Chapter 6

Commission and a turning attempt

Lack of Police seizure

The Police set up an investigation group with four participants the morning after the accident, led by Kjell Larsen. The public prosecutor ordered a "full investigation" on the same day. The Attorney General followed up on 10 April, where he writes to the Public Prosecutor that it is important that the Police secure evidence, and that an "investigation into the causal and liability conditions" is launched. As there were no representatives from the Police or the Prosecution in the Commission, it was "absolutely necessary that the Police and the Maritime Inspector undertake a parallel investigation". This was the Attorney General's clear order.

46
Why didn't the Police immediately seize the rig owner's and the operator's documents?

The Office of the National Auditor on the Police's lack of investigation

In reality, the Police's efforts became a supplementary investigation, not a parallel one. The Commission investigated causal relationships, while the Police assisted them with practical tasks and assessed the ongoing investigation of possible violations that the Commission uncovered. The Office of the National Auditor writes:

> *"We have found no documentation that the Police seized documents from the companies Stavanger Drilling and Phillips Petroleum in connection with the investigation in 1980."* [90]

[90] National Audit Report, p 37

The Commission retrieved documents from Stavanger Drilling four days later without requesting the missing weekly reports. But nothing was seized. According to the Office of the National Auditor, the Police believed that this was the Commission's job. In the event of a seizure of the archives of Stavanger Drilling, Phillips and Veritas, it would be apparent whether the parties to be investigated had purged the archives of material that could be used in a possible criminal case. What we have seen so far in this review is that Stavanger Drilling's archives were in fact purged. Phillips and Veritas have refused access to their archives - in the biggest industrial disaster in Norwegian history. This is nothing less than a public scandal.

When National Auditor actually points out serious weaknesses in the investigation, it appears strange that such findings are not accompanied by formal criticism of the prosecuting authorities. Were these serious neglects due to a lack of legislation on the division of responsibilities between the Police and investigative Commissions? Or were there clear rules in 1980 that were not followed? We here miss a critical review in the Office of the National Auditor's report.

47
Why did the Commission accept that the five brace parts taken up from the North Sea were sold and remelted?

The National Auditor's report from 2021 has a separate chapter on securing and storing evidence. [91] In their interview with investigator Torbjørn Knutsen, he states: *"the Commission took care of the evidence from the steel material"*. The Office of the National Auditor writes: *"The rest of the brace parts that were not the subject of further investigations were laid outside and later chopped up."*

With 123 dead oil workers and 89 survivors, it is surprising that not all evidence was taken care of for posterity. It clearly illustrates that the Commission had made up its mind right from the start that it was only the D6 brace that was relevant for clarifying the causes of the accident. After the rig was overturned in 1983, and long after the brace parts had been discarded, two theories emerged about possible breaks in other braces - before the D6 brace. Whatever one may think of these theories, it is highly objectionable that the

[91] National Audit Report, p 42-44

Commission accepted the removal of possible evidence. And it is equally reprehensible that the Police left it to the Commission to make decisions about this.

Securing evidence

The Commission had, as we have seen, already concluded after a few days that the cause of the accident was the fatigue fracture in the D6 brace. Other possible causes of the accident were not investigated, according to the Office of the National Auditor.

All physical evidence that the Commission believed could be of interest in the investigations into why the D6 brace broke was brought ashore in connection with the initial investigation. The other breaches in the remaining brace parts were obviously not of interest to the Commission. Steel samples and pictures of the other braces were taken, and they were measured. The Oil Museum was allowed to keep some remains. Then they were laid outside and later chopped up.

> *"Already in the summer of 1980, the Commission gave permission for the rods to be melted down. This is revealed in an interview with the Kielland Network. The lifeboats were also destroyed."* [92]

Torgeir Moan from the Commission says in an interview conducted by the Office of the National Auditor that the Commission was concerned with securing physical evidence. But the National Auditor concludes that physical evidence was allowed to be destroyed. As is clear from the question, the middle pieces from five braces that were brought up from the North Sea were resold to the Smelter in Mo i Rana already in the summer of 1980, after some samples were taken to check the steel quality. When indications of an explosion were found in the D4 brace after the turning in 1983, it was no longer possible to check the remains of this brace. There was also interest in checking lifeboat remains. But these were destroyed and buried in a landfill after the Police had taken pictures of them. *"The Police... considered that it was unnecessary to keep this material"*, the National Auditor writes.

