EUROPEAN COURT OF HUMAN RIGHTS
COUR EUROPÉENNE DES DROITS DE L'HOMME

FOURTH SECTION

Application no. 22703/10
by Magn Hakon MULEDAL and Others
against Norway
lodged on 7 April 2010

STATEMENT OF FACTS

THE FACTS

The applicants are (1) Magn Håkon Muledal (born in 1953 and living in Førde), (2) Anders Lindahl (born in 1942 and living in Avaldsnes), (3) Sigurdur P. Hafsteinson (born in 1953), (4) Bjørn Anders Nesdal (born in 1958 and living in Kristiansand), (5) Knut Arvid Nygård (born in 1961 and living in Tananger), and (6) Per Arne Jacobsen (born in 1954 and living in Larvik). They are represented before the Court by Mrs K.H. Øren, a lawyer practising in Oslo.

The circumstances of the case

The facts of the case, as submitted by the applicants, may be summarised as follows.

1. General background

For details regarding the general background to the present case, see the statement of "Facts" in the case of *Vilnes v. Norway* (no. 52806/09), notice of which was given to the respondent Government simultaneously with the present application (Rules 42 § 2 and 54 § 1(b) of the Rules of Court).

2. The factual circumstances underlying the applicants' complaints

The applicants submitted that they were disabled and had lost their work capacity as a result of North Sea diving. Each of them received a disability pension. Some of them had received *ex gratia* compensation from Statoil/Hydro and the State.

(i) Mr Muledal

Mr Muledal worked as a North Sea diver from 1978-1989. He has performed saturation diving periods totalling approximately 500 days and has performed approximately 200 bounce dives. On two or three occasions he has suffered from bends in the joints. He has also suffered several diving accidents and has had near accidents. On a number of occasions, he has been exposed to a gas-cut while diving. During the Alexander Kielland accident, he recovered several dead bodies.

Mr Muledal participated in a so-called "OTS III" test dive at a depth of 360 metres that had lasted twenty-eight days. He lost seven kilos because he could not eat properly during the dive and has suffered from stomach problems since. He also suffered from HPNS.

As a consequence of contracting chronic obstructive lung disease, he lost his diving licence in 1987. For that reason, his former employer, Aker Comex, terminated his employment in 1989. The said disease constituted a 15 % disability. He may also have Post Traumatic Stress Syndrome ("PTDS"). He has a damage to his hearing which might increase his degree of disability. In addition, he suffers from encephalopathy, which represented a 20 % disability.

As from 1990 he received a 50 % disability pension with occupational injury benefits and as from November 2008, he received a 100% disability pension.

(ii) Mr Lindahl

Mr Lindahl served as a North Sea diver from 1970-1993. He experienced decompression sickness twenty times, for which he was not treated. He also experienced decompression sickness on six other occasions for which he was treated, i.e. after diving at depths ranging between 150 to 120 metres on a North Sea saturation dive in 1981. His hearing has been impaired as a result.

During his first saturation dive in 1974, Mr Lindahl and several colleagues experienced a sudden decompression and error in gas-supply due to power failure, leading to unconsciousness among the divers. Mr Lindahl also suffered from general spasms. He submitted that incompetence and routine failings had caused the incident. Mr Lindahl had recovered bodies of people who had died in accidents. He experienced uncontrolled decompressions and near-accidents in which heavy items almost hit him while diving.

Lindahl participated in the test dives Deep Ex I to 300 metres and Deep Ex II to 504 metres. During Deep Ex I, he experienced decompression sickness and Doppler-tests revealed gas bubbles in the artery.

According to a medical statement by Haukeland Hospital in Bergen, diving in the North Sea had caused him injury, including reduced lung

capacity, implying a disability of 20 %. A medical certificate stated that he had experienced neuropsychological and neurophysiological changes, heightened blood pressure and impaired hearing faculties. Furthermore, the medical expert declaration from Dr Hellesøy concluded that he was 30% disabled by PTSD. Since 2003 he has received a 100 % disability pension with occupational injury benefits.

