



INSPECTION & INVESTIGATION DIVISION

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**INDEPENDENT INVESTIGATION REPORT
INTO THE VERY SERIOUS MARINE
CASUALTY**

OF

MV “PALMERTON”

**AT North Sea Wandelaar Pilot Station leaving port of
ANTWERP, Belgium**

ON 22.11.2016

Flag: Antigua and Barbuda W.I.

IMO No.: 9501863 / Official No.: 4670 / Call sign: V2EM7



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OBJECTIVE

Maritime Safety Committee MSC.255(84)

CODE OF THE INTERNATIONAL STANDARDS AND RECOMMENDED PRACTICES FOR A SAFETY INVESTIGATION INTO A MARINE CASUALTY OR MARINE INCIDENT

This code recognizes that under IMO conventions each flag State has a duty to conduct an investigation into any casualty occurring to any of its ships when it judges that such an investigation may assist in determining what changes in the present regulations may be desirable or if such casualty has produced a major deleterious effect upon the environment (SOLAS, chapter I, part C, regulation 21).

The Government of Antigua and Barbuda W.I. is signatory to the major international shipping conventions. The Antigua and Barbuda Department of Marine Services and Merchant shipping (ADOMS) constitutes the flag State Administration together with the Inspection and Investigation Division (ADOMS IID), which is the marine safety investigation Authority, with the chief casualty investigator (CCI).

DISCLAIMER

This report is not written with liability in mind and should not be used in court for the purpose of litigation. It endeavours to identify and analyse the relevant safety issues pertaining to the specific accident, and to make recommendations aimed for preventing reoccurrence of similar accidents in the future.

At all times the ADOMS IID Chief Casualty Investigator strives to balance the use of material that could imply adverse comments with the need to properly explain what happened, and why, in a fair and unbiased manner.

PART A – THE OCCURRENCE

1. Executive summary

MV PALMERTON, a multi-purpose general cargo vessel with own cargo gear and heavy lift capacity, left the port of Antwerp, Belgium bound with cargo to the French port of St. Nazaire.

The voyage commenced by down river passage of the Schelde River with a pilot on board, intending to leave the vessel at the Wandelaar pilot station.

Between the Schelde mouth and the Wandelaar Pilot Station, the free-fall lifeboat unintentionally released and fell to the water causing the death of two crew members executing an ordered task on the lifeboat.

One crew member fell into the water and drowned. The other succumbed to his injuries on the life boat deck.

2. The aftermath

All measures taken after the lifeboat was detected in the water at the stern of the MV PALMERTON were not able to save the lives of the involved crew members. The emergency actions initiated included a SAR helicopter who arrived about 30 minutes after being alerted, but was only able to transport the deceased back to shore. It could not at that time find the overboard crew member. The search operations were ceased at early evening due to darkness and recommenced the following morning without success.

2.1 Fatalities and injuries

All 2 involved crew members of MV PALMERTON lost their lives directly after the incident. None of the measures initiated on board or by shore authorities were able to prevent the loss of life due to the severity of the accident course.

2.2 Impact on the surrounding environment

No direct impact to the environment was noted as the lost free fall life boat was directly retrieved by local authorities and no pollution was noted.



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2.3 Extent of the damage

Damage was not noted to the lifeboat nor its launching davit. No damages to MV PALMERTON or 3rd parties were found.

PART B – GENERAL

1. Regulatory requirements

Other than the SOLAS Part C, Regulation 21 regulatory requirement and the Casualty Investigation Code Part II Chapter 6 Rule 6.1 to investigate into every very serious marine casualty (IMO resolution MSC.255(84) the Antigua and Barbuda W.I. Merchant Shipping Act 2006 (as amended), Part X Chapter 252 demands an investigation where any of the following casualties occur, that is to say:

(b) a loss of life or serious injury to any person, caused by fire on board, or by any accident to a ship or ship's boat, or by any accident occurring on board a ship or ship's boat; or any damage caused by a ship.

Furthermore, the Antigua and Barbuda flag State Administration is guided by Chapter 17 of the Casualty Investigation Code where the objective is defined to investigate into an even not very serious marine casualty (e.g. near-miss incidents) if it is considered likely that the investigation will provide information that can be used to prevent marine casualties and incidents in the future as lesson to learn.

2. Assessment of the occurrence

With the aim to identify lessons to learn the accident was assessed in the light of what evidence could be collected and the consequent restructuring of the run of events leading to the very serious casualty.