Does the Office of the National Auditor agree with the Police's assessment? Again, the National Auditor highlighted important facts without giving concrete and formal criticism. We miss a clear and distinct criticism of both the Commission and the Police for a sloppy and

[92] National Audit Report, p 42

superficial treatment of evidence after such an extensive major disaster. Which laws and regulations applied to the preservation and securing of evidence? What was the usual practice in similar cases? Why is it that the *Norwegian Aviation Investigation Branch* collects every screw and nut after a plane crash, while the Kielland Commission and the Police accepted that the owners dumped and destroyed evidence?

The Commission

As early as 28 March, a public Commission of inquiry was appointed by the Ministry of Justice, with magistrate Thor Næsheim as chairman.
The Commission was made up of a lawyer with no investigative experience, two representatives from the Shipping Association and LO (Trade Union Federation), a platform captain and a professor with technical expertise.

48 and 49
- Who suggested members?
- Why wasn't the Commission made up of people with other types of experience, for example on stability and operational experience from Pentagon rigs?

Pursuant to Section 314 of the Maritime Act, it was decided by royal decree on 28th of March that a Commission of Inquiry of the accident should be appointed. The Ministry of Justice had the power and mandate to appoint the Commission's members and shape its mandate. The Ministry of Justice appointed the following members:

1. Magistrate Thor Næsheim, Sandnes, chairman.
2. Professor at NTH (later NTNU), Department of Marine Construction, Torgeir Moan, Trondheim.
3. Platform manager/sea captain Kåre Holm, Røyse.
4. Former secretary Aksel Kloster, Stord, representing LO.

Captain Holm asked to be relieved of his duties, and on 1 April 1980 the Ministry of Justice appointed platform captain Per Bekkvik, Arendal, as a new member of the Commission. At

the same time, the ministry supplemented the Commission with another member, director Sivert Øveraas of the Norwegian Shipping Association.
Nils Gunnar Gundersen, with extensive experience from Pentagon rigs, gave a lecture on Pentagon rigs for the Commission and the Police in the first days of April. He wondered about the composition of the Commission and suggested bringing in a rig captain with several years of experience from the Pentagon rig "Drill Master". The proposal was rejected.

Who suggested members?
Minister of Justice Andreas Cappelen was central since the Commission was appointed by the Ministry of Justice.
In addition to political leadership, the civil service will usually also be active in searching for people who might be appointed to the Commission. From the civil service, it is likely that several ministries were involved, including the Ministry of Trade and Maritime Affairs.
So far, it is not known who put forward specific name proposals. Nor is it stated in the Commission's report who participated as their scribe or secretary. I have checked with the sons of Andreas Cappelen whether they are in possession of archives after their father. They are not.

50 and 51
- Were there participants in the inquiry Commission who had dual roles that could call into question their competence? How were issues of integrity assessed in the Commission?
- Did Commission member Professor Torgeir Moan have a paid position in Veritas while the work in the Commission was going on?

The Office of the National Auditor reviews the issue of eligibility and dual roles and bases its analysis on the fact that the Norwegian Commission of Inquiry had broad competence and carried out a thorough investigation of the accident. Nevertheless, two of the five members had connections to Det Norske Veritas and the Norwegian Maritime Directorate, both of which were to be investigated. Professor Torgeir Moan from NTH (now NTNU) was a member of Veritas' advisory committee for offshore technology. Sivert Øveraas was a deputy member of two committees for the Norwegian Maritime Directorate. None of them

were assessed for dual roles by the Ministry of Justice. These matters are pointed at by the Office of the National Auditor, without being described as objectionable. The National Auditor also writes that no one, not even bereaved or survivors, *"has questioned the eligibility of the Commission in an interview with us"*.

This is not correct.

