



Office of  
Deputy Commissioner  
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**Marine Advisory: 13/2026**

**Subject: PREVENTION OF SUICIDES AND MISSING PERSON INCIDENTS – CREW WELFARE MANAGEMENT, WATCHKEEPING CONTROLS, AND COMPLIANCE WITH SAFETY MANAGEMENT SYSTEM REQUIREMENTS**

**Ref:**

- (a) SOLAS Chapter IX (ISM Code Implementation)
- (b) ISM Code – Sections 1.2.2, 6, 7, and 10
- (c) Maritime Labour Convention (MLC), 2006 (as amended) – Regulations 4.3 & 4.4
- (d) [Liberian Marine Notice MLC-005/3.3 – Crew Welfare, Health Protection, and Medical Care](#)
- (e) [IMO Resolution A.1047\(27\) – Principles of Minimum Safe Manning](#)
- (f) [IMO Guidelines on Fatigue \(MSC.1/Circ.1598\)](#)
- (g) ILO Code of Practice: Accident Prevention on Board Ship at Sea and in Port
- (h) WHO Guidelines on Mental Health at Work
- (i) ICS Guidelines on Seafarer Mental Health and Wellbeing
- (j) ICS/ITF Seafarers' Health Information Programme (SHIP)
- (k) International Seafarers' Welfare and Assistance Network (ISWAN) – Seafarer Help and guidance
- (l) Maritime Wellbeing platform ([www.maritimewellbeing.com](http://www.maritimewellbeing.com))

**Dear Shipowners / Operators / Masters / Officers and Crew:**

The purpose of this Marine Advisory is to reinforce mandatory safety, welfare, and operational controls related to the prevention of:

- Crew suicides
- Missing persons / Man Over Board (MOB) incidents
- Unexplained personnel disappearances onboard or at sea

Recent casualty data indicates continued fatalities related to deliberate acts (suicide) and missing personnel, often involving delayed detection and inadequate crew accountability.

These incidents highlight the importance of:

- Effective crew welfare and mental health management
- Robust watchkeeping and accountability systems
- Early recognition of behavioral and psychological risk indicators

## **Suicide and Missing Person Casualty Overview**

The Administration has reviewed multiple incidents involving:

- Personnel found deceased in accommodation spaces due to self-harm
- Crew members intentionally going overboard
- Missing personnel identified during routine operations or watchkeeping periods
- Man Over Board incidents with delayed detection

### **Primary Contributing Factors**

#### **1. Mental Health and Welfare Factors**

- Stress, fatigue, and prolonged isolation
- Personal or family-related distress
- Limited access to welfare or psychological support
- Underreporting of mental health concerns

#### **2. Operational and Watchkeeping Deficiencies**

- Failure to promptly identify absent personnel
- Lack of structured crew accountability procedures
- Inadequate supervision during watch cycles
- Delayed response to missing persons

#### **3. Safety Management System (SMS) Weaknesses**

- Absence of procedures addressing psychosocial risks
- Poor reporting culture regarding behavioral concerns
- Inadequate access control to high-risk areas
- Insufficient training in recognizing early warning indicators

### **Marine Casualty Examples**

#### **Case 1 – Suicide (Cabin)**

A crew member was found deceased in the cabin after failing to report for duty. Investigation identified prior behavioral changes which were not escalated.

#### **Case 2 – Suicide (Overboard)**

A crew member intentionally went overboard during the voyage. Evidence found onboard indicated signs of mental distress.

#### **Case 3 – Missing Person (Unobserved Man Over Board)**

A Chief Engineer failed to report for duty and could not be located on board. A delayed search resulted in a suspected Man Over Board incident.

## **Case 4 – Missing Person (Watchkeeping Failure)**

An officer disappeared during the voyage due to the absence of effective watchkeeping accountability procedures.

### **Key Safety Failures Identified**

Investigations identified recurring deficiencies:

- Failure to recognize or escalate behavioral warning signs
- Absence of structured crew welfare monitoring
- Delayed reporting when personnel failed to report for duty
- Inadequate control of access to exposed deck areas
- Weak implementation of fatigue management measures
- Insufficient supervision of crew movements

### **Flag Administration Requirements and Best Practices**

The Administration emphasizes that:

- The ISM Code requires operators to address all risks to personnel, including mental health risks
- MLC, 2006 establishes obligations related to crew welfare, psychological health, and safe working environments
- Mental health is a critical safety factor that may directly influence the risk of suicide and Man Over Board incidents

Shipowners, Operators and Masters shall ensure that:

- Risk assessments include psychosocial and human-factor risks
- Crew welfare is actively managed within the SMS
- Personnel accountability procedures are clearly defined and implemented

### **Required Preventive Measures**

#### **Crew Welfare and Mental Health Management**

Establish procedures to identify behavioral changes, withdrawal, and signs of distress or fatigue. Ensure access to welfare support, including communication channels and confidential reporting mechanisms, and promote early reporting.

#### **Pre-Employment and Pre-Joining Controls**

Shipowners and Operators shall ensure that appropriate pre-employment medical evaluation and fitness assessments are conducted in accordance with MLC, 2006. Where concerns related to mental health or personal wellbeing are identified, individuals should be appropriately assessed and, where necessary, provided with support prior to deployment.

## **Watchkeeping and Crew Accountability**

Implement procedures for personnel verification during watch changes and ensure immediate reporting of absence. Prompt action shall be taken when crew members fail to report for duty or cannot be located onboard.

## **Access Control and Physical Safety**

Control access to open deck areas and overboard exposure points, particularly during night operations and adverse conditions. Ensure adequate lighting, monitoring systems, and safety arrangements.

## **Man Over Board Prevention and Response**

Conduct regular drills, ensure immediate alarm and muster upon suspicion of a missing person, and execute rapid response procedures in accordance with SOLAS requirements.

## **Suicide Prevention Measures**

Include mental health awareness in training programs. Officers shall be trained to recognize early warning signs and escalate concerns appropriately. Masters shall maintain awareness of crew wellbeing and ensure proactive engagement.

## **Fatigue Management**

Ensure compliance with hours of rest requirements and monitor fatigue risks as part of SMS implementation.

## **Reporting and Investigation**

All suicides, suspected suicides, missing person incidents, and relevant near misses shall be recorded, reported, and investigated to identify root causes and corrective actions.

## **Seafarer Mental Health and Welfare Support Resources**

Shipowners and Operators shall ensure that seafarers have access to appropriate mental health and welfare support services. Key resources include:

- ISWAN – Seafarer Help confidential helpline and guidance materials
- ICS/ITF SHIP – practical health and wellbeing guidance
- Maritime Wellbeing platform – online wellbeing tools and self-help resources
- WHO and ILO mental health guidance

Operators should promote awareness and accessibility of these resources onboard and integrate them within Company procedures.

**The Administration emphasizes that prevention of suicides and missing person incidents is a fundamental safety obligation.**

**Strict compliance with Safety Management System requirements, effective crew welfare management, robust watchkeeping accountability, and early identification of risk indicators are essential to prevent recurrence of these incidents.**

For more information, please contact the Investigations Department at [investigations@liscr.com](mailto:investigations@liscr.com).

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