It was found that the free-fall lifeboat on board MV PALMERTON had been serviced shortly before the accident during the last port stay. This apparently led to the vessel's crew not being quite satisfied with the way the release system had been adjusted, taking it into their own hands to readjust it.

Without applying the maintenance securing gear to the free-fall lifeboat, designed to prevent an unintended fall and not following the given safety management procedures in practice, the two crew members climbed on the top of the lifeboat to work on the release system and hook as such holding the boat in place. This most probably caused the boat's unintended release.

This gives two main areas of investigation, the apparent actions by the crew and the service conducted to the free-fall boat prior to the departure from the port of Antwerp.



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3. Instructions

Basis for the investigation into this very serious marine casualty are stipulated in the Antigua & Barbuda Merchant Shipping Act 2006 (as amended).

Captain Nils Beyersdorff located with ADOMS Inspection and Investigation Division (ADOMS IID) in Elsfleth, Germany, vested with the powers as per the Antigua and Barbuda Shipping Act 2006 (as amended) Part II 6.2 is the Chief Casualty Investigator (CCI) of the flag State marine safety investigation Authority. In this commission he initiated a full and separate investigation into this very serious marine casualty. Relevant notifications as per Chapters 5 and 20 of the Casualty Code have been distributed accordingly.

An on scene investigator, vested with the rights of a Power of Attorney, commenced investigations at the earliest practical opportunity on the 23rd of November 2016.

While being in process of acquiring evidence, efforts were successfully applied to liaise with all interested parties involved.

4. Cooperation with the Federal Bureau for the Investigation of Maritime Accidents of Belgium

During the on scene investigation and aftermath the Federal Bureau for the Investigation of Maritime Accidents of Belgium cooperated fully and also assisted in the communication with other local authorities involved.

PART C – FACTUAL INFORMATION

1. The M.V. “PALMERTON



MV Palmerton from port stern

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1.1 Ship particulars

Name of Vessel	MV PALMERTON
Company (ISM Code 1.2)	Harren & Partner Schiffahrts GmbH & Co KG, Hermann-Hollerith Str. 10, 28355 Bremen, Germany
Flag State	Antigua & Barbuda
Port of Registry	St. John's
IMO Number	9501863
Type of Vessel	Other Cargo Ship
Classification Society	DNV GL
Year built	2008
Ship Yard	Taizhou Kouan Shipbuilding Co., Ltd.
Loa (Length over all)	132.93 m
Boa (Breadth over all)	23 m
Deadweight	10124.5
Summer Draft	7,80
Gross Tonnage	11473
Net Tonnage	3834
Main Engine	MAN Diesel SE, Augsburg
Engine Power / Speed	7200 kW
Crew as per MSM Cert.	Total 13
Crew Actual	Total 16
Document of Compliance (Date of Issue)	10.12.1015
Safety Management Cert. (Date of Issue)	10.12.1015
Trading Area	International voyages
Last PSC Inspection	17.10.2016
Any deficiencies noted?	none
Any detentions noted?	none



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1.2 Crew particulars

The crew of MV PALMERTON comprised of Ukrainian nationals from senior to junior ranks with the exception of one Bulgarian national mustered as electrician.

All crew fulfilled their job specific required qualifications and complement certification. Key positions were manned by longstanding crew members who apparently were well familiar with the vessel and its specifics in the heavy lift trade.

1.3 The voyage pattern

The MV PALMERTON had just left the port of Antwerp and approaching the Wandelaar Pilot Station when the accident investigated occurred. Next intended port of call was St. Nazaire, France. As the ship is a heavy lift ship on a tramp trade pattern no fixed line can be described. Voyage orders are mostly given when the cargoes are fixed and thus voyage and cargo planning is conducted shortly before voyages begin.

1.4 The cargo

MV PALMERTON at the time of the accident was partly laden with cargo under deck. No cargo was stowed on open deck.

2. The environmental condition

Shortly after leaving the port of Antwerp, Belgium and passing the Schelde estuary the vessel arrived on the open sea. The conditions were described as good with a wave height of 0.5 m and a wind of beaufort scale 3 from south west. The vessel was not rolling or pitching and visibility was good. The traffic situation in the area was dense and the bridge well manned with look out, officers, sea pilot and the master attending.

No technical problems were apparent and the ship was found in good sailing condition according to the master.

