UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
GULF OF MEXICO REGION

For Public Release

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **07-MAR-2024** TIME: **1500** HOURS
2. OPERATOR: **LLOG Exploration Offshore, L.L.C.**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Seadrill Limited**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING **Air Tugger**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **G25806**
   AREA: **KC** LATITUDE:
   BLOCK: **785** LONGITUDE:

5. PLATFORM:
   RIG NAME: **SEADRILL WEST NEPTUNE**

6. ACTIVITY:
   - [ ] EXPLORATION(POE)
   - [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
   INJURIES:
   - [ ] HISTORIC INJURY

	OPERATOR	CONTRACTOR
[X] REQUIRED EVACUATION	**0**	**1**
[ ] LTA (1-3 days)		
[X] LTA (>3 days)	**0**	**1**
[ ] RW/JT (1-3 days)		
[ ] RW/JT (>3 days)		
[ ] FATALITY		
[ ] Other Injury		

- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

8. OPERATION:
   - [ ] PRODUCTION
   - [ ] DRILLING
   - [ ] WORKOVER
   - [X] COMPLETION
   - [ ] HELICOPTER
   - [ ] MOTOR VESSEL
   - [ ] PIPELINE SEGMENT NO.
   - [ ] DECOMMISSIONING
     - [ ] PA [ ] PIPELINE [ ] SITE CLEARANCE
     - [ ] TA [ ] PLATFORM
   - [ ] OTHER

9. CAUSE:
   - [X] EQUIPMENT FAILURE
   - [x] HUMAN ERROR
   - [x] EXTERNAL DAMAGE
   - [x] SLIP/TRIP/FALL
   - [ ] WEATHER RELATED
   - [ ] LEAK
   - [ ] UPSET H2O TREATING
   - [ ] OVERBOARD DRILLING FLUID
   - [ ] OTHER _____

10. WATER DEPTH: **6607** FT.
11. DISTANCE FROM SHORE: **209** MI.
12. WIND DIRECTION: **SE**
    SPEED: **5** M.P.H.
13. CURRENT DIRECTION:
    SPEED: M.P.H.
14. SEA STATE: **2** FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

Incident Summary:
On 7 March 2024, at 1500 hours, an injury occurred on the Seadrill West Neptune drillship during well completion operations for LLOG Exploration Offshore, L.L.C. (LLOG) at Keathley Canyon (KC) Block 785. A Seadrill West Neptune employee sustained a back and shoulder injury during slip and cut drill line operations. The Seadrill employee was evacuated from the drillship for medical attention, and he was diagnosed with a small tear (torn labrum) and strain to the back of his left shoulder.

Sequence of Events:
On 7 March 2024, a Seadrill Crew was performing slip and cut of 195 feet of a 2-inch diameter drill line on the Main Side. The drill line was spooled off the drawworks drum and coiled on the deck for transportation from the rig floor. When the drawworks approached the end of the line, the Seadrill Crew tied off any slack in the line to the Main Side Cat Head to hold the line in place as to not strike the Main Side Drill Shack window since this occurred in the past. The Drawworks Team completed removal of the clamp and started lowering the drill line to the rig floor. However, the drill line was unable to coil out properly since the slack in the drill line was tied off to the Cat Head that caused the drill line to form an abnormal twist in the opposite direction of the rest of the coiled drill line. The Seadrill Crew attempted to manually flip over the abnormal twist in the drill line without success. The Driller stopped operations and instructed the Seadrill Crew to allow the drill line to be lowered to the rig floor before attempting to correct the abnormal twist. The Seadrill Crew cut the rope that secured the drill line to the Cat Head and lowered the remaining portion of the drill line to the rig floor.

The Seadrill Crew decided to utilize an air tugger and nylon web sling to lift and uncoil the abnormal twist in the 2-inch drill line. The Derrickman informed the Driller that the crew will be lifting the drill line, but he failed to communicate how the drill line was going to be lifted. The Seadrill Crew disconnected the sash cord that was used to lower the rest of the drill line to the rig floor. A nylon web sling was then placed about 4 feet from the end of the drill line. The Air Tugger Operator lifted the drill line about 20 to 25 feet and the drill line righted the abnormal twist. The Air Tugger Operator started to lower the drill line when it slipped from the nylon web sling and fell freely to the rig floor. A Seadrill employee, situated in the line of fire attempted to move out of the way. As he was exiting the area, he tripped over the coiled drill line and fell on his right shoulder and face on the rig floor. The falling section of the drill line, about 19 feet in length and 148 pounds in weight, struck the rear of his hardhat, rolled over his middle back, and left shoulder and came to rest on his legs. The employee reported to the Rig Medic with a sore shoulder and was given over-the-counter medication and an ice pack. An onshore physician was consulted, and it was decided to transport the employee to shore for a further medical evaluation. On 8 March 2024, the Seadrill employee was transported from the drillship to shore by a regularly scheduled helicopter. On 12 March 2024, the doctor diagnosed the Seadrill employee with a small tear (torn labrum) and strain to the back of his left shoulder. Surgery was not required but the Seadrill employee required physical therapy for an estimated time of 10 to 12 weeks.

