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UNITED STATES DEPARTMENT OF THE INTERIOR
MARINE MINERALS ADMINISTRATION
GULF OF AMERICA REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **09-JUL-2026** TIME: **1105** HOURS
2. OPERATOR: **Talos Petroleum LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Seadrill Americas**
   REPRESENTATIVE:
   TELEPHONE:

- [ ] STRUCTURAL DAMAGE
- [X] 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: **G35724**
   AREA: **WR** LATITUDE:
   BLOCK: **107** LONGITUDE:

5. PLATFORM:
   RIG NAME: **Seadrill West Vela**

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

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

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

10. WATER DEPTH: **5918** FT.
11. DISTANCE FROM SHORE: **161** 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:

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On July 9, 2026, a lifting incident occurred on the Seadrill West Vela which was working for Talos Petroleum LLC. Drilling operations were being conducted at Walker Ridge Block 107, OCS-G 35724. A deck crew consisting of a crane operator (CO), banksman (BM), and roustabout (IP) were tasked with repositioning a 2" chiksan rack for backloading. The IP attached the chiksan rack rigging to the crane's fast line. The IP then walked between the chiksan rack and a 550-gallon tote tank while attempting to attach a tagline to the rack. While the IP attempted to attach the tagline, the CO picked up the slack in the chiksan rack rigging. One leg of the four-legged rigging was snagged on the chiksan rack causing the chiksan rack to abruptly shift towards the IP. The IP was caught between the chiksan rack and the 550-gallon tote tank resulting in a broken leg. The rig medic was notified immediately. The rig medic evaluated the IP and consulted with shore-based physician. The decision was made to send the IP to Terrebonne General Hospital for further evaluation via medevac helicopter.

A Pre-General Lifts on Deck checklist was filled out and signed by the CO, BM, and IP. According to witness statements taken from the deck crew, there was a toolbox talk (a pre-job meeting with everyone involved in the task). During the toolbox talk the CO, BM, and IP discussed the task, body placement, and staying hydrated. The deck crew got into position and started the task of repositioning the chiksan rack. The IP successfully attached the chiksan rack rigging to the crane's fast line. The IP attempted to attach the tagline to the load while the CO simultaneously attempted to take the slack out of the rigging.

The CO was taking the slack out of the chiksan rigging while the IP attempted to attach the tag line to the load. One leg of the rigging snagged the chiksan rack causing the rack to swing towards the IP abruptly. The IP was standing between the chiksan rack and a 550-gallon tote tank. The IP was pinned between the chiksan rack and the 550-gallon tote tank resulting in a broken leg.

Crane movement was stopped, the IP freed, and assessed by the rig medic. The IP was sent in for further evaluation via medevac. All work on the deck was suspended and the area was secured for investigation. The scene remained undisturbed until the equipment was confirmed safe and stable. The Offshore Installation Manager (OIM) authorized work to recommence after the scene was fully assessed, evidence collected, and all the hazards were adequately controlled.

The Marine Minerals Administration (MMA) Houma District office was notified on July 9, 2026, and a written report was submitted on September 1, 2026, after multiple extensions were granted due to the nature of the incident. The MMA Houma District issued a preservation order and the MMA Houma District Inspectors (Inspectors) conducted an onsite investigation on July 11, 2026. The inspectors obtained witness statements, pre-job paperwork, pictures, incident reports, and conducted witness interviews with the CO and BM. After reviewing the witness statements and the Pre-General Lifts on Deck checklist, MMA found there was improper identification of the hazards and steps to mitigate them. Also, it was noted that the CO stated the BM told him to take the slack out of the rigging. The BM's witness statement showed that the CO hoisted up without being told to do so. MMA's witness interviews with the CO and BM confirmed that no signal was given to the CO to take the slack out of the rigging.

After reviewing the Pre-General Lifts on Deck checklist, MMA discovered only two hazards were identified. The first hazard was heat and humidity with a control stating to hydrate and take breaks. The second hazard was shortchange (meaning the crew started work earlier than normal to swap from working days to nights) with the control of everyone to keep an eye on each other. The witness statements collected from the CO, BM, and IP noted the controls of body placement and staying hydrated but lacked specific hazards for repositioning the chiksan rack. After reviewing

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Seadrill's Lifting Operations Directive (LOD), it was noted that the CO did have a designated banksman but failed to follow policy by hoisting up without being signaled. Also, the LOD says to use hands free push-pull sticks during lifting operations and to use tag lines as required by the risk assessment. There was no risk assessment for the use of tag lines. The final cause identified was the congested deck limited escape routes. MMA Houma District concludes that the above factors contributed to this incident.

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

Human performance error – Not aware of the hazards. Not following proper procedures.
Communication – Inadequate job instructions provided
Management systems – Inadequate hazard analysis and inadequate written job procedure.

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

Work environment – congested work area.

20. LIST THE ADDITIONAL INFORMATION:

n/a

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

MMA Houma District has no recommendations to the Office of Incident Investigations at this time.

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

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

25. DATE OF ONSITE INVESTIGATION:

11-JUL-2026

26. Investigation Team Members/Panel Members:

27. OPERATOR REPORT ON FILE:

28. ACCIDENT CLASSIFICATION:

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Amy Gresham

APPROVED DATE: **08-OCT-2026**