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PART D – NARRATIVE

On Monday the 21st of November 2016, MV PALMERTON, a multi-purpose general cargo vessel with own cargo gear and heavy lift capacity underwent a substantial on board service of the free-fall lifeboat launching system by a manufacturer certified service company, stowed at the vessels starboard stern.

The service was initiated due to the various deficiencies noted during a service that took place 2 months before, on the 21st of September 2016 under the vessel's class, DNV GL, supervision. The deficiencies noted and subsequently rectified on the 21.11.2016 in regard to the free-fall lifeboat were:

- Free-fall lifeboat hydraulic tank dip stick broken
- Hydraulic tank filter replacement and oil filling required
- Windows without sufficient visibility, in need of replacement
- Lifeboat release cable external protection cracked
- Vibration device on port side loosened
- Rope for emergence release with cutter pin missing
- Additional locking nuts to be fixed

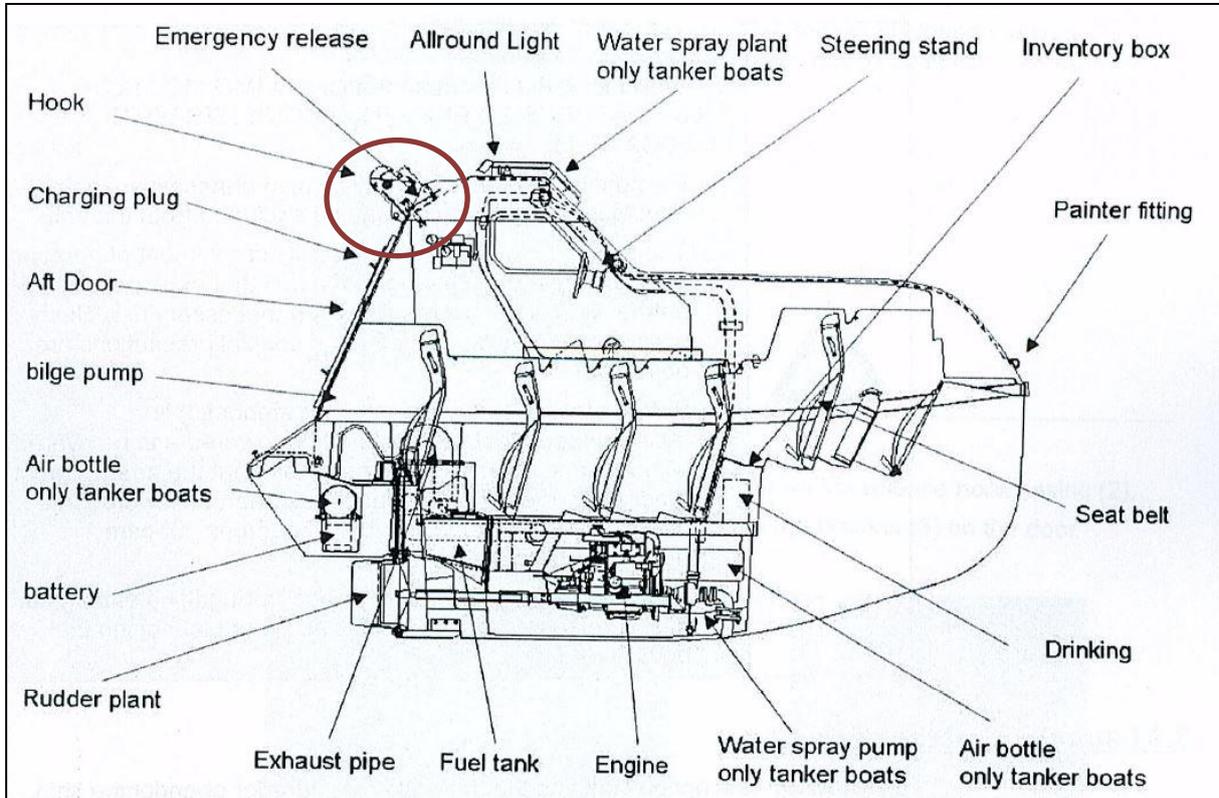
The rectification of the above listed items was also supervised by an attending class surveyor, confirming the same in an official DNV GL survey statement. In the process, the service done to the rescue boat and examination of cargo lifting loose gear of 50 tons and above were also noted and stated as required.

As the life boat underwent a replacement of the release cable the release system had to be reset and secured. This was done as per specifications for the Fassmer Marland Freefall Lifeboat CFL (-T) 49 and confirmed by attending class surveyor.

