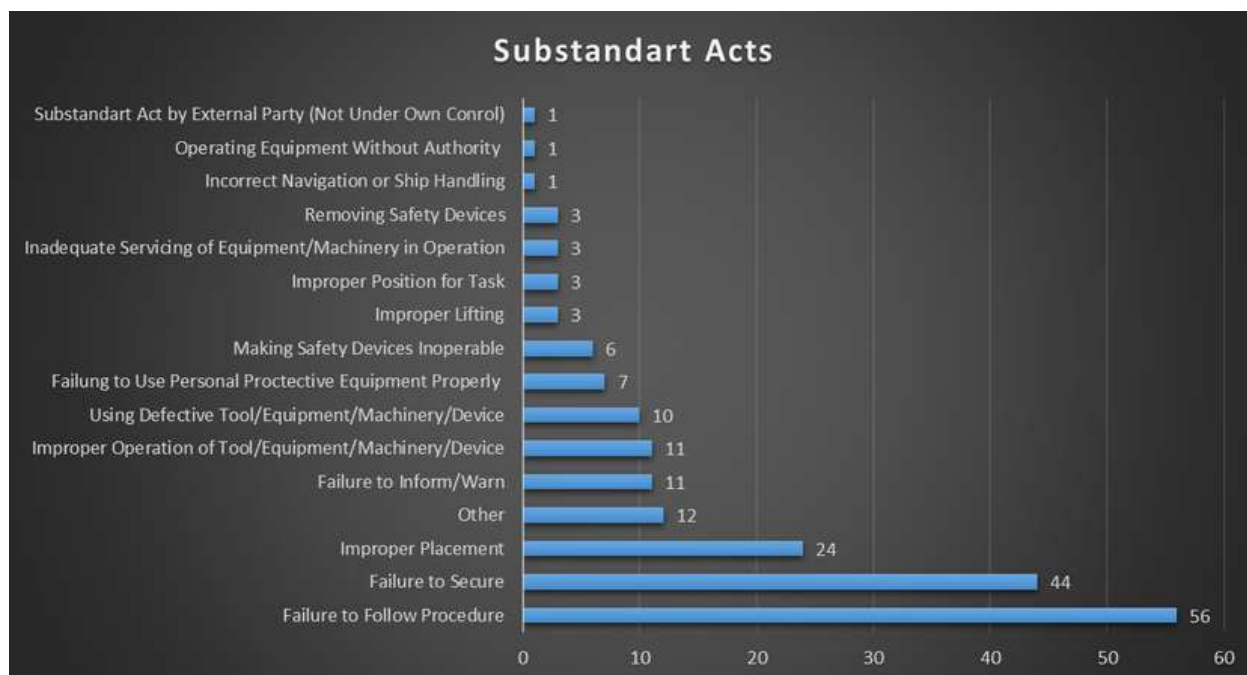


CHART 12 : CAUSES SUBSTANDART ACTS

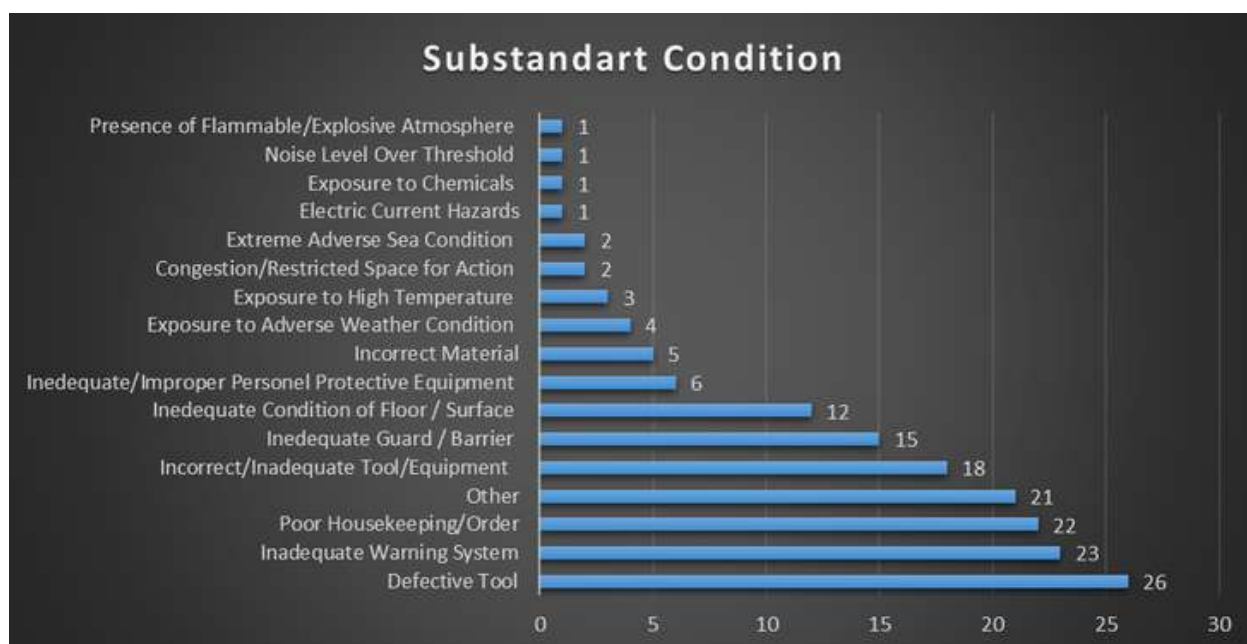


CHART 13 : CAUSES SUBSTANDART CONDITION

INCIDENT NEARMISS ANALYSIS

The analysis of nearmiss, unsafe acts, and unsafe conditions for the period January–March 2026 is presented below.

