

Report

Report title Investigation of an incident resulting in personal injury on Deepsea Nordkapp on 8 October 2025	Activity number 405007010
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Parties involved

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1 Summary

On Wednesday, 8 October 2025, during a lifting operation using the starboard offshore knuckle boom crane on board Odfjell Drilling's Deepsea Nordkapp (DSN) facility, an incident occurred that resulted in personal injury. On Friday, 10 October 2025, the Norwegian Ocean Industry Authority (Havtil) decided to investigate the incident.

The incident occurred during the lifting operation of a long logging tool that had been in use in the lower section of the drill string and placed on the catwalk. The logging tool was to be lifted from the catwalk to the pipe deck using an offshore knuckle boom crane. A deck operator who was acting as a slinger was struck by the logging tool when it began to sway uncontrollably. The deck operator was seriously injured in the upper body and was flown by the SAR service to Haukeland University Hospital for further treatment. At the time of the incident, the work crew directly involved in the incident consisted of a crane operator, a signaller and a slinger.

Under slightly different circumstances, the incident could have resulted in more serious injuries or possibly death.

The direct cause of the incident was that, during the lifting operation, the load was not fully under control, and the injured person (IP) was standing in the path of the load and, at times, directly beneath it. As a result, IP was struck by the load while the crane operator was trying to regain control. The load itself consisted of a tubular logging tool weighing 2.67 tonnes and measuring 11.81 metres in length. While attempting to gain control of the load so it could be placed in the carrier, a swaying motion arose. IP was standing in the way when the load swung and struck IP at chest height.

The investigation has highlighted the importance of effective logistics planning and storage capacity for complex wells and wells that are drilled at a significantly faster pace than previously.

Underlying causes were:

- shortcomings in verifications and follow-up within the organisation
- deficient expertise and experience in the offshore organisation
- shortcomings in the safety culture on board
- incomplete planning and execution of the lifting operation
- inadequate handover at shift change
- inadequate overview of inventory and storage areas.

Four non-conformities were identified by the investigation.

Non-conformities:

- follow-up of organisational and operational factors
- planning and execution of the lifting operation
- transfer of information at shift and crew changes
- handling of hazard and accident situations

2 Background information

During the night shift of Wednesday evening, 8 October 2025, while a lifting operation was in progress using an offshore crane on board Odfjell Drilling's Deepsea Nordkapp facility, an incident occurred that resulted in personal injury. On Friday, 10 October 2025, the Norwegian Ocean Industry Authority (Havtil) decided to investigate the incident.

2.1 Description of the facility and lifting operation

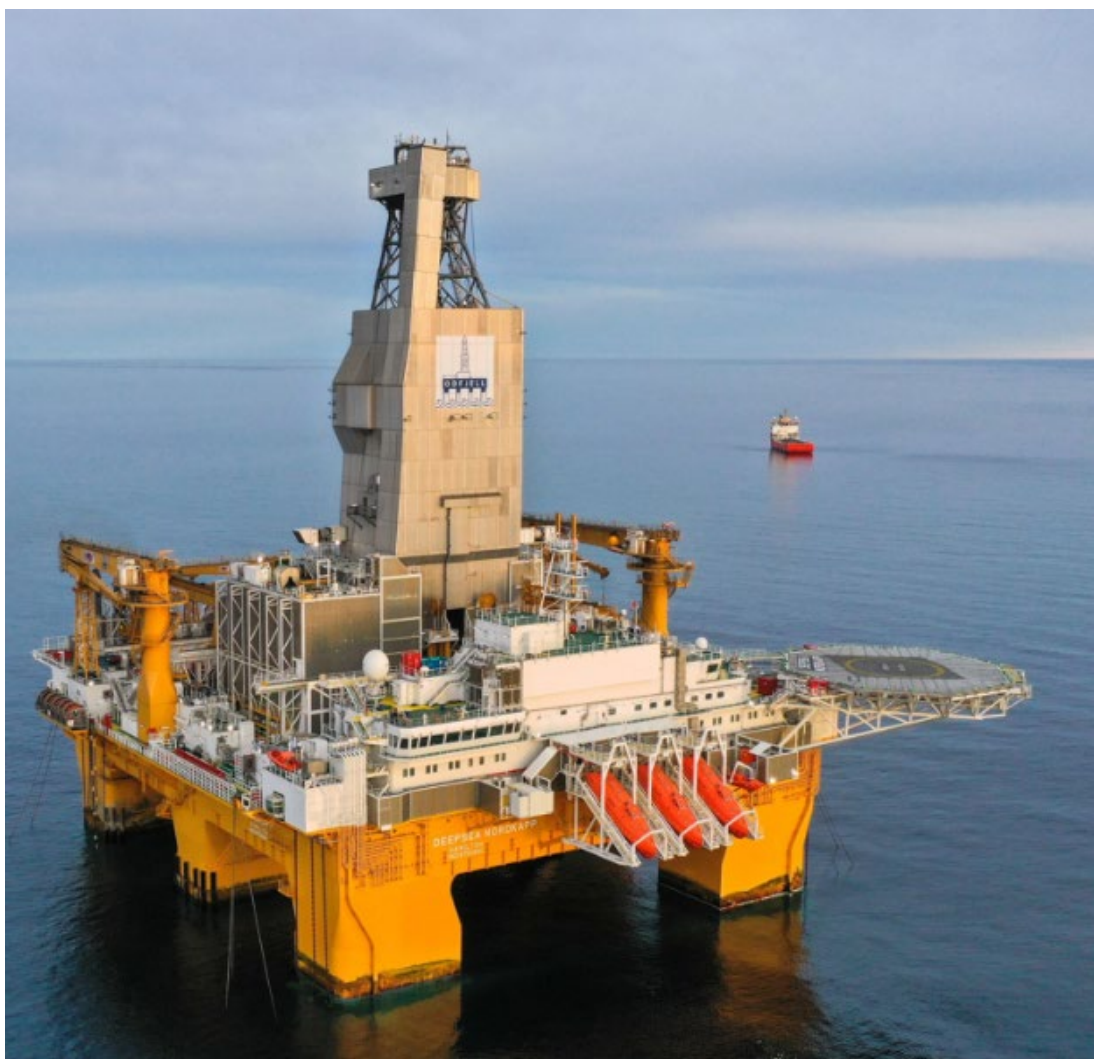


Figure 1: Retrieved from a public website

Deepsea Nordkapp is a semi-submersible drilling facility owned by Odfjell Drilling. The rig was under contract to Aker BP for drilling and completion operations on Aker

BP's Symra field. Aker BP had signed an agreement to extend the lease until the end of 2026.

The incident occurred during the night shift, at around 23:30. The operation underway at the time of the incident was the drilling of well Symra 16/1-EA-2 H. A logging tool for drilling, designated MRIL-WD (Magnetic Resonance Imaging Logging-While-Drilling Sensor), which was used to take measurements in the well, was to be retrieved from the drill floor. The tool consisted of an 11.81-metre tubular sensor section, with a total weight of 2.67 tonnes (referred to in this report as the logging tool). The parts were manoeuvred off the drill deck and placed on the catwalk for further handling onto the storage deck. Prior to this lift, a sealed radioactive source had been lifted in a cargo carrier.

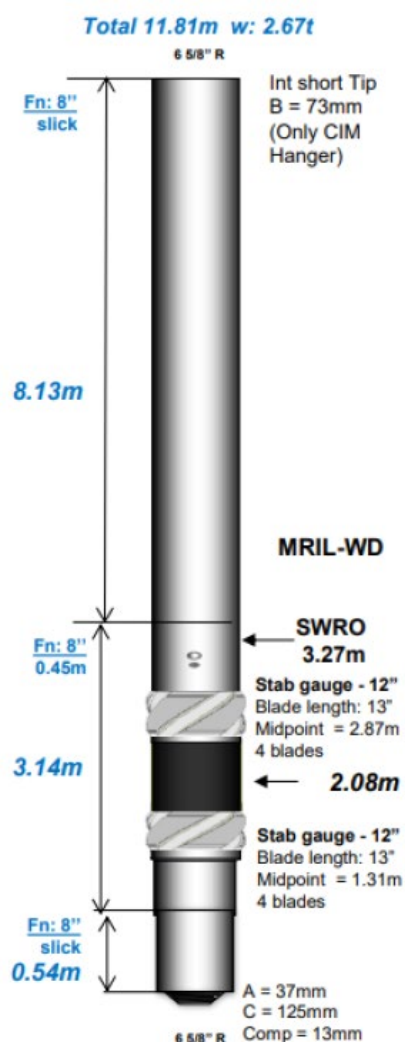


Figure 2: MRIL-WD (Magnetic Resonance Imaging Logging-While-Drilling Sensor), a BHA logging tool that was being lifted when the incident occurred (referred to in this report as the logging tool)

The well operation in progress on DSN was challenging because of the well's particular design, and a large amount of equipment was needed on board to complete the well. This resulted in deck areas that were full, requiring numerous lifting operations.

2.2 Situation before the incident

The weather was calm during the incident, and there was little movement on board DSN.

DSN was working on a well with a complex well structure at Symra. The work required a large amount of equipment on board, which created logistical and storage challenges.