The lifeboat release is positioned as a central release device near the boats helmsman seat from which it can be operated directly. The emergency release is executed by turning of a handle at this location.

The service and supervision were executed without any issues noted. All tools and spare parts were available for the technician to perform the intended work.

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Overall drawing (source: Fassmer handbook on board)

On the next morning before departure the 2nd officer, also nominated safety officer, noted that the life boat release pin at the hook position at the aft top of the boat was fixed in position and could not be moved. This was not as expected and prompted the 2nd officer to discuss the matter with the master and vessel's bosun, who agreed to look into the problem during the day.

MV PALMERTON left Antwerp, Belgium on the 22.11.2016. The departure from port went as planned and the vessel proceeded down the Schelde River under pilotage with the bridge team comprising of the vessel's master, 2nd officer and helmsman. All bridge equipment was apparently in full working condition and no defects were reported.

The weather conditions can be described as good with a wind from south westerly direction at 3 to 4 Beaufort and 0,5 m of sea noted in the deck log book. The visibility was described as good and the officer of the watch had noted no rolling or pitching.



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During the passage, the issue with the stuck hook was discussed on bridge with the master and the 2nd officer present instructing the bosun to prepare the required risk assessment and fitting permit to work. This was done in accordance with the vessel's Safety Management Manuals given procedures.

Shortly after the lunch break, the bosun reported to the 2nd officer, who was on bridge watch, that he and the ordinary seaman (OS) were proceeding to the vessel's stern to commence with the rectification of the apparently stuck safety pin. At about 13:45 local time (LT) the bosun reported via handheld VHF that they had commenced with the work on the free-fall lifeboat.

At about 14:30 LT the 2nd officer noticed a lifeboat in the water near to a red fairway buoy astern of the vessel. After checking with the binoculars and realising it was a life boat in the water, he immediately called the bosun via VHF but received no response. The 2nd officer directly alerted the master that there was a lifeboat in the water astern of the own ship and that he had tried to call the bosun with no response received. At that moment the vessel's apprentice who was returning from an aft store reported by VHF that the bosun was lying on the aft station and that the life boat was missing.

The 2nd officer directly called the master who immediately proceeded to the bridge and took over the command, initiating emergency procedures.

The local pilot assisted the master and his bridge team to allow safe manoeuvring in the high traffic area and also informed relevant shore traffic and pilot stations. The missing OS could not be located in the vicinity of the lifeboat and the bosun was found with very shallow breathing. Under the supervision of the chief officer the bosun was prepared for emergency evacuation by SAR helicopter.

The missing OS could after searching a greater area of the vessel not be found and was presumed to have fallen overboard. Search and Rescue was quickly initiated with the assistance of the pilot but the involved 12 ships searching could not find the missing OS until sundown at about 17:30 LT.

The lost lifeboat was retrieved and brought to shore for the investigation. After close examination of the state of the release gear and condition of the boat as such, it was decided to be allowed to be reinstalled on board as no damages were found.

PART E – ANALYSIS AND COMMENTS

1. The aim

The purpose of the investigation and to determine the circumstances of the accident and safety factors leading to the death of 2 seafarers. Further it is the intention to be able to make recommendations in order to prevent similar accidents in the future.

2. Causal factors

The investigation on scene, statements taken, interviews conducted and documents collected showed that the accident was in a first instance caused by the non-adherence to given safety procedures and non-usage of equipment, as for example the lifeboat maintenance securing device, when performing work on the free-fall lifeboat's hook release system.

It was identified that the company's Safety Management System provided adequate procedures and guidance for the safe operations of the vessel. It takes work safety seriously and provides resources for the crew to plan and execute work in a safe environment, including guidance how to achieve a high personal level of safety with the provided equipment.

The days before the accident the crew of MV PALMERTON as usual completed a busy schedule. The vessel held a Minimum Safe Manning Document requiring a crew of 13. The PALMERTON was manned by a crew of 16, with one navigational watch officer more than required, an electrician and deck apprentice. The resting hours showed adherence to required hours of work and rest and during interviews no indication that fatigue was a contributing factor to the accident could be established.

