SURVIVAL SYSTEMS INTERNATIONAL, INC.'S HIGH LEVEL OVERVIEW OF THE FINDINGS OF THE BRAZILIAN AUTHORITIES REGARDING THE OCEAN AMBASSADOR INCIDENT

In regard to the Ambassador incident the Brazilian Authorities recently issued two reports. The first report is from the Brazilian Maritime Authority Directorate of Ports and Coasts and has been prepared to be sent to the International Maritime Organization (IMO). The second report is from the Naval Inquest Department of the Port Authority Office, to be sent to the Maritime Court's Attorney General. These reports are consistent with each other, however the reports have a somewhat different focus as they are written for different purposes.

The notes below are a high level overview of the findings of these reports by Survival Systems International, Inc. (SSI), the manufacturer of the Triple5 lifeboat release mechanism.

THE NAVAL INQUEST DEPARTMENT REPORT DOES NOT NAME SSI OR SUGGEST THAT SSI WAS RESPONSIBLE FOR THE ACCIDENT

THE NAVAL INQUEST DEPARTMENT REPORT NAMES THOSE POSSIBLY RESPONSIBLE FOR THE ACCIDENT

The Naval Inquest Department report lists the rig owner as possibly responsible, "by negligence and imprudence, in relation to the safety onboard, that is lack of care or of application of the task providing the vessel with the Operating and Maintenance Manual of the manufacturer of the device Triple5 and training of the crewmembers and for noncompliance with Chapters 8 and 10 of the International Safety Management Code (ISM Code) which deals with Maintenance of the Vessel and Equipment".

The report also names 6 rig employees, including the OIM, Supervisor of the Rig, a member of the Department of Safety of Equipment of the Rig, and three of the crew members, as possibly responsible.

The report does not name SSI as a responsible party or suggest that SSI or the design or installation of the Triple5 hooks on the lifeboat in question were responsible in any manner for the tragic accident on the Ocean Ambassador.

KEY POINTS IDENTIFIED IN THE REPORTS

With regards to the Triple5, the Naval Inquest Department report states "No evidence was observed, which indicates the existence of failures in the material or its inadequacy."

The Maritime Authority report states at the time of the accident "the non-existence onboard of the manual of operations and maintenance of the manufacturer".

The Naval Inquest Department report confirms the "inexistence onboard of a Nautical Officer", who should have been responsible for the lifesaving equipment.

The Maritime Authority report confirms that the crew onboard the rig at the time of the accident were "ignorant" of the function of the hook release system and had not received training from the rig owner in the use of the hook release system.

The Maritime Authority report states that fall wires were not released during the operation, the lifeboat was "placed in the water, without the cables of the davit being disconnected." Also that the lifeboat was maneuvered in the ahead and astern positions while still attached to the cables.

The reports note that the lifeboat had to “halt in the ascent of the lifeboat a little before the accident due to the excessive oscillations”, i.e. the excessive swinging of the lifeboat, “When the lifeboat was around 2 meters from the deck of stowage”.

KEY POINTS THAT ARE KNOWN BUT NOT IDENTIFIED IN THE REPORTS

The existence of a misleading crew instruction poster, created by the rig owner, mounted on the rail alongside the lifeboats.

The removal of the primary release handle/indicator. The crew should not have operated the lifeboat with the primary release handle missing and should have immediately contacted the OEM to have it replaced. The helmsman was not able to check the Primary Release Indicator to ensure that the hook up was safe.

The removal of the flat yellow circular interlock cover. The crew should not have operated the lifeboat with the interlock cover missing and should have immediately contacted the OEM to have it replaced.

IF the crew engaged the Emergency Release Ratchet (which was also missing) while the lifeboat was suspended above the sea this would have put them in a position of EXTREME DANGER OF DROPPING THE LIFEBOAT.

There were deep gouges found in the lifting links, probably due to excessive swinging.

SSI trained 10 people on the rig when the hooks were installed in the US. To the best of SSI’s knowledge none of these workers were onboard the rig in Brazil when the accident occurred more than one year later.

REFERENCE TO THE BRAZILIAN MINISTRY OF LABOR AND EMPLOYMENT REPORT

Last year a report was released by the Brazilian Ministry of Labor and Employment that related to the Ambassador incident. This report is specifically referenced in the report from the Naval Inquest Department. An excerpt differentiating the findings, is given below:

“In short, the Report describes the accident based on an interview with Mr. Ronald Williams, Offshore Installation Manager (OIM). Afterwards, during the analysis, illustrated with photos, it is cited “*a dimensional failure of the device*” attributed to “*an error of project in the support equipment of the lifeboat referred to as Triple5*”, which event was **not confirmed at the end of the expert examination, in which the project error was not detected but instead failures in the maintenance and operation of the Triple5 system**”.