The Kielland Network raised the issue of eligibility and dual roles, both in the interview the National Auditor conducted with the board of the Kielland Network, and in a separate comprehensive letter to the National Auditor in June 2019, where we presented the 89 questions that this book discusses. We criticized that Aksel Kloster from LO, after pressure from Phillips, was declared ineligible in 1983 and thrown out of the Commission, while at the same time pointing out Moan's connection to Veritas. [93]

In the report, the Office of the National Auditor criticizes the fact that the Commission chose to use Veritas also during the inquiry work and the turning operation, and pointed out ineligibility: *"In our opinion, it is unfortunate that the authorities involved Det Norske Veritas, which was a party to the case, in the investigative work and the turning operation."* [94]

The Kielland Network pointed out to the Control Committee at the Storting in 2019 that 60 percent of the Commission - three out of five members - were in fact not qualified, if one accepts the ineligibility objections against Aksel Kloster. Sivert Øveraas' eligibility was weakened not only by his position at the Norwegian Maritime Directorate, but also by the fact that he represented the Norwegian Shipowners' Association. While LO was of course not subject to scrutiny, the Shipowners' Association member Stavanger Drilling - as shipowner - was clearly subject to scrutiny. This is not criticized by the Office of the National Auditor.

One of the Norwegian interested parties was therefore directly represented in the Norwegian Commission, which is unusual in such contexts – to say the least.

Put to the fore: The official Norwegian inquiry into the most serious industrial accident in Norwegian history was carried out by an incompetent and biased Commission. This is sensational and highly objectionable, and should of course have led to the Office of the National Auditor recommending a new investigation.

---

[93] Separate letter from the Kielland Network to the Office of the National Auditor of June 19th 2019, questions 50 and 51

[94] National Audit Report, p 137

But they didn't.

52
What was the relationship between the Commission and the Police/prosecuting authority, particularly on the basis that the Commission's members had no investigative experience?

The establishment of a separate inquiry Commission created ambiguities in relation to normal investigation routines. When accidents at sea had to be investigated, it used to be in the form of a so-called "Sea Explanation". This was a judicial body set up to determine the causes of an accident at sea. But what do you do when the government appoints its own ad-hoc [95] Commission? In principle, a Sea Explanation could have been decided, where this legal body then established a Commission of inquiry, but this was not done. Instead, the Commission was appointed by the government.

Who led the investigation into the Kielland accident - the Commission or the Police? As we have seen, the Attorney General was concerned that the Maritime Inspector and the Police should undertake parallel investigations. Neither the maritime inspector nor the Police were represented in the Commission, and thus there was an obvious risk that priorities that would normally have been made in a Police investigation could be damaged.
And that is exactly what happened. The Attorney General's order was not followed. In practice, the Police did not carry out a parallel investigation, but assisted the Commission when necessary. The Commission was clearly superior to the Police and the Prosecutor. The consequences were major shortcomings in the inquiry.

In the Police's main report, it is stated that the Commission and the Police had close cooperation. They exchanged and shared information continuously. The Commission took the main responsibility for the technical investigations, while the Police assisted them with the practical tasks, such as cutting the brace remains from the D leg and transporting them to Statoil's laboratory.

[95] Ad hoc: latin, means «for this purpose» - in this case a Commission established for this one purpose.

In the Police's main report, it appears that the Police followed the Commission's work. As the Commission uncovered possible violations, these were investigated further by the Police.
The Police investigated the following matters:
- Safety training for crews on mobile and fixed installations in the North Sea
- Staffing of mobile devices,
- The auxiliary vessel "MS Silver Pit",
- Rescue equipment.
When it came to the **causes** of the accident, the Police referred to the Commission's investigations.

One may wonder how evidence would have been secured if the investigation had been carried out under the direction of the Police and prosecutor.
For one thing, investigators would not have settled on a main conclusion just days after the accident.
Secondly, the archives would have been seized immediately, both at Stavanger Drilling, Phillips, Veritas and the Norwegian Maritime Directorate. Contact would have been established with the French Police for seizure from the French involved parties.
Thirdly, all wreckage and brace remains would have been taken care of until all legal proceedings had been concluded.

The question of the relationship between the Police and the Commission is therefore very important. The review shows that the system of the time with occasional ad hoc investigative Commissions created ambiguities and weaknesses. Permanent accident Commissions build up experience and develop methods for sound and comprehensive inquiries. In the eighties, there was such a permanent Commission for investigating plane accidents. All wreckage parts were taken care of here. Crashed aircraft were in practice rebuilt, to ensure that all knowledge was taken care of. The contrast is stark: in the investigation after Kielland, brace parts were released, sold and remelted, just a few months after the disaster. And the wreck was sunk in November 1983, long before legal proceedings had ended, despite the protests of the Kielland Foundation and the French parties.