(iii) Mr Sigurdur P. Hafsteinsson

Sigurdur P. Hafsteinsson was employed as a North Sea diver from 1978-1990. He suffered bends on three occasions and has spent more than 300 days in saturation. On several occasions, he experienced fatal accidents and near accidents. For instance, in 1982, while on a saturation dive at a depth of 150 metres, he and three fellow divers had just returned to the chamber when an unskilled worker was about to loosen a clamp that connected the diving bell to the diving chamber. Fortunately, the supervisor had heard the noise and had managed to intervene just in time. Had this operation not been stopped, the divers would have been subjected to an explosive decompression. A similar error had led to the death of five persons and seriously injured a sixth person in a diving bell on the Byford Dolphin rig in 1983.

Once in 1984 Mr Hafsteinsson's umbilical and the diving bell wire had been trapped in drilling wires and had been damaged. On another occasion, when working at a depth of seventy metres, there had been a powerful explosion which had caused sudden pain to his head and ears and, possibly, unconsciousness. He had been bleeding from his ears. Following this accident, he had suffered from impaired hearing. He had taken part in recovering bodies from the Alexander Kielland accident.

In 1983 and 1985, Mr Hafsteinsson had participated in test diving at NUTEC. In the first test dive, called Statpipe, divers had been taken down to 350 metres. In the second test dive, called Troll (the name of the rig), divers had been taken down to 450 metres. At 450 metres, Mr Hafsteinsson could hardly breathe and had panicked. One of his colleagues had collapsed and had to be revived. In 1990, Mr Hafsteinsson's diving licence had been revoked. The medical expert declaration from Haukeland Hospital concluded that diving had caused Mr Hafsteinsson to suffer from an obstructive lung disease constituting a 25 % medical disability. A medical expert in psychiatry had concluded that he suffered from PTSD representing a 35 % disability and that he was 100 % disabled.

(iv) Mr Nygård

Mr Nygård worked as a North Sea diver from 1987-1994. He carried out more than 200 air dives and saturation dives totalling 200 days approximately. He experienced numerous accidents and near-accidents as a North Sea diver. For instance, in 1988 he was almost hit by a crane ball (the massive hook on the vessel's main lifting crane, weighing between 100 and 300 kilos) while working at a depth of 150 metres, and just barely escaped death. His supervisor had apparently removed his headset and had not heard Mr Nygård's message of "all stop" and thereby had not told the crane operator to stop the crane.

In 1990, while working at thirty metres in saturation, an oxy-arc (cutting tool) had exploded in his hand, hitting him hard in the chest, because a riser (a pipe conducting oil and gas between the sea bed and the oil rig) which Mr Nygård was burning had not been emptied of water, although the supervisor had confirmed several times that there was no water pressure in it. Consequently, the water pressure had blown the flame, sparks and oxygenic gas back at the oxy-arc that Mr Nygård was holding, which had thus exploded in his hands.

According to a medical expert opinion, due to diving in the North Sea, Mr Nygård suffered from a chronic obstructive lung disease, amounting to a 15 % medical disability, PTSD representing a 34 % medical disability, diver hands of a 10 % medical disability, encephalopathy of a 14 % medical disability. He received a 100 % disability pension with occupational injury benefits.

(v) Mr Nesdal

Mr Nesdal served as a North Sea diver from 1982-1994. He suffered on two occasions from bends in the joints and on two further occasions from decompression sickness assessed as bends in the lymphs. One instance had been reported as occupational injury. He experienced neurological symptoms on a saturated dive in 1985 and dizziness and nausea in several subsequent dives.

On several occasions, he had been exposed to life-threatening incidents while diving in the North Sea. On one occasion he got stuck in a shaft while hearing on the inter-communication system that divers should immediately revert to the diving bell because the boat was drifting away. Mr Nesdal saw the diving bell moving and was at the last minute found and assisted in being released from the shaft and returning to the diving bell.