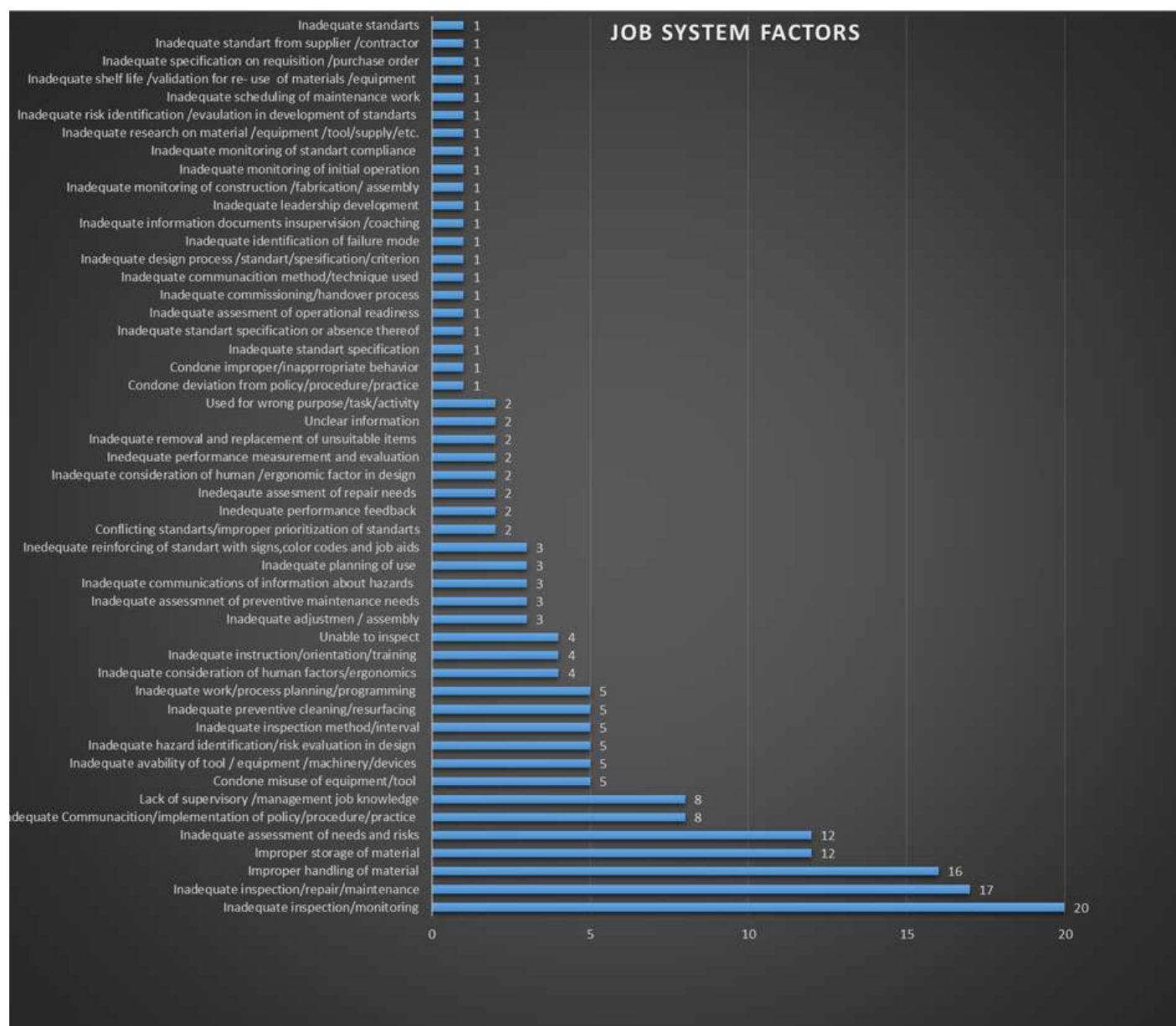


CHART 14 : CAUSES JOB SYSTEM FACTORS

INCIDENT NEARMISS ANALYSIS

The analysis of nearmiss, unsafe acts, and unsafe conditions for the period January–March 2026 is presented below.