These weaknesses led to an inquiry and investigation that did not measure up. Discarded steel and missing items in archives are still a problem, several decades after the accident. As I am writing this book, Veritas and Phillips are still refusing to release the archives for inspection - archives that should have been seized immediately after the disaster. When we look for answers to many of the 89 questions, we are still prevented from gaining insight. The researchers at UiS and the Documentation Project at the Norwegian Oil Museum are still working to gain full access to these "private" archives.

53
What assessments were made by the Commission when they concluded that stability failure was the second factor that led to the accident?

Here, reference is made to questions 40-45 which, among other things, deal with stability failure. As previously stated, it was Professor Emil Aall Dahle who prepared the Stability Report for the Commission.

If the doors and openings had been closed in line with the regulations, the final capsize would have been delayed, according to Aall Dahle. I do not know what discussions took place in the Commission. But it is reasonable to assume that such a professionally strong analysis from one of Norway's leading experts had to be included in the Commission's report.

54
Why was "evacuation and rescue" set up as one of the three main causes of the accident? [96]

The Commission emphasizes one cause as the trigger: the fatigue fracture in the D6 brace. The loss of stability that occurred after the first roll to 30-35° (see question 53)

[96] Kielland Conference 2017, p 17

caused the final overturn to 180° - and many workers who survived the first phase of the disaster lost their lives. In addition, weaknesses in the lifeboats, and a lack of access to survival suits and life jackets were contributing factors to many deaths.
There is reason to ask why the Commission described these two shortcomings as "causes". Both stability failures and weaknesses in rescue equipment can perhaps be better described as consequential damages than as causes? But if the perspective is turned to what caused the individual worker's death, it may be reasonable to describe these two conditions as causes.

55
The investigations carried out in the summer of 1980 of the brace parts at Statoil's Materials Technology Laboratory: Were traces of other cracks than in the D6 brace found? Were traces of termite welding found on braces D4 and/or D3?

In the report from Statoil's Material Technology Laboratory in 1980, no other cracks were reported, with one exception: The long horizontal DE brace had a large and visible crack on the stump that remained on the D leg. Five of the six braces connecting the D leg to the rig broke in two places. Samples were taken from these braces, in addition to samples from the remaining stubs on the D leg. Measurements were also taken, as well as photographs of the remaining brace stumps on the Kielland wreck.
SINTEF also carried out investigations, but no other cracks have been reported there either. Neither of these two reports describe findings of termite welding [97] on any brace.

56
Why was the Insurance Pool not investigated?

As we have seen, the Office of the National Auditor was critical of the fact that neither the Norwegian Commission nor the Police raised questions about liability:
"It is highly objectionable that the authorities did not carry out a complete survey of the responsibility of Stavanger Drilling and Phillips Petroleum after the accident." [98]

[97] «Termite welding" is mainly used to connect railway bars and for other steel reparations
[98] The Office of the National Auditor

The Office of the National Auditor criticizes this but did not carry out such a complete survey itself. The question of responsibility and liability is therefore still on the table as an unsolved task.

What about the insurance pool?
Here, reference is made to questions 27-29. The background to the question concerns Storebrand's dual role as insurance company and owner at the same time. Kielland was declared a total loss already in January 1981, before the Norwegian Commission had submitted its report. Storebrand's share of this settlement was a modest NOK 6 million. While the *insurance company* Storebrand had to pay 6 million, the *investor company* Storebrand was paid 34 million in the settlement, after Stavanger Drilling's remaining debt had been paid. In addition to these 34 million, Storebrand's profited from their share in the Solvang company.

The dual role is clear. If the investigation had revealed errors in the operation of the rig, it would have been appropriate to take out recourse - i.e. demand the insurance money back from the owners. Storebrand would have lost a lot on this. At the insurance settlement, the Norwegian Oil Insurance Pool (NOP) took over ownership of the wreck. And Storebrand had the chairman of the NOP, and handled all the work with Kielland on behalf of the NOP.