Another near accident had happened when he participated in the testing of a ROV (Remote Operated Vehicle, an unmanned submarine operated from the surface), weighing several tons. His umbilical had got hooked on to the ROV and had drifted away, stretching it almost to the point of bursting. Mr Nesdal had also witnessed two divers getting caught in the propeller behind the vessel, one of whom had died. Because of the great variations in the surface crew's level of competence, he had sometimes felt unsafe when receiving assistance from its members.

According to the medical expert statement from Haukeland Hospital, Mr Nesdal suffered from dizziness related to his depression and anxiety, a condition caused by diving and which represented a disability degree of 15 to 20%. The Social Security Office considered him 60% disabled.

(vi) Mr Jacobsen

Mr Jacobsen worked as a North Sea diver from 1975-1985. He had experienced bends on many occasions. He had been exposed to a life threatening situation when using surface-supplied breathing gas in the North Sea in a dive in 1979. He had been diving alone inside the rig construction on the seabed, checking the welding, when he suddenly heard a crack. The hawser attaching the vessel to the rig had torn apart and the vessel had pulled backwards, dragging him along in the umbilical. He risked being caught in the propeller and losing air from the umbilical. Fortunately he had

managed to locate the diving basket on the seabed and to climb onboard the (diving) basket where he received decompression treatment. During that same period, a colleague of his had been squeezed to death by a container during a change over of crew.

On several occasions, he had experienced a loss of seal on the diving bell, causing it to lose pressure and mist over. Losing the seal on the diving bell during a dive was always life threatening. Gas was streaming out of the bell. Reacting quickly to blow down to deeper waters inside the bell, with the surface crew lowering the bell back to working depth to maintain the pressure, was the only way to survive. The divers' lives had depended entirely on their knowledge of how to address the problem and on the skills of diving management at the surface. During a saturated dive in 1978, Mr Jacobsen had experienced the diving bell wire being torn apart and the bell falling to the sea bed. He had been in the chamber, while his fellow-workers had been under the bell. They had received a new wire and had been rescued.

In 1980 Mr Jacobsen had participated with a colleague in the recovery and identification of the deceased after the Alexander Kielland accident. They had spent sixteen days in saturation under the platform, an extremely dangerous operation, and had recovered many corpses. After that incident his colleague had quit diving altogether, whereas Mr Jacobsen had continued.

An expert in psychiatry had concluded that Mr Jacobsen had experienced numerous critical situations and suffered from traumatic strains of stress relating to dangerous and partly life-threatening incidents. He suffered from PTSD mainly caused by North Sea diving. His medical disability was 35%, and he was 100% disabled, which findings had been confirmed by expertise at Haukeland Hospital.

(vii) Dispensations from safety regulations

Pursuant to the 1978 safety regulation, the saturation period for saturation diving should not exceed 16 days. However, the Petroleum Directorate could authorise an extension of the period to twenty-four days and, exceptionally, to thirty-two days, provided this had been agreed between the diving companies and the divers' representatives. Such dispensation arrangements had to be seen against the background that certain operations took more than sixteen days and that avoiding sending in a second team permitted a reduction in certain risks.

The safety regulation further provided that diving from a diving bell was not permitted if the divers' umbilical was longer than twenty-nine metres and that the umbilical of the diver remaining in the bell should not exceed thirty-one metres. This enabled reducing the risk of the diving vessel and the diving bell getting too close to the oil platform.

In both respects, the Directorate practiced a liberal policy in granting dispensations.

According to the applicants, both factors had jeopardised the divers' working conditions and safety. Longer shifts had involved a higher degree of psychological strain in that for longer periods they had been isolated and away from rescue in the event of an emergency. Longer shifts had exhausted the divers and their time off work had become a recovery period

from exhaustion, rather than spare time. The reason for obtaining dispensations had been to reduce personnel costs.

A longer umbilical increased the risk of it being cut off and the divers being dragged over cranes and other installations when the diving vessel was drifting off.

As an example of the authorities' liberal practice in granting dispensations, the applicants referred to a request by Statoil of 23 February 1987 for a longer umbilical (forty-five metres for a main diver and forty-seven metres for an assistant diver, as opposed to twenty-nine and thirty-one metres, respectively) and an extension until 1 January 1988 of the saturation period for divers from the required sixteen to twenty-four days. The applicants pointed to a similar dispensation requested by Elf for the year 1985.