The equipment to be hoisted to the storage deck had been placed on the catwalk by the drill floor crew for further handling by the deck crew. The deck crew consisted of a deck foreman, a crane operator, and four deck operators. During the lifting operation itself, shortly before the incident, one crane operator and one deck operator were present. The other deck operators were on other assignments. The crane operator involved in the incident was undergoing training.

At the time of planning and commencing the lifting operation, the agreement was that a radioactive source would be lifted to the storage area for radioactive sources by the starboard aft winch house. The logging tool itself was to be lowered onto the cuttings deck (wood deck), which is part of the pipe deck. The radioactive source was packed in a carrier, while the logging tool was secured by two fibre slings for attachment to the crane hook. The plan was to use the starboard offshore knuckle boom crane for both the lifting operations.

2.3 Abbreviations

IP	Injured person
DSHA	Defined Situations of Hazard and Accident
IMO	International Maritime Organization
ISM	International Safety Management
MR (Master's Review)	Quote from Odfjell's procedural documentation: <i>Master's Reviews are performed to ensure the Offshore Installation Manager's periodical review of the safety management system and reporting its deficiencies to the shore-based management are performed in accordance with the provisions of the International Management Code for the Safe Operation of Ships and for Pollution Prevention, the ISM</i>

	<i>Code.</i> This is an annual review of the requirements of the IMO Code, with an emphasis on safety, conducted by the offshore installation manager.
DSN	Deepsea Nordkapp
STEP	Sequentially Timed Events Plotting
MSL	Maritime Section Leader. Head of the Maritime Department and operations manager for lifting operations
QHSE	Quality, health, safety and environment
SAFE card	Reporting card on DSN
WP	Work Permit
SJA	Safe Job Analysis
HTO	Human, Technology and Organisation
GA	General Alarm
HSE	Health, Safety and the Environment
OIM	Offshore Installation Manager
SAR	Search and rescue
POB	Personnel on board
HAZID	Hazard Identification
CCTV	Closed Circuit Television
KPI	Key Performance Indicator

Terminology

Catwalk	Machine for transporting pipes between the pipe deck and the drill floor
Pipe deck	Storage area for pipes

3 Havtil's investigation

Composition of the investigation team:

- [REDACTED]
- [REDACTED]

The police and Havtil were notified of the incident by Odfjell Drilling shortly after it occurred.

The incident occurred on Wednesday, 8 October, and Havtil was notified verbally by Aker BP on October 9 at 00:30. On Thursday, 9 October, a meeting was scheduled between Odfjell Drilling and Havtil, during which Odfjell Drilling provided information about the incident.

The police decided to investigate the matter and asked for our assistance. We participated in an interview with the police on 10 October via Teams. During the interview, new information came to light. Based on this new information, Havtil decided to investigate the incident.

The investigation team conducted the investigation from 10 October 2025 to 24 February 2026, in the form of:

- 15 interviews via MS Teams; see the list of interviewees in section 14.2
- a review of relevant documentation; see section 14.1 for a list of the documents reviewed
- a review of Odfjell Drilling's follow-up and verifications of its governing documents
- a review of Odfjell Drilling's internal investigation report.

The investigation was conducted using the STEP and HTO methods.

4 Sequence of events

Three people were directly involved in the incident. These were the crane operator and two deck operators, who served as the signaller and the slinger, respectively. The MSL was operationally in charge of the lifting operation.

4.1 Background information on the personnel involved

- The crane operator involved had worked on DSN for about 1.5 years as a deck operator and had been undergoing training as a crane operator since April 2025. The individual had completed the mandatory training courses and 53 of the 150 required operating hours on the cranes.
- IP was serving as a slinger for the lifting operation at the time of the incident. He held a crane operator's certificate and had extensive experience as a crane operator, deck operator and a deck foreman. However, the individual had not been on board DSN since 2019 and was working his second shift on board when the incident occurred. IP was seconded from Odfjell's expert group to DSN to cover sickness absence.
- The signaller was involved right at the end of the operation. He had been working on board DSN since the facility was new in 2019. This person had worked as a deck operator for a long time.
- The mentor for the crane operator involved, who was in training, was a crane operator himself and had extensive experience as a mentor.
- A cooperation agreement had been entered into with the training provider responsible for the G5 training of the crane operator involved.
- The deck foreman was the leader of the work crew and had extensive offshore experience. However, the deck foreman was not familiar with all the members

of the work crew on that shift, since this was his first trip and only their second shift together. The deck foreman held crane operator certification and was also designated to serve as an independent mentor for crane operators in training.

- MSL was operationally responsible for lifting operations, but had no experience of lifting operations and had not completed training as an operations manager.

Comment on roles, as defined in NORSOK Standard R-003, Appendix A:

- the signaller directs the crane operator during a lifting operation, usually via radio
- the slinger attaches and releases the load from the crane hook, and the slinger may touch the load, but only after consulting with the crane operator and not before the load has been stabilised.

For both roles, it is important that they always remain in a safe area when the load is in motion and have a clear escape route. This is referred to as "keeping your escape clear".

4.2 The sequence of events

The crane operator, IP and the rest of the deck crew arrive on Deepsea Nordkapp on Tuesday, 7 October.

The shift began on Wednesday, 8 October at 19:00 (night shift). A routine shift meeting was held with the entire shift in attendance:

- the deck foreman
- the mentor for the crane operator involved (mentor)
- the crane operator involved (crane operator)
- the deck operator who was injured was the slinger during the incident (IP)
- the deck operator who served as the signaller during the incident (signaller)
- a deck operator who was not involved in the incident.

The deck crew worked on various tasks until the coffee break at around 22:00. After the coffee break at 22:00, the crane operator was asked by the deck foreman to perform two lifting operations. The mentor was not present and was therefore not involved in the decision. The two lifting operations involved:

- moving a radioactive source from the drill floor to the landing area for radioactive sources by the starboard aft winch house
- lifting a logging tool from the catwalk down onto the cuttings deck, which is part of the pipe deck.

A briefing was held between the crane operator, the signaller, and IP before they began the first lifting operation.

While the crew was out on deck working, the deck foreman and the mentor held a meeting indoors to review the deck crew's competence and get to know each another.

The first lifting operation involved a load carrier containing a radioactive source that was to be lifted from the catwalk to the landing area for radioactive sources (starboard aft winch house). The roles were assigned as follows:

- IP to sling the load carrier on the drill floor
- the signaller to be on the storage deck by the starboard aft winch house
- both to serve as signallers and slingers on their respective storage decks.

Since the crane operator had a clear view of the area, only one deck operator was involved in the lifting operations.

The second lifting operation involved moving the logging tool from the catwalk down to the cuttings deck. The logging tool was provided and owned by a third party. The logging tool was secured with two fibre slings that were to be attached to the crane hook. The way it was slung caused the logging tool to have an asymmetrical centre of gravity, so that it hung askew on the hook. The end that later struck IP was higher above the deck than the other end.

Shortly after the logging tool was lifted from the catwalk, an instruction concerning changes to the lifting operation were received over the radio in English. The instruction came from a person unknown to IP, the signaller and the crane operator. The parties involved were informed that the logging tool was not to be placed on the cuttings deck after all, but instead be loaded into a custom carrier. Uncertainty then arose as to where this carrier was located. The crane operator therefore chose to swing the logging tool out over the water while the discussion was taking place over the radio. In interviews, it emerged that:

- it was difficult to understand what the person was saying, as his English was hard to understand, and it turned out that he represented the company that owned the logging tool
- the amount of information transmitted directly over the radio while the lift was in progress was perceived as disruptive
- the parties involved in the lifting operation considered it very risky to return the logging tool to the catwalk from which it had been lifted
- the parties involved assessed that the logging tool could make an interim stop at the originally planned landing area on the cuttings deck
- the person on the radio expressed concern that the logging tool might be damaged by this
- IP and the signaller were asked to find a long carrier with a custom crate or cradle into which the logging tool could be packed

- it was unclear where the carrier was located on board, so IP and the signaller began searching while the crane operator left the logging tool hanging over the water
- the owner of the logging tool emphasised the importance of ensuring that the logging tool was oriented correctly when it was placed in the carrier.

The carrier, which was difficult to place the logging tool in, was soon located in the middle of the pipe deck, among several other carriers. The deck crew was not familiar with carriers equipped with protective crates/cradles like this one.

The pipe deck where the carrier was located was crowded with other carriers and equipment, which made it very difficult for the deck operators to “keep their escape clear”. IP adopted the role of both signaller and slinger, while the other signaller continued with other tasks nearby that were unconnected to the lifting operation in progress on the pipe deck.

At that point, the logging tool was hanging askew, and because of its length, it was difficult to handle. During lowering, the logging tool underwent uncontrolled lateral swaying motions. IP touched the logging tool several times and was positioned underneath it on several occasions. Touching the logging tool had not been authorised by the crane operator.

The use of a tag line or push-pull stick was deemed impractical, and it would have been difficult to find a suitable position from which to use it

In the final stages of the lifting operation and just before the incident occurred, IP requested assistance over the radio. The reason was that it became difficult to try to control the logging tool using his body and arms while he was trying to direct the crane operator over the radio. The subsequent sequence of events was as follows:

- the signaller who was working nearby came over to the area where the lifting operation was taking place and took over the role of signaller, in agreement with the crane operator
- almost immediately after that, IP was struck by the logging tool when it made an unexpected sideways movement
- the blow IP received from the logging tool was so powerful that he fell to the ground and remained there, suffering serious injuries to the upper body
- the control room was notified that an incident involving personal injury had occurred
- the logging tool was quickly lowered into a provisional position and unhooked from the crane hook by the signaller
- the crane was secured and the lifting operation was terminated
- we were informed that, following the incident, no general alarm was sounded and that OIM was alerted after 8 minutes

- the injured person was removed by stretcher and transported to Haukeland University Hospital by SAR helicopter.