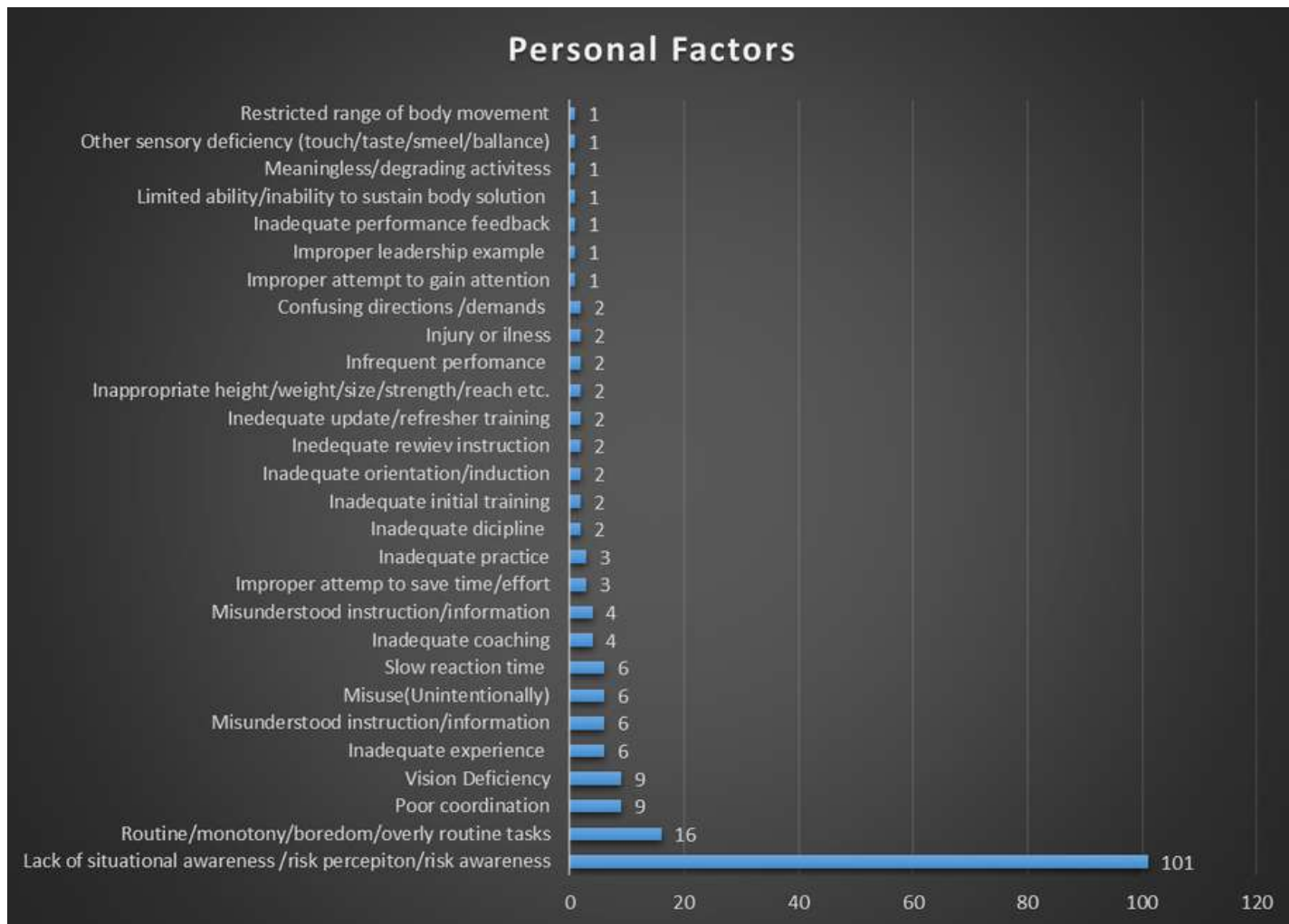


CHART 15 : CAUSES PERSONEL FACTORS

Q1 2026 KPI ANALYSIS BY VESSEL

Vetting Score (PSC, SIRE, CDI, Terminal Inspection)