(viii) Decompression tables

When the diving companies applied for an authorisation for diving based on rapid return of the divers to the surface, this was normally with the divers' consent. The diving companies using tables involving shorter decompression time and thereby lower labour costs had a competitive advantage over other companies operating with longer saturation periods. In order to strengthen their own competiveness, the companies treated the decompression tables which they used as confidential information that should not be disclosed to other diving companies or to the Norwegian authorities.

At the initial phase tables for bounce diving developed by the US Navy were being used. The Labour Inspection Authority had no access to tables used in saturation diving. In 1972 it took the initiative to develop Norwegian tables. A German research body was contacted but the cooperation turned out to be difficult.

In the above-mentioned Lossius report (section 5.7.4, first paragraph, p. 220), the following observation may be found with regard to diving tables:

> "The time factor is essential because the purpose of the table is to take the divers up to surface pressure without injuries, while a long lasting decompression may be uncomfortable for the divers. For the commercial diving in the North Sea, the time factor was also a competition factor between the diving companies – the company holding the fastest tables was often assigned the contract. The consideration of the divers was therefore contradictory to the strong commercial forces. This problem was well known to oil companies, diving companies, the divers, diving doctors and the Norwegian authorities."

In a letter of 21 June 1984 to the Diving Medical Advisory Committee the Petroleum Directorate stated:

> "Even when taking into consideration the different approaches to establishing a decompression profile based on different attitudes to the effect of time, PO2 and other factors on gas elimination during decompression, we find the difference between the slowest and fastest table disturbing.
>
> The difference in decompression time from 1000 feet is close to a week when comparing the fastest and slowest table. In fact the fastest table we have considered is faster than the Duke Emergency Decompression profile from a saturation dive....This Duke table is in other companies used as dive profile for aborted dives in serious

> emergencies... and it looks more like a modified USN 5 treatment table than anything else."

In 1990, the Petroleum Directorate initiated a programme of standardisation of compression- and decompression routines. The standardised diving tables that were introduced in 1991 used as a basis the most conservative diving tables that existed in the industry on the assumption that this would optimise the safety of divers.

In a report of January 1991 on the comparison of the saturation diving tables and preparation of conditions for standardisation, the Petroleum Directorate stated that a common framework of diving tables would significantly optimise divers' safety, provided that a common and simple system of reporting injuries and illnesses sustained in saturation diving be developed in parallel.

After the introduction of standardised tables, decompression sickness became a rare occurrence. By that time, the applicants had already suffered from decompression sickness on a number of occasions and had sustained injuries.

(ix) Supervision

The Labour Inspection Authority, which was responsible for supervising diving activity in the North Sea until 1978, had one employee specifically entrusted with the task of supervising the entire petroleum industry inshore and offshore. He had no particular competence or experience in diving. The inspections conducted were directed at technical devices rather than diving methods and routines

The Lossius report included the following observation (at page 76):

> "It is uncertain but little likely that the Labour Inspection was familiar with the significant occurrence of decompression sickness. Interviews with the pioneer divers and the diving medical experts have revealed that the work environment in the North Sea, both before and after 1978, accepted decompression sickness as part of diving, a disadvantage that one tried to avoid, but nevertheless something that went together with diving. The illness was treated with recompression and considered finalised. The Labour Inspection seemed familiar with, but nevertheless unengaged in, the problem of time pressure during bounce diving and many divers' sense of insecurity in the work situation – the risk of being put onshore."

In a letter to Statoil, dated 23 March 1990, the Petroleum Directorate observed:

> "There is reason to believe that there was insufficient supervision of the diving industry in the period from the early 60s until the Norwegian Petroleum Directorate issued temporary regulations for the Norwegian continental shelf."

With regard to the Labour Inspection's supervision of diving, the Lossius Commission stated (section 5.7.5, penultimate paragraph):

> "Time pressure during bounce-diving and the lack of security in many divers' working situation – the risk of being put onshore – was a problem the Labour Inspection appears to have become familiar with, but it did not pay any particular concern."