Why was the insurance pool not scrutinized? Or more precisely: Why was Storebrand not scrutinized for its dual role as owner and insurance company? Storebrand worked intensely against the bereaved's demands to turn the rig around, and there is good reason to assume that the motives were financial. Turning the rig over could reveal serious operational errors, which in turn could trigger recourse and claims for repayment of the insurance. For the insurance companies, including Storebrand, this would be a financial advantage. For the owners, including Storebrand, a recourse would mean a major loss.
We have seen that there is still a great need for access to the Veritas and Phillips archives. The same applies to the Storebrand archives. None of them have so far provided insight.

57 and 58

- Why was clauses and secrecy decided? Who decided this?
- What was the rationale for continued clauses and secrecy?

Lack of transparency and leaks

The Office of the National Auditor points out that the Commission shared little information with the public while the investigation was ongoing, and that the bereaved and survivors did not receive information before the report was presented. In addition, they point out that many of the background reports to the Commission were not publicly available. [99]
The Norwegian authorities neither translated nor assessed the report from the French experts. It was presented in 1985 and should have led to the Ministry of Justice being able to carry out a comparative investigation of the two Commissions' reports. This did not happen. The Norwegian Commission leaked information to the Norwegian interested parties, while the French were allegedly biased. Here, the Office of the National Auditor should have asked critical questions whether the Commission and the Norwegian authorities deliberately placed the responsibility and liability for the accident outside the country, so that our new and very lucrative industry was not too severely challenged?

The Office of the National Auditor at least had the French report translated in 2021, which provides a solid basis for a new and more comprehensive investigation of the disaster.

At the time, the Norwegian Commission of Inquiry chose to close the investigation to public scrutiny, apparently with the approval of the client, the Ministry of Justice. This was accepted in 1980, where there was a far weaker culture of openness than today. Perhaps that is the explanation for this decision? Or was it an assessment that a closed process best served Norwegian interests?

At the same time, the Office of the National Auditor points out that *"the interested parties, i.e. those who could be criticized, received information about the investigation during the course of the investigation*". [100] This fact is also documented through access to the Stavanger Drilling archives, where it appears in several places that the board received ongoing

[99] National Audit Report, p 44ff
[100] National Audit Report, p 32

information from the investigation of themselves and others. There is strong reason to assume that the same applied to the operating company Phillips. According to the Office of the National Auditor's interview with Torgeir Moan, the "interested parties" were briefed on the facts during the investigation and were allowed to give input on which investigations the Commission should carry out on the wreckage of the platform. [101]

The Office of the National Auditor pointed out these factors, but nevertheless failed to issue formal criticism.

Technical investigations and missing documents

The Commission was able to carry out technical investigations in Norwegian professional environments and obtain many documents, but key documents were missing, according to the Office of the National Auditor's report. Torgeir Moan stated in an interview with the Office of the National Auditor that it was *"important that investigations were carried out by independent institutions and not by Veritas, the Norwegian Maritime Directorate or others involved in the accident"*. [102] The Office of the National Auditor's archive review gives a different picture. Veritas carried out calculations that were included in some of the Commission's background reports. Norwegian parties thus were included in the process, while French circles were "considered by the Commission to be biased". [103] I find this disparity between the Commission's assessments of the French, American and Norwegian parties outrageous, and in my opinion, it greatly weakens the confidence in the Norwegian Commission of Inquiry.

The Office of the National Auditor pointed out these facts and criticized the use of Veritas both in the investigation and in turning operation operations. *"It is objectionable that the authorities involved Det Norske Veritas in both the investigative work and the turning operation, as they were a party to the case."*

It is worth noting that the science institute SINTEF was used by the Commission to a large extent, according to the Office of the National Auditor. SINTEF had and still has a very close connection to NTH (now NTNU), where Professor Torgeir Moan was employed. The use of SINTEF should therefore also have been considered.

[101] National Audit Report, p 33
[102] National Audit Report, P 33
[103] National Audit Report, p 33-34

Diving and surveys

Divers carried out several missions for different clients, from the time the rig was still out in the field and until the last turning operation in the autumn of 1983. Immediately after the accident, divers investigated damage to pipelines and carried out searches for missing persons. They picked up many of the dead, before this search was interrupted by the start of production at Edda. Divers examined the rig when it was in Kårstø in the first month and contributed during both turning operation operations.