BSEE Investigation:
On 28 March 2024, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up Investigation on the Seadrill West Neptune. BSEE met with LLOG and Seadrill representatives and gathered all available incident related documents including the Seadrill Permit to Work Standard Operating Manual (SOM) for Pre-Slip & Cut Drill Line, the Seadrill SOM for Slip & Cut Drill Line, Witness Statements, and the National Oilwell Varco Product Data Sheet for the air tugger.

The BSEE Incident Investigation Team determined that the following series of events resulted in the incident. During slip and cut drill operations, an abnormal twist formed in the 2-inch diameter drill line as it was being spooled out from the drawworks onto the rig floor. To remove the abnormal twist, the end of the drill line was connected to a nylon web sling and attached to an air tugger. The air tugger lifted the drill line to approximately 20 to 25 feet and the drill line abnormal twist straightened out. As the drill line was being lowered by the air tugger, the nylon web sling lost its bite that allowed 19 feet of the 2-inch diameter drill line weighing 148 pounds to fall freely to the rig floor striking the Seadrill employee.

The BSEE Incident Investigation Team determined that the cause of the incident was improper use of a nylon web sling that allowed the drill line to slip out, the crew deviated from the normal procedures for slip and cut drill line, poor communication, lack of supervision, tying off the drill line to the cat head that caused the abnormal twist, and the Permit to Work SOM for slip and cut drill line lacked instructions.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

Equipment Failure. Improper Use of Equipment. The improper use a nylon web sling that lost its bite allowed the 2-inch diameter drill line to slip through the sling and fall freely to the rig floor injuring a Seadrill employee.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Management Systems:
• Inadequate management of change procedures. The Seadrill Crew deviated from the normal procedures for slip and cut drill line by tying of the drill line to the Cat Head.
• Job procedures not followed. Poor pre-job task and the Permit to Work Standard Operation Manual for slip and cut drill line lacked instructions.

Supervision: Inadequate supervision. The Supervisor for the slip and cut drill line operations was not aware of the Seadrill Crew's plan of using a nylon web sling.

Communication: Inadequate job instructions provided. The Driller was informed by the Derrickman about that the Seadrill Crew's decision to lift the 2-inch drill line, but he failed to communicate to the Driller how this operation was going to be performed.

20. LIST THE ADDITIONAL INFORMATION:

List of Appendices:

21. PROPERTY DAMAGED:

No property was damaged during this incident.

NATURE OF DAMAGE:

Not applicable.

ESTIMATED AMOUNT (TOTAL): **$**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE Lafayette District makes no recommendations to the Office of Incident Investigations regarding this incident.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

A G-110 Incident of Non-Compliance was issued to document that LLOG Exploration Offshore, L.L.C. (LLOG) failed to comply with the regulatory requirement to operate in a safe and workmanlike manner. On 7 March 2024, LLOG Exploration, L.L.C. (LLOG) reported an incident on the Seadrill West Neptune when a Seadrill employee injured his middle back and left rear shoulder during cut and slip drill line operations. The injury occurred on 7 March 2024 when a 2-inch diameter drill line was being lowered by an air tugger from about 20 to 25 feet from the rig floor. The drill line slipped from the nylon web sling and fell striking a Seadrill employee who had fallen to the rig floor on his right shoulder when he was exiting the cone of exposure. Approximately 19 feet of the drill line weighing about 148 pounds struck the rear of the employee's hard hat, rolled over his middle back, and left rear shoulder and came to rest on his legs. He reported to the Rig Medic with a sore shoulder, and he was given over-the-counter medication and an ice pack. An onshore physician was consulted, and the employee was evacuated from the drillship for a medical evaluation. The doctor diagnosed that the employee had sustained a small tear (torn labrum) and strain to the back of his left shoulder. Surgery was not required but the Seadrill employee required physical therapy for an estimated time of 10 to 12 weeks.

LLOG shall submit a letter of explanation to the BSEE Lafayette District Manager concerning this incident, along with its plans to prevent all future incidents of this nature.

25. DATE OF ONSITE INVESTIGATION:

28-MAR-2024

26. Investigation Team Members/Panel Members:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR:

Mark Malbrue

APPROVED DATE: **07-JUL-2024**