As to diving tables, the Lossius Commission stated that while the Norwegian authorities gradually had access to diving tables, they did not become public, and diving companies kept them confidential to a great extent (Lossius section 5.7.4, penultimate paragraph). According to the

applicants, the authorities had refrained from abolishing dangerous diving tables because of their confidentiality, and divers had not been in a position to know whether they accepted working from dangerous diving tables when accepting work for a diving company.

The pioneer divers were critical of the Labour Inspection's competence and supervision. The Lossius Commission confirms to some degree their criticism, in stating that:

> "In accordance with [the supervision of] onshore industry, he [the person responsible for diving supervision] focused on fire safety, strength in cranes, cables and other materials... Less focus was given to diving methods and routines, and attitudes of divers and the diving management... One might question whether his qualifications were satisfactory, and this must have been known to his superiors." (Lossius-report, page 76, Section 5.7.5, right side, second paragraph)."

An additional staff member was hired during the last period of the Labour Inspection's supervision of North Sea diving, before the Norwegian Petroleum Directorate took over the responsibility and supervision in 1978, starting with five staff members.

(x) Professional training

The applicants pointed out that in addition to having satisfactory knowledge and equipment to stay under water, professional divers needed to perform numerous duties such as welding, localisation, installation, dismantling and guiding of equipment, etc. (Lossius report, section 4.3.2, pp. 56 and 57).

Despite the varied and demanding work, the Lossius report stated that there was no organised training of North Sea divers in the first years of the petroleum industry. The Labour Inspection Authority's only requirement for professional divers was an approved medical certificate (Lossius report, section 4.3.3, first paragraph, p. 57).

The first diving certificate requirements entered into force in 1979 and in 1980 the State opened a diving school.

(xi) Reporting practices and investigations of accidents and near-accidents

According to the applicants a culture of under-reporting of accidents and near accidents prevailed in North Sea diving. The Government took no adequate steps to address the under-reporting and accepted that accidents and near accidents were not investigated. Therefore, oil companies and diving companies did not suffer any consequences as a result of malpractice. They were not compelled to address the cause of accidents and near accidents. On this matter the Lossius Commission stated (section 5.11, p. 89 of the report):

> "The feeble supervision may also indicate that the directorate lacked understanding of the risk of harm which working in the North Sea involved, in particular for divers. Lack of comprehension of the risk of harm may be related to the fact that the Directorate most likely did not have a realistic perception of the extent of the damage, partly because of the lack of reporting from oil companies and contractors, but also partly because of the directorate's lack of involvement."

(xii) Protection of North Sea divers from chemicals in water and air

The applicants submitted that divers had been exposed to dangerous chemicals that existed in, for instance, drilling mud and breathing gas, as well as bacteria growth in decompression chambers. For nearly forty years the subject had not been the subject of any scientific research and only in 2006 had a study been produced. The so-called Thelma Report concluded that divers had been exposed to organic pollution and that the diving bell had been the most polluted system. Whilst the testing and monitoring of chemical exposure had not complied with applicable procedures laid down by the industry itself and its contractors, it had not been possible to calculate the full level of pollution and health risk in hyperbaric activities. This should be a priority in the future.

Furthermore, the report stated that no survey was available of the amount of activities that had taken place in polluted areas and that increased knowledge of seabed pollution would facilitate the estimation of risk and level of health-damaging pollution in the diving bell (possibly since divers carry mud with them from the seabed into the diving bell). Consequently, necessary preventive measures could be implemented prior to an operation or the use of the diving bell.

The report concluded that there was a lack of knowledge relating to the effects of divers' exposure to chemicals. However, North Sea divers continued to live with those effects and with the uncertainty as to which chemicals had caused them.

(xiii) Test diving

The applicants explained that test diving could be divided into two categories, depending on the objective of the dive. The primary objective of *experimental* diving had been research, namely to explore and develop new equipment, technical processes, operational procedures, diving tables, and learn about human reactions to hyperbaric exposure. The objective of *verification* diving had been to confirm whether certain dives were safe or not. The petroleum or diving companies had carried out verification dives primarily in order to document that work operations had been possible at ever greater depths.