59
Who was responsible for the fact that no Kielland divers were summoned for Police questioning or questioning by the Commission of Inquiry?

Responsibility for this must be shared by the Commission and the Police. The fact that the divers were not questioned illustrates the great weaknesses of Commissions that are set up to investigate a single incident, and that the Police were in practice was pushed aside.

60
Who dived - and for whom?

The first diving operations in the days after the accident were made from the diving vessels *Seaway Falcon*, *Wildrake* and others. The divers worked in eight-hour shifts. When Phillips restarted production on Edda after six days, divers were still actively searching for casualties. More and more victims were being found. Then mud was pumped out from Edda, and the visibility was completely destroyed. Many of the 30 missing are apparently still there, under a layer of mud. Many of the divers reacted to this and thought it was disrespectful. The divers were moved to areas where there was still visibility.
In the Memory Bank there are many interviews with divers, who describe the diving operations. [104]

[104] The Kielland Memory Bank, book 3, p 125ff

After the first dives that were carried out on the field in the days after the accident, the platform was towed in to Kårstø in the southwest coast of Norway. An extensive visual examination of the wreck was carried out here, both with divers and with an ROV (remotely operated underwater vehicle). *Bloms Oppmåling* was engaged by the Commission for this mission, which took place at the end of April 1980. Everything was filmed and many photos were taken. The films – a box of old VHS cassettes – were found at the Oil Museum in 2020. These films document that the Commission were wrong on several points, and some clips were shown in TV2's documentary series about Kielland in 2022.
So far only a small proportion of the films have been repaired and digitized. The documentation project at the Oil Museum is working to make the rest of the films available. The films and the report from Blom's survey were exempted from publication by the Commission.

Before the attempt to turn the rig in the autumn of 1980, the rig was also checked by divers, both to inspect and to attach air bags. One of the 37 missing was found by divers during this work.

There was also considerable diving work before the second turning operation project. Veritas carried out diving inspections in both 1981 and 1982. In 1983, divers from Stolt-Nielsen were central to attaching large buoyancy tanks to the four remaining platform legs. The French Commission also used divers for inspections after the rig was uprighted.

61 and 62
- Which of the divers' observations were kept secret and classified, and by whom?
- Why are the reports to Veritas from the divers about several cracks in braces not attached to the public report?

All these diving operations were documented through photos and films. All of them were excluded from the public by the Norwegian Commission, and many of them have still not been traced.

In 1982, it was reported in the media that during diving Veritas had found several cracks in the braces. These reports were not included when the Commission delivered its additional report in 1983. I have never seen any attempt to justify or explain this.
Work is still ongoing to digitize and review the films found at the Oil Museum. Veritas carried out several of the diving operations. And as is well known, Veritas still refuses access to the archives.

The first turning operation operation: Nicoverken and SD Marine

The Nordli government (Labour) had pledged in the days after the accident that everything would be done to find those missing after the accident, and that the rig would be turned around. Turning around the rig would also enable inspections on board which could secure all traces related to the causes of the accident.

Stavanger Drilling and the Oil Insurance Pool believed in 1980 that it might be possible to turn the rig around, repair it and put it back into use. The government did not order the owners and insurance companies to carry out a turning operation, but instead allowed the owners to carry out this operation based on financial motives.
The owners gave the assignment to Nicoverken Norge AS and English SD Marine. Both companies were small and newly established, and they engaged the American Scot Cobus to lead the operation.

63 and 64
How did Nicoverken and SD Marine get the job - tender or direct award?
Who decided this choice - operator, shipping company or insurance company?

The first turning operation attempt was a nightmare for those of us left behind. It took an incomprehensibly long time before a decision was made to turn around the rig 180 °.

Economic motives came before humane ones. Right from the start, many were skeptical that beginners in the salvage industry should get the job. And when it all ended with a failure, it caused deep disappointment and frustration for those of us who hoped that the turning operation would lead to more of the missing people getting a grave - and at the same time a strong basis for the inquiries.

These questions are in many ways an expression of this frustration and the very low trust in owners and authorities.