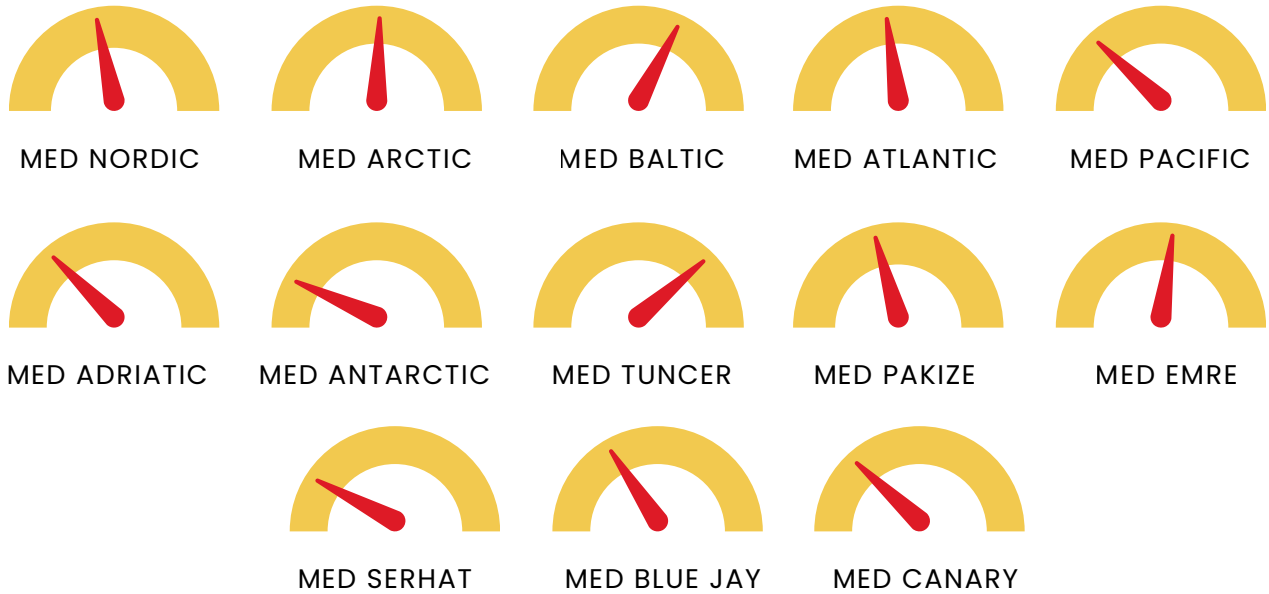


CHART 16 : VETTING SCORE

Best Practice & Lessons Learned & Nearmiss Score

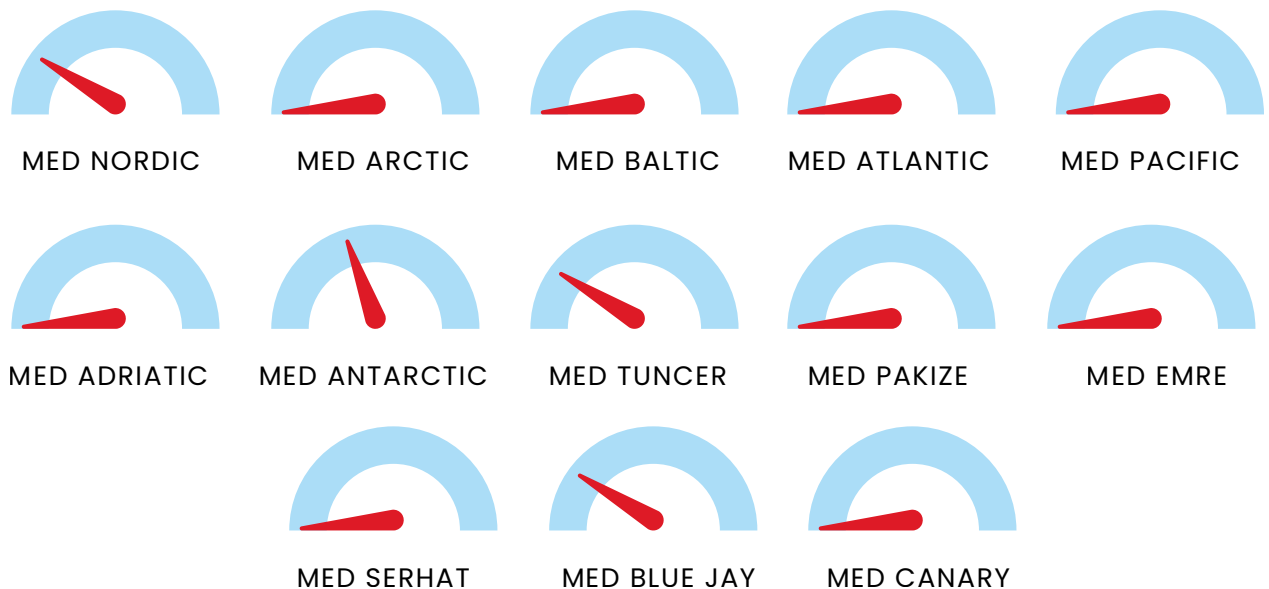


CHART 17 : NEARMISS REPORT SCORE

SAFETY AWARDS

Since 2023, a new reward system has been implemented to enhance inspection performance, safety awareness, and reporting culture across the fleet.

Within the scope of this system:

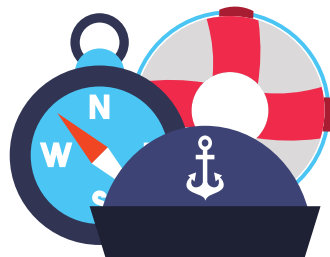
Personnel who submit the highest number of near-miss reports on each vessel during each quarter are rewarded with additional internet allowance at the end of each month. If the awarded personnel completes their contract, the reward is carried forward and reactivated upon joining their next vessel.