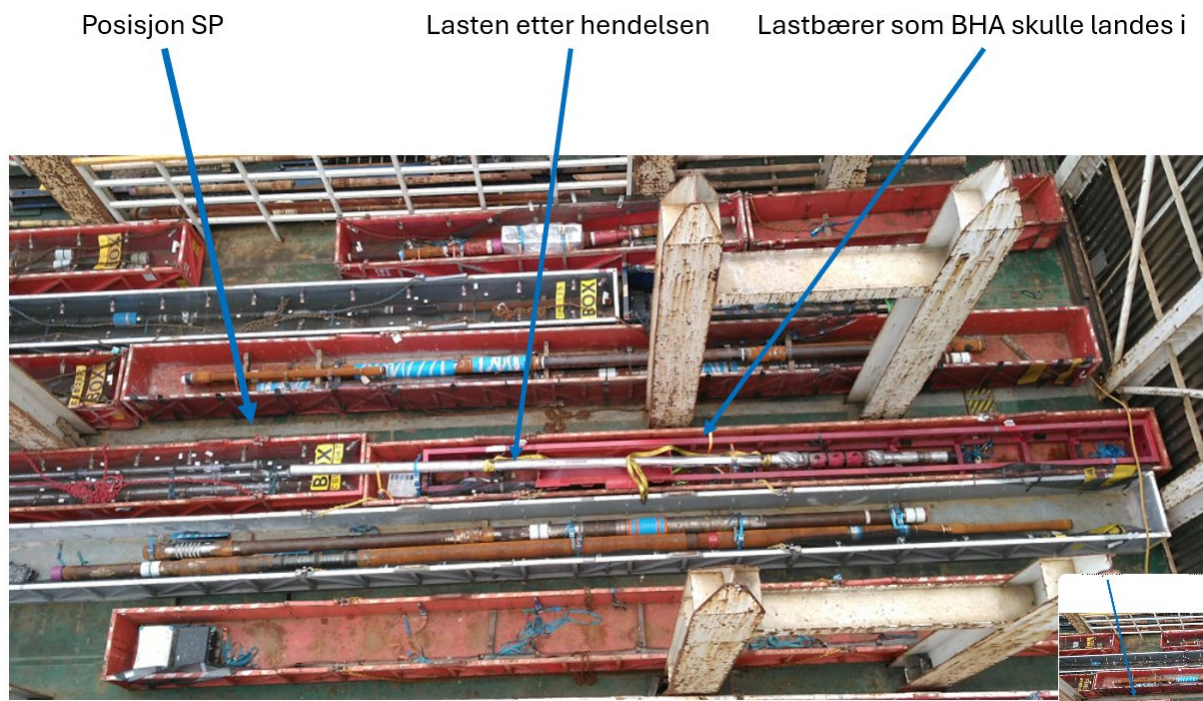


Figure 3 – Overview of the incident

5 Potential of the incident

5.1 Actual consequences

IP was struck by the logging tool, resulting in a broken arm as well as several broken ribs. In addition, the person sustained internal injuries.

The incident did not result in any property damage or environmental contamination.

5.2 Potential consequences

Under slightly different circumstances, the incident could have resulted in more serious injuries or possibly death. Havtil does not know whether IP will suffer long-term damage as a result of the injuries he sustained.

6 Direct and underlying causes

The investigation identified a number of direct and underlying causes of the incident.

6.1 Direct causes

The direct cause of the incident was that, during a lifting operation, the load was not fully under control, and the injured person (IP) was standing in the travel path in front of and, at times, directly beneath the load. As a result, IP was struck by the load while the crane operator was trying to regain control.

6.2 Underlying causes

The investigation identified several underlying causes.

6.2.1 Inventory and Inventory overview

Through interviews and meetings with Aker BP, we were informed that, at the time of the incident, the storage decks on DSN were filled to capacity with carriers and equipment, and that the well in progress was particularly demanding and required a large amount of material on board the rig. Previously, supply vessels or storage vessels had been used for temporary storage, but this option was not considered during this operation. Neither Aker BP nor Odfjell Drilling had assessed the lack of storage space on board DSN as a risk.

It was verbally communicated to the MSL on board that the amount of stored equipment on the rig posed a safety risk. It was Aker BP's representative on board who was responsible for keeping track of the equipment. The inventory of equipment stored on board was updated only when cargo was received on the rig. If equipment or carriers were moved around on the facility, no one was responsible for keeping track of this.

A lack of oversight, combined with overcrowded and cramped cargo decks, was a contributing factor to the incident; see the section below for more details.

6.2.2 Expertise and experience in the offshore organisation

Several of the parties involved in the incident (both those carrying out the work and those with line management responsibility offshore) were new to their roles, new on the shift, or undergoing training:

- IP travelled out to DSN at short notice. IP was part of Odfjell's in-house talent pool and was working his second night shift. IP had not been on board since 2019
- the deck foreman was new on this shift and did not know all the members of that particular deck crew
- the crane operator was in training and was not authorised to operate the offshore crane without a mentor present, whether in the crane cab or as a deck operator

- MSL was new to the role and also new as an operations manager (it was his fourth time on duty) and he had still not completed the mandatory training course
- MSL was operations manager for lifting operations and was on his fourth trip to DSN. Training as a operations manager had not been completed, and he lacked experience of lifting operations
- OIM was a deputy for this role and was in training as an OIM
- a third party representing the company that owned the logging tool to be retrieved was making his first trip to the Norwegian Continental Shelf.

The only directly involved person with experience in his role aboard DSN participated only in the very final phase of the lifting operation as a signaller.

A generic organisational chart is shown in the figure below. The organisational chart shows that everyone, from the OIM down to the deckhands, was either new to or inexperienced in their roles. The red boxes indicate the roles mentioned in the bullet points above, while experienced personnel are shown in the green boxes.

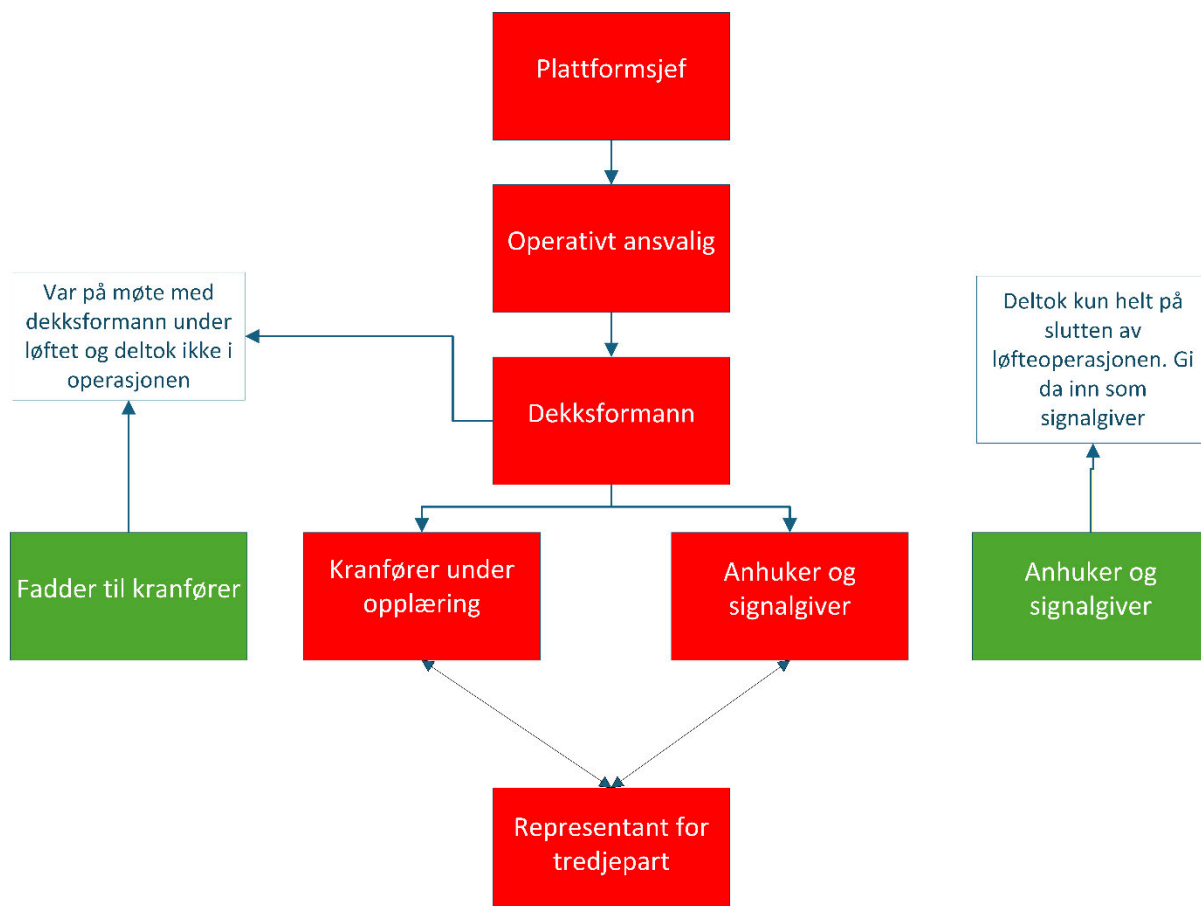


Figure 4 Illustration of the relevant part of Nordkapp's offshore organisation. Red indicates individuals on the shift with insufficient experience and expertise.