Test diving had primarily been carried out at *NUI AS/ Nutec AS* (*Norsk Undervannsintervensjon* - Norwegian Underwater Intervention Ltd, and, apparently referring to Falck Nutec safety company in Norway) in Bergen and in the Norwegian fjords. Onshore test diving had taken place in the *NUI/Nutec* facilities which had enabled diving under similar pressure and conditions as North Sea diving. *NUI* had been established in 1976 by the State body *NTNF* (Norwegian Scientific Research Council) and *Det norske Veritas* (an independent foundation providing risk management services). Other owners had been the oil companies *Statoil*, *Norsk Hydro* and *Saga Petroleum.* In 1985, *Nutec* had been transformed into a private limited liability company, which in 1998 had split into two companies, namely *Nutec* and *NUI*. The latter had then continued medical research into diving and had been a State-owned limited liability company.

The first applicant, Mr Muledal, to some extent, and more particularly the second applicant, Mr Lindal, and also to a certain degree the third applicant, Mr Sigurdur P. Hafsteinsson, provided detailed accounts of their

individual experiences of test dives which had caused them pain, suffering and injuries and had allegedly not been carried out with their informed consent.

The applicants submitted that in 1988 the Labour Inspection Authority had addressed a request to the Petroleum Directorate that deep dives be stopped until the medical risk had been cleared and an evaluation had been made of whether deep sea dives offshore were medically safe. The Petroleum Directorate had appeared unreceptive and sceptical towards the medical warnings against dives deeper than 180 metres. Its Chief of Information had responded that based on current technical and medical knowledge the Directorate considered it safe to dive down to 400 metres. At that time, maintenance and repair of pipes required divers, it being considered practically impossible to replace divers with remote control underwater technology.

The applicants submitted that the *NUI/Nutec* and the Petroleum Directorate's pragmatic attitude towards permitting and facilitating deep sea diving in order to allow the development of oil and gas fields which required diving capacity had been beneficial to the oil industry and the Norwegian oil economy. However, it turned out that it was not necessary to fully utilise that capacity.

According to the applicants, as from the adoption of new regulations in 1991 diving below 180 metres was considered as deep diving because of its potential for High-pressure nervous syndrome ("HPNS"). Diving below this depth was currently deemed unsafe by the Petroleum Directorate.

3. Judicial compensation proceedings

On 30 December 2005 the first applicant, Mr Muledal, Mr J. and Mr K., together with twenty-eight other North Sea divers, instituted proceedings against the State before the Oslo City Court (*tingrett*) claiming compensation. The second to sixth applicants were among the twenty eight claimants.

On 28 February 2005 another North Sea diver, Mr Vilnes, whose application (no. 52806/09) under the Convention is being dealt with simultaneously with the present one, had instituted compensation proceedings against the State before the City Court (*tingrett*).

On 30 December 2005 Mr Muledal whose application (no. 22703/10) under the Convention is being dealt with simultaneously with the present one, together with Mr J. and Mr K. and twenty-eight other North Sea divers, also brought compensation proceedings raising similar claims.

On 31 March 2006 Messrs Engebretsen and Eng, who have also lodged an application with a number of others (no. 24329/09) lodged compensation proceedings against the State before the City Court.

After a preliminary session on 7 August 2006 the City Court decided to join all the above cases. On 21 January 2007, after a change of lawyer by Messrs Engebretsen and Eng, it disjoined the action brought by them from those lodged by the other claimants.

Pending the outcome of the proceedings, the proceedings brought by the above-mentioned group of twenty-eight litigants (including by the second to sixth applicants) were adjourned.

Mr Muledal's action was upheld in part by the City Court but was rejected by the Borgarting High Court and the Supreme Court, by judgments dated 10 August 2007, 28 November 2008 and 8 October 2009, respectively.

For more details regarding the judicial proceedings, see the statement of "Facts" in the case of *Vilnes v. Norway* (no. 52806/09), notice of which was given to the respondent Government simultaneously with the present application (Rules 42 § 2 and 54 § 1(b) of the Rules of Court).