The service company contracted to carry out maintenance on board MV PALMERTON's free-fall lifeboat launching equipment after deficiencies had been found 2 months earlier during a service conducted, were certified to perform the executed work by the equipment manufacturer. The vessel's company has the policy in place to ensure that only certified service companies service on board safety equipment and in cases of boat launching devices and similar equipment the vessel's management always orders the classification society to provide a surveyor to monitor and confirm the work done in writing. Both services, in September 2016 and the one directly before the accident were conducted in this manner and are thus in full compliance with the then regulations of the Antigua & Barbuda issued circular laying down the requirements for the servicing of life boats and their launching devices, Circular SOLAS 2012-014 Independent Service providers for inspection and testing of LSA.



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As per taken crew, officer and master statements the issue found by the 2nd officer concerning the securing pin of the lifeboat's hook release system was discussed. It was agreed that the bosun and the OS would, after preparing as required by the company's SMS, try to fix the problem of the apparently stuck hook safety pin.

Prior to the actual job a tool box meeting was held, a risk assessment and permit to work filled out and way forward verbally agreed on bridge with the master and 2nd officer present. The bosun and OS then proceeded to the boat deck, located at the vessels stern by themselves with the equipment and tools needed on hand.

The work preparation and safety measures taken, including the personal protective equipment (PPE) donning, was at no time supervised or checked by the officer responsible as required by the company's SMS procedure and before filled form. The bosun and OS commenced work without supervision.

As both involved crew members were the only persons on scene and both tragically lost their lives, no information or details on the how the work was practically conducted and how the situation evolved at the life boat could be assessed. The positions of either crew members cannot be reconstructed. The launching arrangement on board showed no signs of failure or damage. The release of the free-fall lifeboat seemed to have technically taken place as intended from an on board point of view. It was clearly to be seen that the life boat maintenance securing or simulated launch device cannot have been connected at the time of the unintended release. The assessment of the lifeboat when landed ashore also showed no signs of damage or failure. All was found in a position expected when the boat is released except for a covering plate that was detached and later found on the boat deck. The safety bolt and split splint where both attached to their cords and hanging down the side from the hook fixing. The release bolt with attached lever to allow release from the inside of the boat was found in a nearly open position. The closed position would have had to be approximately 30° more in aft direction, but no indicator that the release segment and mechanism had been correctly reset is installed to clearly show the required closed setting. It could not be assessed if this position was left by the service technician or later caused by the work on the release system by the vessel's crew. The inside helmsman release was found untouched and in a closed position.

The 2nd officer's findings prior the departure of MV PALMERTON, the hook safety pin not movable or stuck, suggest, with the above findings, that the hook might have been already released when the crew commenced working at the accident scene. This also fits the statement in the lifeboat's Operator's Manual under the prefix *Caution*, advising to secure the boat before checking the system (see next page for quote).

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Lifeboat hook as found after retrieval from sea with both safety pins (source: taken on scene)

Below: Release Bolt lever for release from inside
(source: taken on scene)