In the 2023 Master's Review (MR), a lack of expertise and a lack of an overview of expertise were among the observations. Examples of these from MR 2023 include:

- *"During 2023 we have experienced that personnel not familiar on the rig or in the company are sent offshore to replace sick leave or similar"*
- *"There have been examples where personnel are sent offshore or personnel are working in higher positions without required training".*

Similar findings were again identified in MR 2024 as still outstanding. The action plan established for this observation specifically states that the procedure must also include a list of courses and certifications, such as those for crane operations. The MR 2024 states:

- *"Establish an L4 procedure that specifies the training requirements [...]"*
- *"In general lack of knowledge and follow up of RIDER as governing system for competence".*

In interviews, it was noted that concerns have been raised about too many new workers being sent offshore.

6.2.3 Handover

The transfer of information at shift and crew changes is an important part of the organisational barrier. The transfer of information relevant to health, safety and the environment should help ensure that the incoming shift can perform their work safely and securely.

Odfjell Drilling's governing document L3-MODU-ALL-PR-006N states that shift handover procedures must include the following elements:

- status of ongoing operations
- scheduled operations for the next 48 hours
- QHSE/risk
- concurrent operations.

The same document refers to a format to be used for shift and crew handovers.

A review of handover documentation from various dates revealed that information concerning the last three bullet points above was missing. The template referred to in L3-MODU-ALL-PR-006N was not used. It emerged in several interviews that the subject of the last three bullet points above was not discussed verbally either.

6.2.4 Planning and execution of lifting operations

Odfjell has adopted NORSOK Standard R-003N as the basis for its internal management system for the safe use of lifting equipment.

In connection with the investigation of the incident and the lifting operation itself, we have identified several breaches of governing documents, such as Odfjell Drilling's own procedure "L3-MODU-NO-TO-PR-012N – SAFE USE OF LIFTING EQUIPMENT."

Planning:

Lifting operations must be planned in advance and, if possible, entered into a planning system. It emerged from several interviews that this was not the practice on board.

An interview revealed that a discussion about the work took place before the lifting operation began. The discussion focused on only two of the operations:

- moving a radioactive source from the drill floor to the landing area for radioactive sources (starboard aft winch house)
- lifting a logging tool from the catwalk down onto the cuttings deck, which is part of the pipe deck.

Odfjell Drilling carried out the lifting operations as routine lifts. A routine lift in accordance with the company's procedures requires little or no additional planning.

According to the materials handling plan for DSN, the overhead crane is to be used for lifting operations between the pipe deck and the catwalk. However, for this lifting operation, it was deemed most appropriate to use the offshore knuckle boom crane.

No special considerations were made, nor was a preliminary assessment conducted, as to whether the offshore crane was suitable for lifting the long, sling-mounted logging tool. With the overhead crane, the logging tool would have had two attachment points to the crane, which would have provided steering, control and stability for the logging tool. The role of the slinger would then have been to hook and unhook the load.

When lifting long loads, tag lines or similar gear may be used to maintain a safe distance from the load. It emerged in interviews that this was deemed to be unsuitable for controlling the long logging tool. At the same time, one of the interviewees stated that it was planned to use a push-pull stick. Odfjell Drilling's procedure requires that if a specific operation requires personnel to be in direct contact with the load – for example, using a push-pull stick – that the operation must be reviewed in a HAZID, and a separate procedure must be established describing the mitigating measures to be implemented. Such an operation requires a WP. A WP had not been established or applied for in connection with the lifting operation in question. Internal documents require that the operator approve the use of these

assistive devices, which had not been done either. By using the offshore knuckle boom crane to perform the lifting operation, the personnel involved chose a method that was challenging for the crane operator, especially without the aid of a tag line or push-pull stick. Since the logging tool was attached only to the crane hook, it was difficult to control the load without being in direct contact with it.

During the actual lifting operation, a third party – who owned and was responsible for the logging tool – gave an instruction by radio that the operation had to be modified, as the logging tool was not to be placed on the cuttings deck after all. Instead, it was to be placed in a specially designed carrier containing a crate for the logging tool itself. The deck operators began searching for the crate described by the third party. They did not know where the crate was located. After locating it on the pipe deck, just beyond the cuttings deck, the deck operators decided to continue the lifting operation. At this point, IP took on the role of both slinger and signaller. This was despite the fact that the lifting operation had now been modified and further complicated, since the logging tool had also to be placed in a custom crate.

In the event of changes during a lifting operation, Odfjell Drilling's management system sets the following requirements: "If the assumptions on which the planning and risk assessment were based change during the operation, the operation must be halted, and the need for a new risk assessment and the implementation of any corrective safety measures must be evaluated." Following this change, the lifting operation should have been halted and replanned in accordance with the established procedure. In our view, given such a change, the operation should have been classified as Level 2, based on our interpretation of Odfjell's management system. Level 2 requires a WP, SJA, or other safety measures if they still planned to carry it out using the offshore crane.

Implementation:

Odfjell's own lifting manual stipulates that "*All unnecessary use of radio, noise, or activity that may distract the operator of lifting equipment shall be avoided*". During the lifting operation, an outside third party intercepted the radio communication and altered the plan for the operation. Several interviews have revealed that it was difficult to understand what the third party was saying, and that this was perceived as a significant disruption during this part of the lifting operation. It also emerged during the interviews that it was not uncommon for personnel who were not directly involved in the lifting operation to join the communication channel and cause disruptions or alter the plan for the operation.

The change meant that the logging tool was to be placed in a custom carrier. The carrier had openings designed to protect vulnerable parts of the logging tool during transport, which made it difficult to place the logging tool in the cradle. The openings had to be open so that the logging tool could be securely placed in the cradle. The

carrier was located on the pipe deck. The pipe deck was crowded with other carriers and equipment, making it difficult to keep an escape route clear for carrying out the lifting operation. It has emerged from interviews that all the equipment on the deck made it confusing and challenging to work there. Odfjell Drilling's procedure for the safe use of lifting equipment states: *"All personnel involved in the lifting operation must ensure that they have a clear escape route during all phases of the operation. Those involved in the lifting operation must continuously assess whether the area where the operation is taking place is considered a cramped landing area"*. Several interviews have revealed that cramped cargo decks have been a challenge on board for quite some time.

According to witnesses and CCTV footage, in an attempt to guide the logging tool into the cradle in the load carrier, IP made physical contact with the logging tool on several occasions in order to gain control of it. A general requirement in NORSOK R-003 regarding safe lifting operations is that the slinger must not come into contact with the load until it has been stabilised and the all-clear has been given by the lifting device's operator. There is also a requirement that the crane operator and the slinger must communicate before the slinger makes contact with the load. This was not adhered to on board DSN during the lifting operation in question.

Furthermore, CCTV footage shows that IP was also positioned in such a way that there was not a clear escape route at all times due to the overcrowded cargo deck. IP was also periodically positioned directly beneath the load and in its travel path. This positioning is identified as one of the direct causes of the incident.

6.2.5 Work permits

Odfjell Drilling's governing document for work permits, "L3-MODU-ALL-HSE-PR-014N – ARBEIDSTILLATELSE", states:

A WP is required for medium-risk work. This is work that, due to the risks involved, requires coordination and clarification within a specific area or system. For medium-risk work, an SJA is required if hazards have not been adequately identified and controlled through relevant procedures or work instructions.

The need for an SJA shall be based on the following criteria:

- *the first time you are performing the task(s)*
- *procedure/work instructions/documentation not clear*
- *[...]*
- *workers who lack experience of the task*
- *the risks are unclear to the workers.*

6.2.6 Follow-up of own organisation

In the course of our investigation, we have examined whether the company's overall follow-up activities were a contributing factor to the practice and manner in which the lifting operation was carried out during the course of the incident.

Odfjell Drilling has two main categories for follow-up:

- L1-CORP-QU-PR-011 - AUDITING
- *"This procedure describes how audits for Odfjell Drilling will be planned, reported conducted and followed up."*
- L3 – INSPECTIONS - -MODU-ALL-QU-PR-008
 - "This procedure provides a framework of systematic inspections in a variety of activities to raise and maintain company standards"
 - This document describes several different methods for follow-up, and the following should be noted in particular:
 - Management inspection
 - Self-verifications.

The basis for L1 – AUDITING:

L1 – Auditing is Odfjell's highest level of oversight of its organisation and operations. The process is described in the governing document "*L1-CORP-QU-PR-011-AUDITING*"

In interviews and in Odfjell Drilling's governing documents, the following processes were highlighted as key to establishing a risk-based foundation for an "L1 audit plan":

- management inspection
 - Described in the L3 procedure "MODU-ALL-QU-PR-008".
- Master's Review
 - OIM's annual report on offshore operations in relation to the IMO and ISM Codes.
- annual team meetings (onshore)
 - we are told that there are meetings onshore once a year. We requested documentation or minutes from these meetings. These were not received, but reference was made to part of the Master's Review (MR)
- It was emphasized in an interview that a member of DSN's onshore organisation played a key role in incorporating relevant DSN information and risks into the L1 auditing process.
- critical operations/projects
- output from the management review, statistics and analysis

Our investigation has revealed that several of the processes listed did not, in practice, constitute a sufficient risk-based basis for the "L1 Audit Plan".