AWARDS

1ST PERSONNEL 15 GB
2ND PERSONNEL 10 GB
3RD PERSONNEL 5 GB

In addition, vessel performance is evaluated over a three-month period based on several criteria, including inspection performance, Best Practice and Lessons Learned submissions, near-miss reporting activity, waste generation, and other relevant indicators. The vessel achieving the highest overall score is awarded accordingly. At the end of the year, the best-performing vessel is also rewarded with equipment or facilities based on crew preference (e.g. common area coffee machines, PlayStation, Xbox, gym equipment, etc.).

- For the first quarter of 2026, the best-performing vessel based on performance metrics was identified as Med Tuncer. Following crew request, sports equipment was supplied to the vessel.



Top Reporting Personnel

Name	Total Report
İbrahim Cem Arda	7
Gürkan Özkan	6
Tamer Mavruk	6
Bayram Sonar	5
Çağlar Akkaya	5
Mustafa Samed Çelikel	5
Yetişcan Tozluyurt	5

CHART 18 : TOP REPORTING PERSONNEL

Safety & Vessel Performance Awards

Top Performer 1st Quarter

In the first quarter of 2026, the vessel with the highest number of reports and also ranked first in the quarterly vessel performance scoring table was Med Tuncer. The crew member with the highest number of reports was 2nd Engineer İbrahim Cem Arda, with a total of 7 reports.



The crew member who achieved the highest number of reports in Q1 2026, 2nd Engineer İbrahim Cem Arda, will be rewarded with an additional 15 GB of internet allowance in his next contract.

Q1 2026 Safety Award – MED TUNCER

As part of the campaign, Med Tuncer has been ranked as the top vessel in the fleet. In recognition of this achievement, a piece of gym equipment will be provided to the vessel in line with its needs.

BEST PRACTICE & LESSONS LEARNED REPORTING APPRECIATION NOTE

We would like to thank all our vessel masters and personnel who have demonstrated due diligence in submitting Best Practice and Lessons Learned reports during the first quarter of 2026.

In Q1 2026, a total of 4 Lessons Learned and 1 Best Practice have been published.

The ranking of reporting activity by job position is as follows:

<i>RANK</i>	<i>TOTAL REPORT</i>
Master	4
3rd Officer	1

CHART 19 : TOP REPORTING RANK

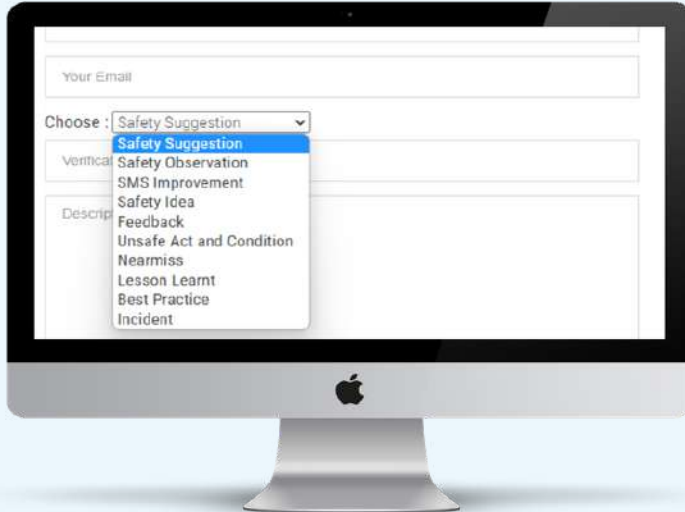
The list of vessels with reported submissions for Q1 2026 is provided below:

<i>VESSEL NAME</i>	<i>TOTAL REPORT</i>
Med Antarctic	2
Med Tuncer	1
Med Nordic	1
Med Blue Jay	1

CHART 20 : TOP BEST PRACTICE&LESSON LEARNED REPORTING VESSELS



COMPLAINTS & REQUEST



In 2022, thanks to the “Reporting” section added to the YMN Tanker website, our personnel are now able to share their suggestions without the obligation of stating their name.

