

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **11-APR-2026** TIME: **0345** HOURS

2. OPERATOR: **Murphy Exploration & Production** (
REPRESENTATIVE:
TELEPHONE:
CONTRACTOR: **NOBLE DRILLING CORPORATION**
REPRESENTATIVE:
TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- 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: **G16987**
AREA: **WR** LATITUDE:
BLOCK: **425** LONGITUDE:

8. OPERATION:

- PRODUCTION
 - DRILLING
 - WORKOVER
 - COMPLETION
 - HELICOPTER
 - MOTOR VESSEL
 - PIPELINE SEGMENT NO.
 - OTHER
- TEMP ABAND
 - PERM ABAND
 - DECOM PIPELINE
 - DECOM FACILITY
 - SITE CLEARANCE

5. PLATFORM:
RIG NAME: **NOBLE STANLEY LAFOSSE (FKA PACIFIC SHARAV)**

6. ACTIVITY: EXPLORATION (POE)
 DEVELOPMENT/PRODUCTION (DOCD/POD)
 DECOMMISSIONING

7. TYPE:

INJURIES:

| | | |
|---|---|---|
| <input type="checkbox"/> HISTORIC INJURY | | |
| <input checked="" type="checkbox"/> REQUIRED EVACUATION | 0 | 1 |
| <input type="checkbox"/> LTA (1-3 days) | | |
| <input type="checkbox"/> LTA (>3 days) | | |
| <input type="checkbox"/> RW/JT (1-3 days) | | |
| <input checked="" type="checkbox"/> RW/JT (>3 days) | 0 | 1 |
| <input type="checkbox"/> FATALITY | | |
| <input type="checkbox"/> Other Injury | | |

9. CAUSE:

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

- POLLUTION
- FIRE
- EXPLOSION

LWC HISTORIC BLOWOUT
 UNDERGROUND
 SURFACE
 DEVERTER
 SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION HISTORIC >\$25K <=\$25K

10. WATER DEPTH: **8820** FT.
11. DISTANCE FROM SHORE: **160** MI.
12. WIND DIRECTION:
SPEED: M.P.H.
13. CURRENT DIRECTION:
SPEED: M.P.H.
14. SEA STATE: FT.
15. PICTURES TAKEN:
16. STATEMENT TAKEN:

On April 11, 2026, an employee suffered a hand injury from an incident that occurred on the Noble drillship Stanley Lafosse, which is working for Murphy Oil Corporation. Drilling operations were being conducted at Walker Ridge Block 425, OCS-G 16987, Well Chinook #5. Two roustabouts (RSTB1) and RSTB2 (IP) were tending to a tag line connected to a cantilever basket over the side of the vessel, from different decks. RSTB1 was located on the aft lower transfer deck and the IP was located on the aft tensioner deck. Following the release of the tag line from RSTB1 the full weight of the tag line was supported by IP which is 40 lbs. of tag line. The IP's left hand was pulled into the outboard vessel handrail and resulted in an injury to the top of the left hand. After the incident no immediate pain was reported, but discomfort developed later and was reported to the on-board medic. The decision was made to send the IP ashore by helicopter due to swelling. Medical evaluation identified a small bone fracture to the left pinky finger. On April 13, 2026, IP received a release with limitations that require finger splint.

RSTB1 and IP were assigned in tandem to control a tagline attached to a cantilever-mounted personnel work basket. The basket was manned and positioned along the port side of the vessel to conduct rust remediation activities on the vessel hull. A task risk assessment (TRA) was in place as well as a lift plan and work permit. A pre job meeting was conducted.

RSTB1, second in tandem and holding the dead end of the tagline, communicated with the IP of his intent to release the tagline to reposition himself for a better angle. Upon release of the tagline tension by RSTB1 control of the basket was maintained by the IP. Following the release of tension by RSTB1, the IP has the full weight of the tag line in her hands. The IP's left hand was pulled into the vessel outboard handrail. This resulted in an injury to the top of the left hand.

At the time of the incident no immediate pain was reported, but discomfort developed later and was reported to the on-board medic. The IP was initially examined by the medic and returned to duty. The decision was made to send the IP ashore by helicopter due to swelling. Medical evaluation identified a small bone fracture to the left pinky finger. An incident investigation report was started by Noble.

The Bureau of Safety and Environmental Enforcement (BSEE) Houma District office was notified orally, and a written report was submitted in 15 days. The BSEE Houma District Inspectors (Inspectors) were able to conduct an onsite investigation on April 16, 2026, and photos, witness statements and TRAs were obtained. After reviewing the TRAs and documents, BSEE found it to be inadequate. The TRAs are generic and not job specific. They fail to include hazards associated with handling large taglines, positions of personnel to handrails, performing operations on multiple decks and over the side activities. Also, it was found that there was poor communication between RSTB1 and the IP, loss of situational awareness with hand placement in the line of fire to the handrail, and inadequate hazard recognition with the weight of the tagline and resulting shock load when released. The IP was wearing proper PPE as per the first report and the pictures submitted by the operator. Finally, BSEE concurs with the findings in Noble's incident investigation report.

After conducting an onsite investigation, reviewing pictures, documents and the Noble incident investigation report, BSEE concluded that the hazards associated with handling large taglines (consider weight, size, need for additional personnel, hand off procedures and handling). BSEE believes that a proper hazard analysis would have prevented this incident.

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

Managment systems - inadequate hazard analysis

Communication - inadequate job instructions provided

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

Human Performance Error - inattention to task. Not aware of hazards.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

N/A

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

BSEE Houma District does not have any recommendations for the Office of Incident Investigations at this time.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

N/A

25. DATE OF ONSITE INVESTIGATION:

28. ACCIDENT CLASSIFICATION:

16-APR-2026

26. Investigation Team Members/Panel Members:

29. ACCIDENT INVESTIGATION PANEL FORMED:
NO

27. OPERATOR REPORT ON FILE:

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED

DATE:

29-MAY-2026