Relevant follow-up activities:

- According to Odfjell Drilling, Management Inspection is a key process for the onshore organisation to monitor the offshore organisation. Our review of the

last six Management Inspection reports revealed weaknesses and shortcomings related to, among other things, the description and documentation of the inspection, reporting to Synergi, the completion rate (which focus areas were addressed during the inspection), and participation in the inspections. The interviews revealed that the reports produced as a result were of poor quality and unsuitable as a basis for, or input into, the L1 plan.

- The MR is limited to follow-up of the IMO and ISM requirements (flag state requirements). This is highlighted by Odfjell Drilling as the offshore management's assessment of the offshore organisation. A review of MRs for 2023 and 2024 revealed that several initiatives from 2023 had been closed but were reopened in 2024 and remained open. Examples of these issues include a lack of clarity regarding competences, a lack of training, and a lack of clarity regarding requirements, including in the area of logistics at DSN. Several of the observations were still open at the time of the incident.
- We requested information and feedback from the annual team meetings
- However, this feedback was not documented but was included in the Master's Review. This document is a preformatted template for the OIM's evaluation of specific points related to ISM and IMO
- Self-verifications (L3-MODU-ALL-HSE-PR-038) are described in the governing document as "*...activities can be conducted before, during and/or on completion of an activity, risk based activities shall be prioritized. Supervisors/Leaders/Managers that have the relevant competence requirements for position to undertake the verification has to join safety delegate and other crew members the first times performing a Self-verification. Self-verifications must be conducted at the worksite and also incorporate the service providers onboard.*"

Self-verifications are documented using SAFE cards. Over 7,000 items were reported in 2025. These 7,000+ SAFE cards, together with the management inspections conducted, did not reveal the challenges related to:

- full cargo decks
- deficient compliance with procedures
- lack of expertise and experience in the shift
- shortcomings in handover routines
- lack of oversight of the offshore organisation by offshore management
- a lack of safety culture for preventing hazardous situations such as this one.

Summary:

The investigation revealed that several of the follow-up activities targeting the offshore operational environment had weaknesses, such as the onshore organisation's direct follow-up of offshore operations via *Management Inspections*. The basis for establishing a risk-based L1 audit plan also had weaknesses.

It is difficult to draw a definitive conclusion as to whether shortcomings in the company's follow-up were a cause of the incident. At the same time, the investigation revealed strong indications that more relevant and tailored follow-up measures could have helped prevent the inappropriate work practices that led to the incident.

Examples of such factors related to the incident include:

- deficiencies at handover
- challenges related to limited deck space and storage areas
- lack of compliance with procedures related to crane and lifting operations
- monitoring of competence and a lack of minimum requirements for competence
- a lack of structure and implementation of verification activities within the offshore organisation.

It is our assessment that the company does not require more follow-up activities, but that those described in the governing documents should be planned and carried out in a more risk-based and appropriate manner.

6.2.7 Safety culture

An important safety barrier is the right to halt dangerous activities. This is also something the management of Odfjell Drilling is clear about. Interviews revealed that there were challenges in the operational teams offshore on DSN. In the summer of 2025, a "Safe Summer" campaign was launched, featuring a dedicated coach who was on duty during all shifts on DSN. This proactive campaign focused on the safety culture on DSN, addressing the topics of communication, development and team building. In October 2025, safety culture was also addressed at a "Safety Performance Conference".

Interviews and a review of CCTV footage reveal that several of the people who participated in and observed the lifting operation did not halt the work.

The investigation revealed that the way the lifting operation was carried out was considered standard procedure on board. We discovered:

- lack of visibility regarding cargo in the loading areas
- inadequate performance of handover
- lack of planning and risk assessment of work tasks
- undisciplined radio communication
- the establishment of L1 verification plans and the low quality of the Management Inspection
- lack of follow-up of offshore work crews
- a high level of activity associated with the need for, and performance of, materials handling to and from the drill floor using lifting equipment

- failure to halt hazardous work.

The findings above confirm that there are shortcomings in the safety culture.

7 Lessons for the industry following the incident

The drilling rate (metres per day) offshore on the Norwegian Continental Shelf is increasing, leading to challenges in materials handling. This requires greater storage capacity and more rigorous planning at every stage of the logistics chain.

7.1 Time pressure

An important KPI for a drilling rig is the number of metres drilled per day. This has increased significantly in recent years. Increased drilling speed places a greater workload on the logistics division due to a larger volume of equipment and more lifting operations.

7.2 Storage space on the rig

The well to be drilled was a complex one, both in terms of the casing programme and its length. This also meant a large amount of equipment that was challenging to store on board. In several interviews, it was mentioned that a standby vessel had been used as a temporary storage area for previous wells, and that this had been beneficial in terms of maintaining order and keeping track of equipment on board.

7.3 Insufficient information about the incident provided to Havtil

Havtil received notification of the incident from Odfjell Drilling on 8 October and further information about the incident on Thursday, 9 October. Havtil assisted the police in an interview on Friday, 10 October. During the interview, new information about the incident came to light. Based on this new information, Havtil decided to investigate the incident.

A lack of information and details in reporting gave us a misleading impression of the incident when we received the original notification and information about the incident from Odfjell. As a result, it took some time before the investigation was launched.

7.4 Learning from other incidents

Shortcomings in handover and planning, as well as a lack of oversight of high-risk activities, have been identified as contributing and underlying causes in several incidents involving materials handling and lifting operations.

8 Emergency preparedness

It is the OIM or their deputy who decides when to activate the General Alarm (GA). During this incident, it took approximately 8 minutes for OIM, who was asleep, to be alerted, and a few more minutes before he was informed of the situation. The OIM's night shift deputy decided not to deploy the GA.

Emergency preparedness management of the incident:

The incident involved a personal injury (Odfjell Drilling's DFU-19). A medic was roused and the first-aid team was alerted by the bridge. A SAR helicopter was requisitioned early in the process. The injured person was carried to the SAR and flown to the hospital shortly thereafter.

Alarm, notification and mobilisation:

A general alarm (GA) is required to:

- inform all personnel on board of the emergency
- ensure that emergency response resources are available in the event of an escalation
- prevent personnel from getting in the way and halt activities that could make the situation worse
- ensure that the emergency personnel have mustered and been informed

In Odfjell Drilling's emergency response plans and DFU-19, the GA is described as the first step in managing the incident. The last two DFU-19 training sessions (July/August 2023) included the use of the GA.

During this incident, the GA was not triggered by a manager on the bridge, despite internal requirements set out in procedures and protocols established during previous training.

Response and rescue:

The first-aid team was mobilised and attended to the injured person.

A SAR helicopter was requisitioned and carried out the evacuation to the hospital.

Performance requirements in DSN's emergency response plan:

A POB check is critical for gaining an overview and determining whether there are additional casualties or if other incidents have occurred in parallel. Without deploying a GA, it is difficult to obtain an overview of this.

Chapter 6 of DSN's emergency response plan states: "[...] *An overview of the key time requirements in the emergency response plans is shown in Figure 6-1 [...]*". Within 1 minute, the OIM must be notified and a PA announcement must be made. The emergency response team must be in place within 6 minutes.

The OIM was alerted 8 minutes after the incident was reported to the bridge and determined that a GA was not necessary at that late stage.

Normalisation and conclusion of the emergency response operation:

After the evacuation, the situation was brought under control, but the lack of GA and POB checks indicates non-conformity with procedures.

The emergency response plan was not followed.

Other comments:

In the 2023 MR, an initiative was proposed to establish an L4 procedure to specify training requirements for all members of the emergency response team (as the MR noted that this was lacking). It was reported as closed, but the same motion was raised again in the MR for 2024 with the following text: *"Establish an L4 procedure that specifies the training requirements for emergency team members, including guidelines for situations where we are not in compliance with course/certificate requirements"*

Other relevant initiatives:

The 2024 MR also includes a motion with the following text:

"In general lack of knowledge and follow up of RIDER as governing system for competence.

[...] but our experience is that some teams were not sufficiently robust during incidents. Especially emergency management and technical teams, as well as fire teams. Further improvements are needed to ensure an effective response during incidents."

9 Regulations

Odfjell Drilling has chosen to adopt the NORSOK R-003N standard on the safe use of lifting equipment as a norm for ensuring compliance with regulatory requirements related to lifting operations.

10 Observations

10.1 Non-conformities

10.1.1 Planning and execution of lifting operations

Odfjell Drilling had not ensured that lifting operations on Deepsea Nordkapp were approved, supervised and carried out in a safe manner.

Rationale

The lifting operation was not carried out in a safe manner, in that:

- the applicable requirements and procedures for lifting operations were not followed
- the applicable requirement that personnel possess the requisite competence to perform the activities was not met
 - the operations manager was not qualified for the task
 - the crane operator was certified but was not qualified to perform and supervise the lifting operation
 - the deck operator was not qualified to control the load.

See chapter 6.2.4 for a detailed description.