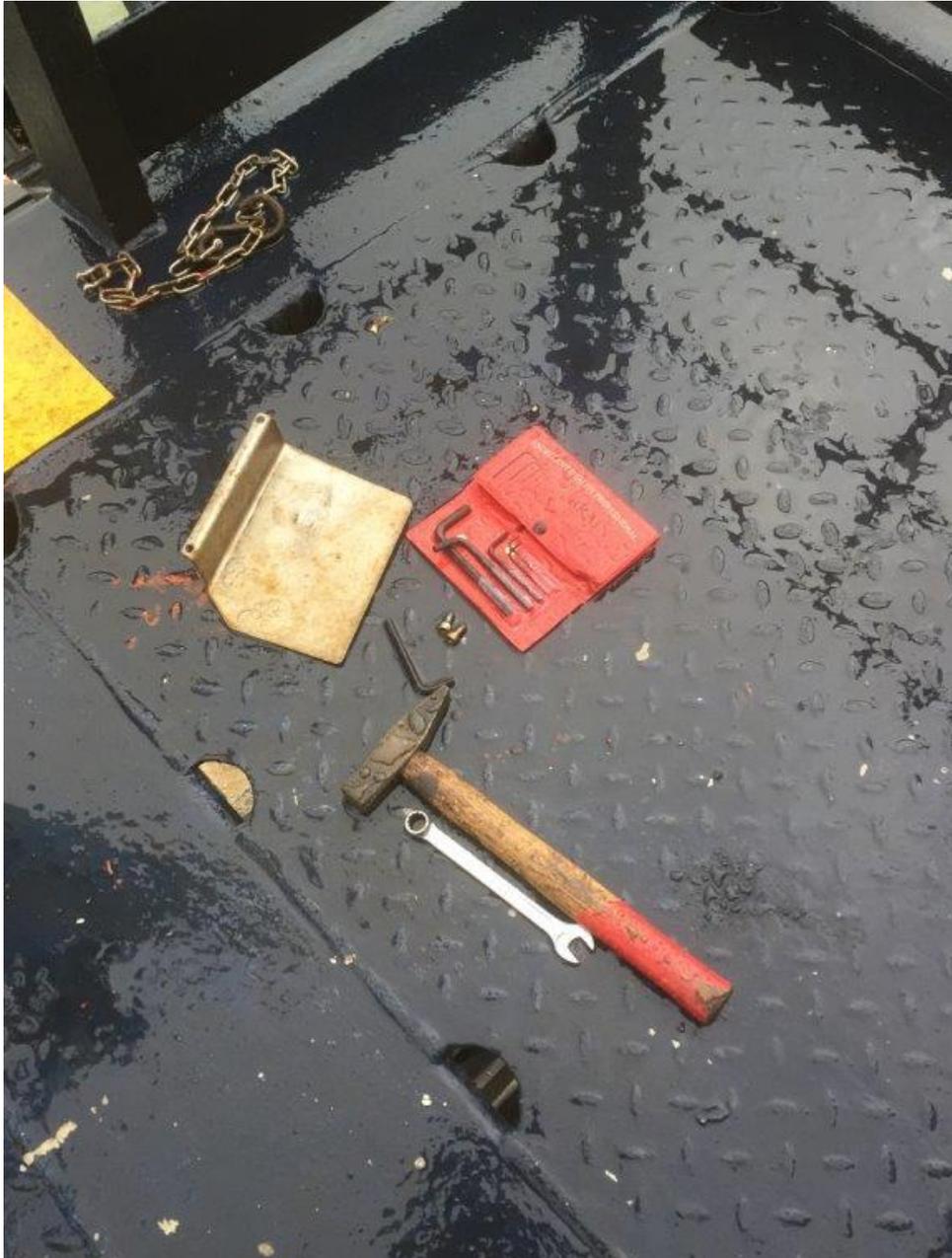
Handbook Quote:

Caution:

If release hook safety pin cannot be removed off the hook casing without excessive force, the hook might be released. Secure boat release hook and check system.

End Quote

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Tools and hook covering plate as found on the lifeboat deck (source: taken on scene)

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Finding the release hook safety pin stuck and not able to be moved suggest that this open position as pointed out in the Operator's Handbook was left behind most possibly by the service company having not reset the hook position fully but in a more open position. When the crew then tried to free the safety pin as instructed by the officer responsible, the hook released fully allowing the boat to launch in free fall to sea as no maintenance securing or simulated launching device was attached.

No reason for performing the job at hand without securing the lifeboat as per set procedures and instructions available could be assessed by the investigation. There was no indication of time pressure. The bosun was a very experienced member of the crew having sailed multiple contracts over the past 6 years on the MV PALMERTON. The OS assisting the bosun was on board since 5 months and had also received the required safety induction as documented in the company's Safety Management System (SMS). The bosun was described as very familiar with the free-fall lifeboat and launching equipment having assisted and conducted many lifeboat drills, simulated and full launchings.

The supervising 2nd officer had prepared the check on the hook configuration on paper and verbally instructed the crew members but had not checked the situation at the boat deck as he was still on navigational watch approaching the Wandelaar Pilot Station. Due to the vessel's construction with a forward located accommodation and navigational bridge and the lifeboat deck at the stern it was not possible to see the area where the two crew members were working.