COMPLAINTS

The applicants alleged that there had been a violation of Articles 2 and 8 of the Convention on account of the State's failure to protect their lives and health from injuries, respectively, while at work as divers for the oil industry in the North Sea and at the testing facilities at NUI/NUTEC. As a consequence of their diving they had sustained disabilities and lost their capacity to work. The authorities of the respondent State had failed to ensure a legal framework of safety regulations to protect the divers, had automatically and widely granted exemptions from safety regulations, had failed to carry out adequate supervision, had allowed companies to keep decompression tables secret despite the frequent occurrence of decompression sickness among divers.

The applicants Messrs Muledal, Lindahl and Sigurdur P. Hafsteinsson submitted that the State had violated their right to protection against inhuman treatment under Article 3 of the Convention in failing to prevent that the test diving in which they had participated take place and/or establish an effective supervisory mechanism and/or stop the test diving when the divers demanded withdrawal. They submitted that they had not been adequately informed about the experiment and its consequences, and that the test diving had not been carried out in accordance with their prior consent.

QUESTIONS TO THE PARTIES AND REQUESTS

1. Having regard to the amounts paid to the applicants under the various compensation schemes and to the justifications for these payments, particulars of which are requested from the parties, as well as the possibilities available under national law for establishing liability, have the applicants lost their "victim" status for the purposes of Article 34 of the Convention?

2. Bearing in mind also the decision taken by the Oslo City Court to adjourn the compensation proceedings lodged by the second to sixth applicants pending the outcome of the proceedings (to which the first applicant was a party), could they be considered to have fulfilled the

requirement of exhaustion of domestic remedies stipulated in Article 35 § 1 of the Convention?

3. Whatever the answer to question 2 above, to what extent have the applicants, having regard to the scope of the proceedings before the national courts, fulfilled formal admissibility requirements (six months and exhaustion of national remedies) under Article 35 § 1 of the Convention?

4. Having regard to factors such as:

(a) the fact that the diving operations in question had been carried out by private companies;

(b) the State's overall involvement in the petroleum sector, as an owner of the natural resources in question, in oil extraction through companies partly or entirely owned by the State, as a legislative and administrative regulator, as a supervisor and as a collector of taxes and levies;

(c) the legislative and administrative framework put in place in order to safeguard safety in diving operations, including with regard to such matters as the planning and conduct of diving operations, professional qualifications, equipment and medical follow-up and assistance;

(d) practices of authorisation for diving operations and dispensation from requirements regarding the length of umbilicals and saturation time;

(e) the manner of administrative supervision and control of diving operations;

did the authorities of the respondent State fail to fulfil their obligations vis-à-vis any of the applicants:

(i) under the substantive aspect of the right to life under Article 2 of the Convention?

(ii) under Article 3 of the Convention to protect the applicant against inhuman and degrading treatment?

(iii) under Article 8 of the Convention on account of any failure to take appropriate measures to protect the applicant's health?

(iv) under the procedural aspect of Articles 2 and/or 3?

5. Has there been a violation of Article 3 of the Convention on account of any failure by the respondent State to protect any of the applicants against inhuman and degrading treatment in the context of test diving?

6. The Government are requested to provide particulars on:

(a) what the authorities knew about the risk of death and serious injury involved in diving in the North Sea generally, when they acquired such knowledge and any steps taken by them in order to gain knowledge on the matter.

(b) ay measures taken by the authorities to protect the North Sea divers' lives and health and their timing;

(c) any guidelines that may have existed on the approval of decompression tables;

(d) any requirements of professional qualifications applicable to divers taking part in North Sea diving operations;

(e) the practices of granting dispensation and any safety requirements applied in this respect;

(f) the functions of the bodies entrusted with supervision and control and the human resources assigned to them to perform this role.

(g) the safety rules applicable at any given time to diving in the North Sea.

(h) any such measures as mentioned in (a) to (g) above taken with regard to test diving.

7. The Government are requested to provide an English translation of the Supreme Court's judgment of 8 October 2009.