Requirements

The Activities Regulations, section 92 concerning lifting operations

The Activities Regulations, section 21 concerning competence

10.1.2 Transfer of information at shift and crew changes

Odfjell Drilling had not ensured the transfer of information at shift and crew changes of importance to health, safety and the environment when performing lifting operations on Deepsea Nordkapp.

Rationale:

Through interviews with both operational and managerial personnel and our review of handover documentation, it emerged that operations that had been performed or were to be performed during the shift were not documented or discussed by the personnel involved. Assessments of HSE risks and concurrent operations were also not included in the handover documentation. The handover procedure outlined in Odfjell Drilling's governing documents was not followed. See also chapter 6.2.2 on handover.

Requirements

The Activities Regulations, section 32 concerning the transfer of information at shift and crew changes

10.1.3 Handling of hazard and accident situations

During the lifting incident on Deepsea Nordkapp, Odfjell Drilling had not ensured that measures were implemented as quickly as possible to rescue personnel in the event of an accident.

Rationale

A General Alarm (GA) was not triggered when the injury was reported.

The lack of a GA and an 8-minute delay in notification to the OIM meant that the emergency response personnel on board were unable to implement the necessary measures as quickly as possible.

A GA would have helped ensure that activities were halted and that emergency response resources were available at an earlier stage.

Requirements

The Activities Regulations, section 77 concerning the handling of hazard and accident situations

10.1.4 Follow-up

Odfjell Drilling's follow-up had not identified any weaknesses in the performance and management of lifting operations on Deepsea Nordkapp.

Rationale

Odfjell Drilling has carried out a number of follow-up activities but has not identified any significant weaknesses in key organisational processes. In our investigation, we detected the following:

- Several key follow-up activities within the company, which also formed the basis for the "L1 Auditing" plan, had weaknesses
 - our review of the last six *Management Inspection* reports revealed weaknesses and shortcomings in the description, documentation of the inspection, reporting to Synergi, completion rate and participation in the inspections. It was confirmed in an interview that the reports were not suitable as a basis for an L1 plan.
 - Our review of *Master's Reviews* for 2023 and 2024 showed that initiatives from 2023 that had been closed were apparent again in 2024 and that they were continued in 2024
 - *Self-verifications*, documented through SAFE cards, did not reveal any challenges related to full cargo decks, non-compliance with procedures, lack of expertise and experience on shifts, deficiencies in handover routines, lack of follow-up of the offshore organisation by the offshore management, or lack of structure and implementation of verification activities.

See section 6.2.6 for a further description of shortcomings in the identification, planning and implementation of the company's follow-up activities.

- governing documents concerning handover were not followed; see section 6.2.2
- In connection with the execution of the lifting operation, a lack of expertise and experience among the operational and managerial personnel was not identified as a risk or followed up; see section 6.2.1.

- A number of breaches of the governing documents relating to lifting operations were not identified. This applied to requirements concerning:
 - planning of lifting operations
 - use of an overhead crane for lifting operations between the pipe deck and the catwalk
 - contact with the load during lifting operations
 - change to a lifting operation
 - use of radio
 - clear escape routes during lifting operations
- Odfjell Drilling has itself identified challenges with the offshore operational teams at DSN. In the summer of 2025, a proactive campaign was launched to raise awareness of safety culture, addressing the topics of communication, development and team building. In October 2025, safety culture was addressed at a multidisciplinary meeting, where, according to the interviews, the way a lifting operation of this type was planned and executed was considered standard procedure on board. Several people on board and participants in the lift itself witnessed the operation without halting it. See chapter 6.2.7 for a further description of safety culture.

Requirements

The Management Regulations, section 21 concerning follow-up

11 Barriers that worked and those that did not

11.1 Barriers that worked

In our assessment, the emergency response measures on board – including first aid and the transport of the injured person from the accident site to the helideck and onward by SAR to Haukeland Hospital – functioned as described in the DSN emergency response plan.

11.2 Barriers that did not work

Our investigation revealed that several key barriers failed to work. For detailed descriptions, please refer to, among other things, Chapter 6 and the safety incidents identified in STEP; see section 14.3.

Some key barriers relating to safe lifting operations that did not work include:

- personnel involved in or witnessing the lifting operation, who should have been in a position to understand the risks, did not give a stop signal to halt the operation
- all personnel involved in the lifting operation must ensure that they have a clear escape route during all phases of the operation
- the load was handled manually, without the use of equipment for controlling it.

- a lack of risk assessment for lifting operations related to:
 - selection of an offshore crane instead of an overhead crane
 - changes to the load travel path and the lifting operation
 - competence within the operational team
- the handover was inadequate
- failure to verify measures implemented to ensure compliance with the company's own management system in respect of lifting operations.

12 Discussion concerning uncertainties

Havtil has not been on board Deepsea Nordkapp to inspect the area where the incident occurred. As a result, certain matters were not addressed in the investigation, such as:

- the crane operator's line of sight from the crane cabin (the overhead crane was parked between the landing area and the crane cabin)
- lighting conditions at the time of the incident
- the physical conditions on the cargo deck, the cargo carrier involved in the incident, and other conditions on board.

13 Assessment of the company's investigation report

Odfjell Drilling's investigation is consistent with our own investigation regarding the sequence of events, the conditions on board before, during and after the incident, and the direct cause of the incident.

Our review has identified shortcomings in how the company monitors and ensures compliance with its own management system. The report from Odfjell Drilling does not shed much light on these shortcomings.

The investigation team was led by, and partly comprised of, personnel from the part of the organisation responsible for establishing Odfjell Drilling's programme for follow-up of the organisation. This includes, among other things, a programme for monitoring the organisational and operational aspects of lifting operations.

14 Annexes

A: Relevant sketches/figures/etc.

14.1 The following documents were used as a basis for the investigation:

VEDLEGG NR 03 - DSN - DAGLIG HANDOVER MARINE - TIRSDAG 15. OKT 07.00 - DOCS-2691038

VEDLEGG NR 04 - DSN - DAGLIG MARINE HO 08.10.25 - DOCS-2691046
DSN - Deepsea Nordkapp - Information gathering

VEDLEGG NR 01A - DSN - ORGANISASJONSKART DSN OFFSH
 VEDLEGG NR 01B - DSN - L1-CORP-009-32 - ORGANISASJORGANISASJONSKART
 DSN ONSHORE
 VEDLEGG NR 01C - DSN - L1-CORP-009-010 - ORGANISASJONSKART TECHNICAL
 SERVICES - KRAN OG
 VEDLEGG NR 01D - DSN - L1-JD-MODU-OFS-006 - JOB DESCRIPTION CRANE
 OPERATOR
 VEDLEGG NR 01E - DSN - L1-JD-MODU-OFS-004 - JOB DESCRIPTION DECK
 FOREMAN CRANE OPERATOR
 VEDLEGG NR 01G - DSN - L1-JD-MODU-OFS-008 - JOB DESCRIPTION ROUSTABOUT
 VEDLEGG NR 02B - DSN - L4-MODU-DSN-C-PR-109N - SIKKER BRUK AV
 LØFTEINNRETNINGER
 VEDLEGG NR 02C - DSN - L4-MODU-DSN-C-PR-128N - LØFTEOPERASJONER OM
 BORD DSN
 VEDLEGG NR 02D - DSN - L4-MODU-DSN-C-PR-131N -
 MATERIALHÅNDTERINGSPLAN
 VEDLEGG NR 02E - DSN - L4-MODU-DSN-C-PR-133N - ROLLER OG ANSVAR UNDER
 LØFTEOPERASJONER DSN
 VEDLEGG NR 02F - DSN - L4-MODU-DSN-C-WI-170N - SPERREPLAN
 VEDLEGG NR 03A - DSN - L4-MODU-DSN-C-PR-108N - DSN RIGG SPESIFIKT
 VEDLEGG C NORSOK R-00
 VEDLEGG NR 04A - DSN - DSN DECK CREW COMPETENCE -
 VEDLEGG NR 04B - DSN - CV - ██████████ MO
 VEDLEGG NR 04C - DSN - CV - ██████████ DEEPS
 VEDLEGG NR 04E - DSN - CV - ██████████ DEEPS
 VEDLEGG NR 04F - DSN - CV - ██████████ DEEPSEA N
 VEDLEGG NR 05A - DSN - 3745-MM-RD-101-001 - MATERI
 Investigation Report - Njord A - Falling objects following a collision between an
 offshore crane and a derrick
 DSN - Deepsea Nordkapp - Additional documents related to the investigation - Havtil
 email dated 16 October 2025 - Response - Version 2 - dated 24 October 2025 - Docs-
 2691187
 DSN - Deepsea Nordkapp - Supplementary documents related to the investigation -
 Havtil email dated 21 October 2025 - Response - Version 1 - dated 24 October 2025 -
 Docs-2692359
 DSN - Deepsea Nordkapp - Additional documents related to the investigation - Havtil
 email dated 16 October 2025 - Response - Version 2 - dated 24 October 2025 - Docs-
 2691187.pdf
 DSN - Deepsea Nordkapp - Additional documents related to
 Despatch notification
 VEDLEGG NR 01A - DSN - ██████████ KURSBEVIS
 VEDLEGG NR 01B - DSN - ██████████ - KOMPETANSEBEVIS
 VEDLEGG NR 01C - DSN - ██████████ RIGGERKOM