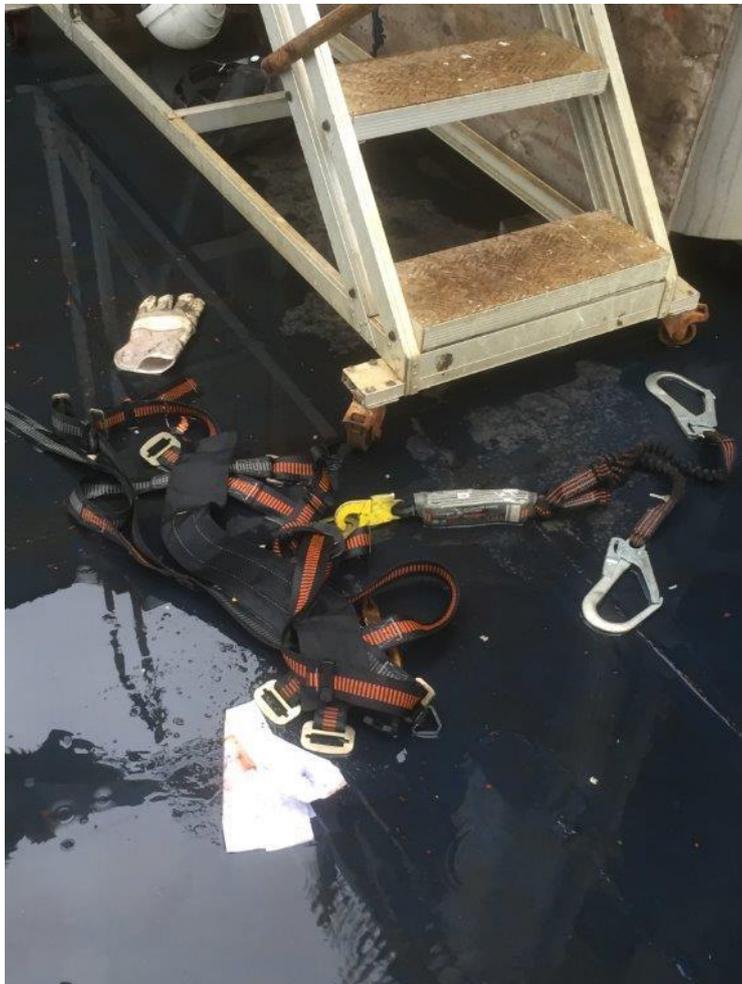


View from aft of the bridge to the stern of the vessel where the lifeboat is situated behind the funnel (source: taken on scene).

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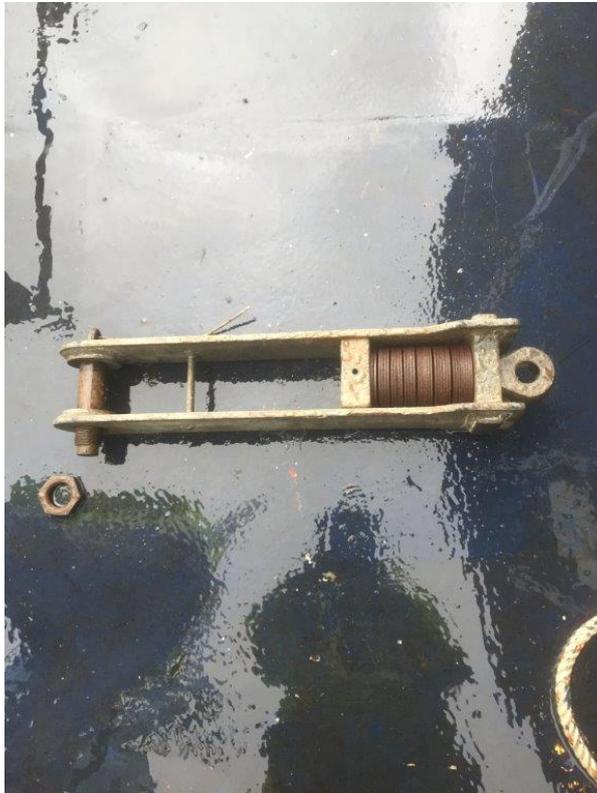
The investigation established that at no time the responsible or job executing personnel had consulted the Freefall Lifeboats Operator's Handbook. It contains highlighted and easily understandable instructions and warnings exactly for the scenario found on board the MV PALMERTON and its lifeboat.

In addition Personal Protective Equipment was available and taken to the lifeboat deck but not used. The safety harnesses were lying on deck and had not been donned as required by the company safety procedures laid down in the SMS.