In June 1980, a tender round was carried out under the auspices of Stavanger Drilling, where several well-reputed salvage companies signed up - SMIT Tak International and the Ugland group, among others. Nevertheless, it was two small and newly established companies that won the tender: *Joint Venture Consortium (JVC)* which consisted of *Nicoverken Norge AS* and *SD Marine Ltd*.

Nicoverken Norge AS established itself in Stavanger at the end of the seventies and was a Norwegian branch of the Swedish Nicoverken. The company was engaged in ship repairs.

SD Marine Ltd was a newly established British company based in Southampton. The two founders had previously been employed by the well-reputed "Structural Dynamics". In a garage they built a model of Kielland, where they experimented with turning the rig with air balloons.

It caused a stir that the unknown JVC was given such a large and complicated assignment, and especially that JVC outbid recognized salvage companies, with what many called the "Donald Duck method": Carl Barks had in one of his stories raised a ship with ping-pong balls. The management of Stavanger Drilling justified the choice of JVC with lower price.

There is little doubt that Stavanger Drilling had the right to decide. They owned the wreck right up until after the failed turning operation operation in December. This led to the Oil Insurance Pool declaring a "total loss" in January 1981, and the pool taking over ownership of the wreck.

According to the Norwegian Petroleum Act, Phillips as operator was responsible for correcting all damage that occurred within the Ekofisk licensee. There is no indication that either Phillips or the owners and insurers believed that this also included responsibility for what was to be done with the wreck.

65
One of the two welders who carried out illegal welding work on the day of the accident - Tommy Andersson - was employed by Nicoverken Norge AS. Is there a connection between the fact that this company was both engaged for this welding work, and was given the task of turning the platform?

Reference is made to questions 36 and 37.

There has previously been a story that Tommy Andersson and the Irishman Robbie Morrison from the Scottish company "*NTL Rig Equipment*" both arrived at the rig with the supply boat "*Norindo Sun*" at 22.20 on 26th of March. It turns out that Tommy Andersson was on the crew member lists and had been on board for around a week. Robbie Morrison does not appear on the crew lists. Both perished.

Several welders were on board, connected to the extensive work of preparing the rig for drilling assignments. Several have reported welding on the structure, and it is this type of work that is described as “illegal” in the question. Welding on the structure should not take place at sea.

I have found no documentation that there is any direct connection between the welding work at Kielland and the awarding of the contract for turning the platform.

66
Is there any documentation in the archives of SD Marine or Nicoverken Norge AS on the assignment?

The archives of the "Joint Venture Consortium" or of the two companies that failed with the turning operation attempt have so far not been reviewed. As you know, UiS and the Documentation Project are busy with archival research, and these archives will hopefully also be reviewed.

From the Memory Bank:

"On one side was a small cinema hall and on the other side was the large cinema hall. We showed the movie ‘The Rose’. The last thing 40 men heard was The Rose. I think about that at funerals and weddings."

“Those were Texas times. My safety course was: Here you have a helmet, wear it when you are on deck. Lifeboat course upstairs and downstairs. Lifeboat exercises were always in the middle of the cinema. Then there was one who crossed off that all six of us had been there."

“Veritas got away with this too easily. They cannot have examined and approved further operation when the conditions were as they were."

Theis Salvesen, galley boy

"A memorial gathering can create a community of people who have experienced the same thing, people I don't know, but with the same feelings and thoughts as me. The fact that you are not alone can be a good comfort."

Tone Skirstad, daughter

"You search for answers why your father is dead. And when things are kept secret, you become critical. Then it's no wonder that there are conspiracy theories."

"The most important thing about the Kielland accident is greater transparency about what happened. Secrecy makes those left behind feel insecure. It should be clear that everything about Kielland must be opened. All documentation must be available. We must have all the available information.”

Kent Amundsen, son

"Came on board Kielland early in the morning. Was on the drill deck. Most of the drilling equipment was there. The rig had been converted into a residence, but had now been assigned a drilling mission, and I was there to prepare it for drilling. It was supposed to start drilling. The top of the derrick had been taken off. The block (45 tons) was in the rail corridor."

Leif Wiig Abrahamsen, underwater engineer Stavanger Drilling