You can access our website at www.ymntankers.com.tr and simply click on the “Reports” section located in the top menu



Through the reporting section, the following categories can be submitted either anonymously or with name disclosure:

- Safety Suggestion
- Safety Observation
- SMS Improvement
- Safety Idea
- Feedback
- Unsafe Act and Unsafe Condition
- Near Miss
- Lesson Learned
- Best Practice
- Incident



Reporting and feedback are the cornerstones of learning and continuous improvement. It has also been proven that effective reporting increases motivation and performance while maintaining a strong culture of continuous training and development. In this regard, as a company, we highly value your opinions and encourage you to share them with us. With this newly implemented reporting system, we aim to receive more feedback from our vessel personnel and continuously improve both our policies and SMS documentation. Please do not hesitate to submit any suggestions, requests, or complaints you may have.

Important Note:

In order to submit a report, the result of the mathematical operation in the “Verification Question” field must be entered into the required box.

Choose :

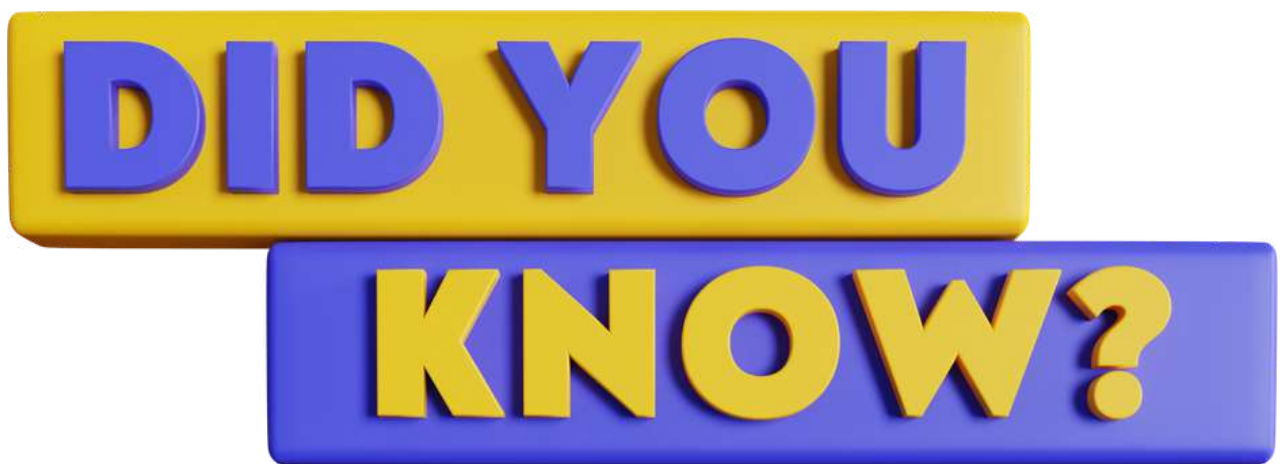
Verification Question: $8 + 2 = ?$

DID YOU KNOW?

Every year, an average of 2,500 marine accidents occur worldwide. Approximately 70% of these incidents are related to ship operations, such as berthing/unberthing manoeuvres and cargo operations.

The majority of marine accidents are caused by the following factors:

- Human Error
- Fatigue
- Poor Communication
- Non Compliance with Procedure
- Inadequate Risk Assessment
- Poor Maintenance



Around 80% of these accidents are considered preventable.

SAFETY MESSAGE



SAFETY IS NOT JUST A PRIORITY; IT IS A CULTURE WE BUILD TOGETHER.



YMN TANKER MARINE MANAGEMENT SA



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Sarkuysan-Ak İş Merkezi S Blok
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Our Mission:

To provide technical and commercial ship management services that meet and exceed safety, environmental, and customer requirements. We conduct our operation in a manner to ensure that Quality, Health, Safety, Security and Environmental considerations remain a top priority for the Company's management and employees.

Our Vision:

To be recognized as among the best international ship operators and managers in the chemical tanker industry, with a reputation for outstanding performance, reliability, and safety standards.

Thanks to the "reporting" section added to the YMN Tanker website at the end of 2022, our staff will now be able to share their recommendations anonymously.

Reports can be submitted by clicking the report button on www.ymntankers.com.tr



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YMN TANKER