Safety Harness as found on deck (source: taken on scene)

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Simulated launching device found detached on deck
(source: taken on scene)



Davit hook and securing connection detached/open
(source: taken on scene)

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PART F – FINDINGS

1. Safety issues

- No maintenance securing or simulated launching device was applied before working on or at the free-fall lifeboat
- The company SMS procedures were not adhered to in practice before and during the execution of the instructed task. A tool box meeting was held discussing the intended work, a risk assessment was made and written up and a permit to work form for working aloft issued by the responsible officer and confirmed by the nominated crew members. In practice all three pre work actions were not adhered to.
- Supervision of the work preparation and task as such was not conducted by the responsible officer as he remained on watch, neither by the vessel's master who was involved in the preparation of the work intended. The crew members tasked were left to themselves.
- After the service and repairs conducted on the launching arrangement were completed, no testing was conducted to confirm function. The reset hook arrangement was only checked by the safety officer (2nd officer) when the service personnel and class surveyor had already left.
- The design of the on-load release system allowed the reset position of the hook to be confirmed visually, it did not allow for easy visual checking that the release segment and mechanism had been correctly reset. This means that the hook could appear to be properly reset when it was actually not. The Manufacturer has highlighted the issue of a stuck safety pin indicating that the hook is released in the lifeboat manual which apparently was not referred to at all in this case on board MV PALMERTON.

2. Lesson to learn

- Adherence to the on board safety procedures and other instructions available such as operation manuals and the supervision and checking thereof is required for safe operations.
- Toolbox meetings and verbal preparation and instruction is if possible best done, or in parts done, at the specific work location to allow better understanding of all involved and direct supervision.



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- When safety equipment is serviced and/or gear is reset, the designated vessels staff should check correct reinstallation and/or setting with the servicing company staff present to possibly allow rectification by the service specialist and correct confirmation by the present class surveyor.

3. Recommendations

- In order to ensure compliance with updated Life Saving Appliance Service Provider Authorisation it is to be for all Antigua & Barbuda registered vessels referred to **Information Notice 2017-006 (Rev 3) Authorisation of Service Providers for LSA** as attached to this report.

Elsfleth, 14.02.2020

Nils Beyersdorff
Chief Casualty Investigator



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PART G – ATTACHMENTS

1. Documents and certificates

- Antigua and Barbuda Information Notice 2017-006 (Rev 3) Authorisation of Service Providers for LSA

2. Addresses and contacts

Marine Safety Investigation Authority
Antigua and Barbuda W.I. Flag State Administration

ADOMS IID

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	Information Notice 2017-006 (Rev 3)
	DEPARTMENT OF MARINE SERVICES AND MERCHANT SHIPPING (ADOMS)
	Authorisation of Service Providers for LSA

This Information Notice provides guidance on the authorization of service providers, to work on lifeboats, rigid rescue boats, launching appliances and on-load release gear on board Antigua & Barbuda ships.

1. Circular 2012-014 is now revoked
2. The Antigua Department of Marine Services (ADOMS) no longer approves individual service providers to conduct statutory survey work on lifeboats, rigid rescue boats, launching appliances and on-load release gear, on board Antigua & Barbuda flag ships.
3. ADOMS therefore no longer has any Independent Lifeboat Service and Testing Organisations (ILSTOs).
4. ADOMS now accepts service providers authorized by the Original Equipment Manufacturer (OEM), or one of our IACS authorized Recognised Organisations (ROs), listed on our web site. <http://abregistry.ag/technical-services/recognised-organisation/>
5. In order to maintain the validity of applicable international certification on Antigua & Barbuda ships, all thorough examinations, operational testing, repair and overhaul work undertaken on lifeboats, rigid rescue boats, launching appliances and on-load release gear should be conducted in accordance with SOLAS Chapter III Regulation 20, as applicable and MSC.1/Circ.1206/Rev.1.
6. Care should be taken to ensure that service providers conducting work on Antigua & Barbuda ships are authorized by either the OEM, or an RO, in accordance with 4. above.
7. Any concerns about the activities of service providers should be addressed in the first instance to the authorizing body (OEM or RO), but if this does not resolve the concern then such cases should be reported to ADOMS Technical Department.
8. IMO MSC 96 approved amendments to SOLAS Regulation III/20 regarding operational readiness, maintenance and inspections and also instructions for onboard maintenance, specifically under IMO Resolution MSC 402(96). The group of service providers described in para 6. above may conduct work under IMO Resolution MSC 402(96) provided that OEM approval for the ship specific equipment is in place.
9. In cases where a manufacturer is no longer in business or no longer provides technical support, the Administration may, on a case by case basis, authorize a service provider to service the equipment if the service provider had prior authorization for the equipment and/or long-term experience and demonstrated expertise as an authorized service provider can be provided

This new resolution addresses the 5 yearly cycles for inspections, maintenance cycle of LSA, roles and responsibilities and the competence requirements and enters into force on 1 January 2020.