VEDLEGG NR 01D - DSN - 12797 - SLINGER CERTIFICATE
VEDLEGG NR 01E - DSN - CV 221025 ODFJELL DRILLING
VEDLEGG NR 02 - DSN - KURSBEVIS PNI SENSOR G5 ROY
VEDLEGG NR 03A - DSN - L4-MODU-DSN-D-PR-302N - MOTTAG NYTT PERSONELL
VEDLEGG NR 03B - DSN - GODKJENNING FRA OIM - INNLEIE IP
VEDLEGG NR 04 - DSN - DFU19 AKUTT MEDISINSK TILFELLE
VEDLEGG NR 07A - DSN - SYNERGI NUMMER 240776 - KRAN OG LØFT TEKNISK
VERIFIKASJON
VEDLEGG NR 07B - DSN - 2651697 - DSN TECHINCAL VERIFICATION DRILLING
EQUIPMENT
VEDLEGG NR 08 - DSN - SYNERGISAKER KNYTTET TIL KRAN OG LØFT HENDELSER
VEDLEGG NR 10A - DSN - L3-MODU-ALL-HSE-PR-014 - PERMIT TO WORK
VEDLEGG NR 10B - DSN - L3-MODU-ALL-HSE-PR-047 - SIKKERHETSSTANDARD
VEDLEGG NR 10C - DSN - L1-CORP-HSE-PR-004N - OBSERVASJONSKORT
VEDLEGG NR 01 - DSN - L3-MODU-ALL-HSE-PR-024N - INTERN
RADIOKOMMUNIKASJON - REV. 5 - DATO 02.02.2024 - DOCS-2692257.PDF
DSN - Deepsea Nordkapp - Extra documents
VEDLEGG NR 01 - DSN - DEBRIEF ETTER PERSONSKADE IFM personskade i
løfteoperasjon
VEDLEGG NR 02 - DSN - TIDSLINJE - DOCS-2691653
VEDLEGG NR 03 - DSN - AUDIT AND VERIFICATION PLAN
VEDLEGG NR 04 - DSN - L2-NO-TO-PR-001N - KRAV TIL DOKUMENTERT
OPPLÆRING AV OPERATØR
VEDLEGG NR 05 - DSN - OVERSIKT OVER MØTER OMBORD for å håndtere risiko og
arbeidsoppgaver
VEDLEGG NR 06 - DSN - BILDER FRÅ SB KRAN TIL SKADESTED
VEDLEGG NR 07 - DSN - DDR 08.10.25 - DOCS-2691658
VEDLEGG NR 08 - DSN - DDR 09.10.25 - DOCS-2691659
VEDLEGG NR 09 - DSN - KRANBOK FOR PRAKTISK OPPLÆRING PNI
VEDLEGG NR 10 - DSN - DSN DECK LOAD PLAN - DOCS-26
VEDLEGG NR 11 - DSN - L4-MODU-DSN-E-MA-101N - BEREDSKAPSPLAN DSN
VEDLEGG NR 12 - DSN - L3-MODU-ALL-HSE-PR-006N - OFFSHORE HANDOVER
VEDLEGG NR 13 - DSN - L4-MODU-DSN-D-PR-116N - DSN ARBEIDSTILLATELSE
RUTINER OMRÅDE- OG SYSTEMANSVARLIG
VEDLEGG NR 14 - DSN - L1-JD-MODU-OFS-003 - MARINE SECTION LEADER
VEDLEGG NR 15 - DSN - L1-JD-MODU-OFS-026 - DRILLING SECTION LEADER
VEDLEGG NR 16 - DSN - KVALIFIKASJONSKRAV OPERASJONELT ANSVARLIG
VEDLEGG NR 17 - DSN - L1-JD-MODU-OFS-001 - OFFSHORE INSTALLATION
MANAGER
VEDLEGG NR 19 - DSN - L3-MODU-NO-TO-PR-012N - SIKKER BRUK AV
LØFTEUTSTYR
VEDLEGG NR 20 - DSN - L1-JD-MODU-OFS-021 - TOOLPUSHER
VEDLEGG NR 21 - DSN - KVALIFIKASJONSKRAV TIL IP

VEDLEGG NR 22 - DSN - L3-MODU-ALL-HSE-PR-014N - ARBEIDSTILLATELSE
VEDLEGG NR 23 - DSN - L3-MODU-ALL-QU-PR-008 - INSPECTIONS
VEDLEGG NR 02 - DSN - L4-MODU-DSN-D-PR-302N -
MOTTAKINTRODUKSJONSIKKERHETRUNDE MED NYTT PERSONELL
VEDLEGG NR 03 - DSN - DAGLIG HANDOVER MARINE - Daglig Handover Marine
VEDLEGG NR 04 - DSN - DAGLIG MARINE HO 08.10.25 - Daglig Handover
DSN - Deepsea Nordkapp - Supplementary documents related to the investigation -
Havtil email dated 17 October 2025 - Response - Version 1 - dated 18 October 2025 -
Docs-2691646
VEDLEGG NR 01 - DSN - POB 08.10.2025 - DOCS-2691648
VEDLEGG NR 02 - DSN - MRIL-TOOL TEGNING - DOCS-2691647
Video showing the incident
VEDLEGG NR 09 - DSN - 6X PTW ASSESSMENTS - PERMIT
VEDLEGG NR 10A - DSN - DFU 19 CREW 1 AND 2 06_08_23
VEDLEGG NR 10B - DSN - UTKLIPP - TRENINGSMATRISSE D
VEDLEGG NR 10C - DSN - DFU 19 CREW 3 AND 4 20_08_23
VEDLEGG NR 10D - DSN - DFU 19 CREW 5 AND 6 27_07_23
VEDLEGG NR 11 - DSN - L4-MODU-DSN-E-MA-101-01 - ALARMINSTRUKS
VEDLEGG NR 14A - DSN - FORBEDRINGSFORSLAG - LAGERDEKK
VEDLEGG NR 14B - DSN - FORBEDRINGSFORSLAG - BESKYTTELSE
VEDLEGG NR 15A - DSN - DEEPSEA NORDKAPP COMPETENCIES
VEDLEGG NR 15B - DSN - TRAINING REQUIREMENTS - DOC
DSN - Deepsea Nordkapp - Additional documents related to the investigation - Havtil
email dated 29 October 2025
VEDLEGG NR 01 - DSN - L3-MODU-ALL-TO-PR-042 - LIFTING EQUIPMENT
OPERATIONS
VEDLEGG NR 02 - DSN - L3-MODU-ALL-HSE-PR-006 - APPENDIX 1
VEDLEGG NR 03 - DSN - L3-MODU-ALL-HSE-PR-006 - APPENDIX 2
VEDLEGG NR 05A - DSN - HANDOVER DRILLING 07_10_2025
VEDLEGG NR 05B - DSN - HANDOVER DRILLING 07_10_2025
VEDLEGG NR 05C - DSN - HANDOVER DRILLING 08_10_2025
VEDLEGG NR 05D - DSN - HANDOVER DRILLING 08_10_2025
VEDLEGG NR 07 - DSN - L3-MODU-ALL-HSE-PR-038 - SELF-VERIFICATION
VEDLEGG NR 08A - DSN - L3-MODU-ALL-QU-PR-008 APPENDIX 1
VEDLEGG NR 08B - DSN - QHSE VERIFICATION - MANAGEMENT
VEDLEGG NR 08C - DSN - L3-MODU-ALL-QU-PR-008 APPENDIX 1
VEDLEGG NR 08D - DSN - L3-MODU-ALL-QU-PR-008 APPENDIX 1
VEDLEGG NR 08E - DSN - L3-MODU-ALL-QU-PR-008 APPENDIX 1
VEDLEGG NR 08F - DSN - L3-MODU-ALL-QU-PR-008 APPENDIX 1
DSN - Deepsea Nordkapp - Clarification regarding competence requirements for
deck operators and operations manager - Havtil email dated 4 November 2025 -
Response - Version 1 - Date 10

DSN - Deepsea Nordkapp - Additional documents: information regarding the DSN investigation - Havtil email dated 7 November 2025

VEDLEGG NR 01 - DSN - L1-CORP-QU-PR-011 - AUDITING

VEDLEGG NR 02 - DSN - 234010 - ISM INTERNAL AUDIT

VEDLEGG NR 03 - DSN - 234304 - MASTERS REVIEW 2024

VEDLEGG NR 04 - DSN - 228722 - MASTERS REVIEW 2023

VEDLEGG NR 05 - DSN - 240874 - EMERGENCY PREPAREDNESS AUDIT REPORT

VEDLEGG NR 06 - DSN - 240757 - ISM INTERNAL AUDIT

VEDLEGG NR 07 - DSN - 234012 - EMERGENCY PREPAREDNESS AUDIT REPORT

VEDLEGG NR 08 - DSN - L3-MODU-ALL-QU-PR-002 - MASTER REVIEW

VEDLEGG NR 09 - DSN - L1-CORP-009-028 - QHSSE AVDE

VEDLEGG NR 10 - DSN - SAFETY PERFORMANCE COACHING

VEDLEGG NR 11 - DSN - VERIFICATION OF EFECTIVENESS

VEDLEGG NR 12 - DSN - CONTENT SAFETY PERFORMANCE D

VEDLEGG NR 13 - SAFETY PERFORMANCE DAY 2 - AGENDA

VEDLEGG NR 14 - DSN - AUDIT AND VERIFICATION PLAN

VEDLEGG NR 15 - DSN - L1-CORP-QU-GL-031 - VERIFICATION OF EFFECTIVENESS OF ACTIONS

VEDLEGG NR 02 - DSN - L3-MODU-ALL-HSE-PR-005N - OFFSHORE HMS MØTER - REV. 10 - DATO 16.08.2024 - DOCS-2695994

VEDLEGG NR 01 - DSN - STATUS KOMPETANSE [REDACTED] PR 071125 - DOCS-2695983

Odfjell Drilling - Investigation Report L2 - Deepsea Nordkapp - Personnel injury - Person struck by BHA during crane lift - Date of incident 08.10.2025 - Synergi 244762

VEDLEGG NR 02 - DSN - MASTERS REVIEW 2024 - SYNERGI UTSKRIFT - DOCS-2700103

DSN - Deepsea Nordkapp - Additional documents related to the investigation - Email from Havtil dated 24 November 2025 - Response - Version 1 - dated 28 November 2025 - Docs-2699291

VEDLEGG NR 01 - DSN - MASTERS REVIEW 2023 - SYNERGI UTSKRIFT - DOCS-2700104

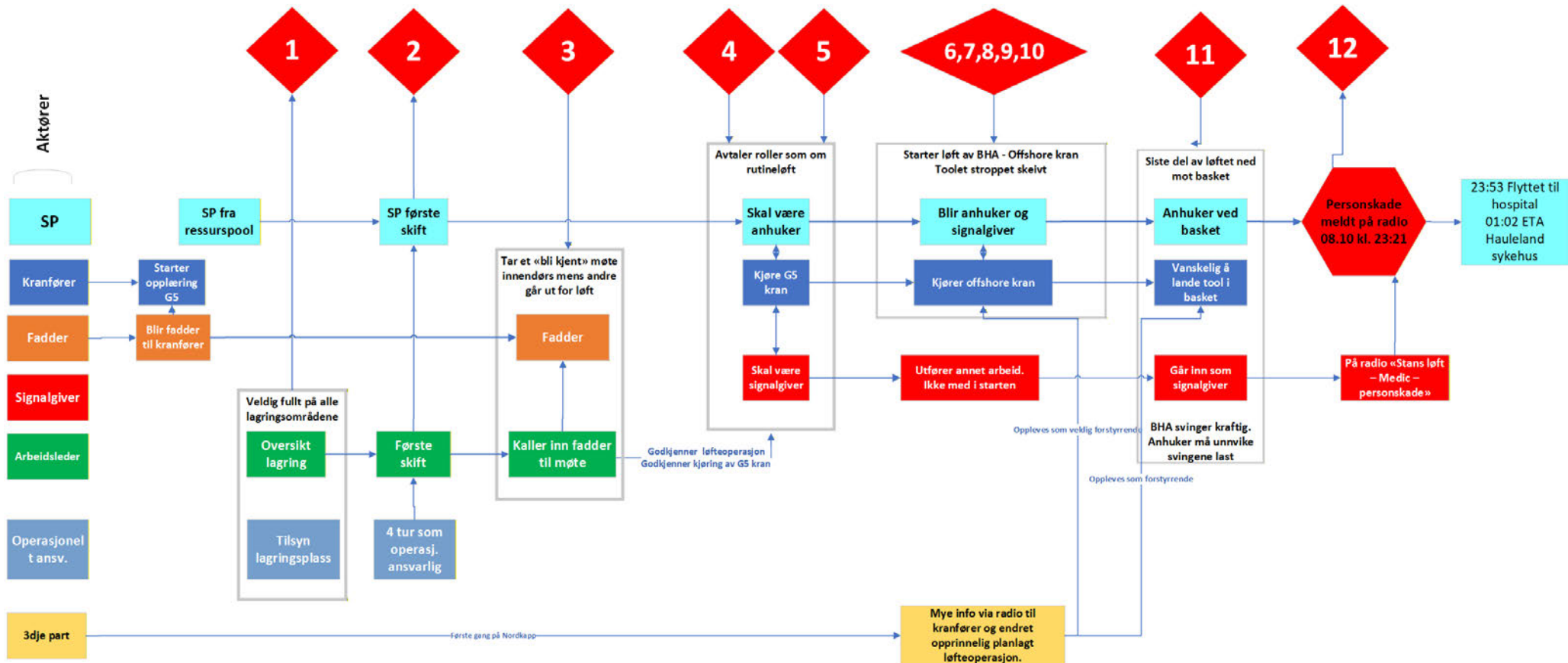
VEDLEGG NR 01 - DSN - L3-MODU-ALL-HSE-PR-007 - OFFSHORE LEADERSHIP - REV.NO. 6 - DATE 16.07.2024 - DOCS-2703373

DSN - Deepsea Nordkapp - Additional documents related to the investigation - Havtil email dated 12 December 2025 - Response - Version 1 - dated 17 December 2025 - Docs-2703349

14.2 List of interviewed personnel: Interview list

Exempt from publication

14.3 STEP overview of the sequence of events leading up to the injury



1. Trange dekk meldt som bekymring fra dekk og kran
2. Flere nye i sikkerhetskritiske oppgaver
3. Fadder og dekkformann på møte under løfteoperasjon
4. Mangler ved planlegging av løft. Ikke del av handover.
5. Kranfører under opplæring for G5 offshore kran
6. Finner ikke tilhørende spesialbasket
7. Flere endringer gjennom løfteoperasjonen og «Støy» på radiosambandet
8. Fadder eller formann deltar ikke i operasjon
9. Ingen stans av arbeid ved farlige situasjon
10. Endret rollefordeling ifm med løfteoperasjonen
11. Anhuker (IP) under last og uten ryggen fri
12. Ingen GA aktivert

Figure 5 Simplified version of the STEP diagram showing the main elements of our investigation

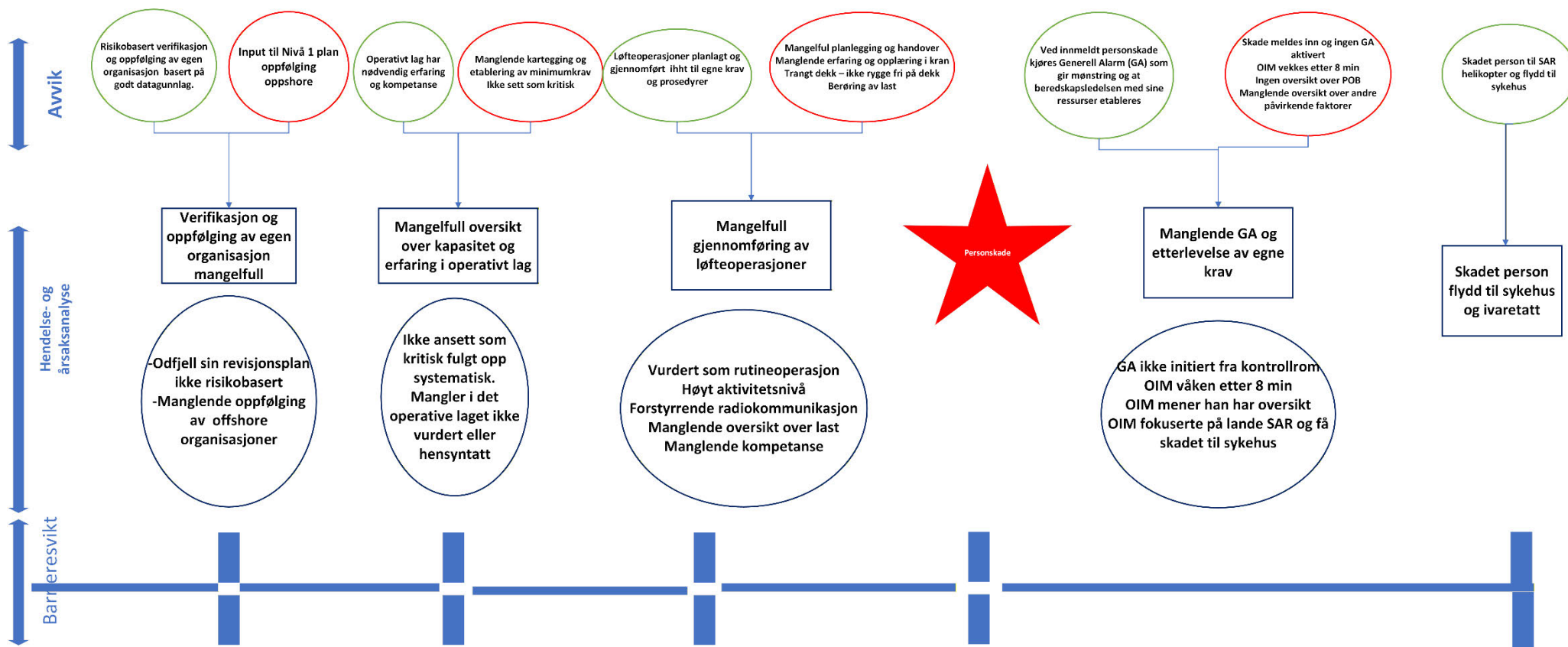


Figure 6 Simplified HTO analysis of the key elements that led up to the incident and then until the SAR barrier functioned.