1. OCURRED
   DATE: 05-MAY-2016   TIME: 0930   HOURS

2. OPERATOR: LLOG Exploration Offshore, L.L.C.
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: Seadrill Limited
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: G33764
   AREA: MC   LATITUDE: 895
   BLOCK:   LONGITUDE:

5. PLATFORM:
   RIG NAME: Seadrill West Neptune

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

7. TYPE:
   HISTORIC INJURY
   REQUIRED EVACUATION 1
   LTA (1-3 days) 1
   LTA (>3 days) 1
   RW/JT (1-3 days)
   RW/JT (>3 days)
   Other Injury

   FATALITY
   POLLUTION
   FIRE
   EXPLOSION

8. CAUSE:
   EQUIPMENT FAILURE
   HUMAN ERROR
   EXTERNAL DAMAGE
   SLIP/TRIP/FALL
   WEATHER RELATED
   LEAK
   UPSET H2O TREATING
   OVERBOARD DRILLING FLUID

9. WATER DEPTH: 3682 FT.

10. DISTANCE FROM SHORE: 52 MI.

11. WIND DIRECTION: WNW
    SPEED: 17 M.P.H.

12. CURRENT DIRECTION: NNE
    SPEED: 2 M.P.H.

13. SEA STATE: 4 FT.
The following incident occurred onboard the Drillship Seadrill West Neptune on 5-May-2016 at approximately 09:30-hrs. The incident occurred after a successful crane lift had been performed. The Injured Person (I.P.) is a rig roustabout and the incident occurred on the pipe skate deck aft of the rig floor. The injury (right arm) required an evacuation of the I.P. from the facility. After further medical evaluation, surgery was required to repair the Ulna bone in the right arm.

The crane crew consisted of an Assistant Crane Operator (ACO) and two Roustabouts. A lift of a TIW valve from the rig floor to the sub-sea set back area had just been completed. Prior to conducting the lift the ACO noticed that one of the guide arms at the end of the crane boom was stuck at a 90-degree angle. (Each guide arm weighs approximately 300-lbs.). The ACO decided to proceed with the lift without notifying any supervisors concerning this issue. The ACO then positioned the crane boom over the handrail of the port riser skate bridge area. This was done in order for the roustabout (I.P.) to access the stuck guide arm. NOTE: Seadrill has a policy in place for all crane and lifting operations to be hands free. After instruction from the ACO the I.P. reached up with his left hand and touched the guide arm causing it to break loose. Witness statements state that as the guide arm was coming down the I.P. attempted to stop the guide arm with his right hand/arm from colliding with the handrail. At this time the I.P.'s arm was caught between the guide arm and the handrail causing the injury.

Witness interviews have stated that this guide arm had become stuck on at least three previous occasions, although no written records or reports were available.

No former risk assessment as per Seadrill Directive was performed prior to this task being conducted.

This was also the I.P.'s first hitch on this rig and was directed to perform a task that he had never previously performed.

Two of the three personnel involved in the operation were new to their positions.

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

- Human error. (Poor hand/arm placement).
- Lack of experience by personnel involved.
- No tools were used to aid the crew in freeing-up the Guide Arm. (Seadrill’s Hands Free Policy).

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

- The decision to perform the freeing of the Guide Arm was made by the ACO who had never performed this task previously.
- The I.P. placed himself directly in the line of fire by manually handling the Guide Arm.
No supervision was present at the immediate job site.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED: None

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The BSEE New Orleans District makes no recommendations to the Office of Incident Investigation.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

G-110 (C) 250.107 (A) At the time Incident Investigation was conducted it was determined the Lessee did not perform all operations in a safe and workmanlike manner.

This resulted in an injury (Right Arm) requiring the I.P. to be evacuated from the facility.

25. DATE OF ONSITE INVESTIGATION:

10-MAY-2016

26. ONSITE TEAM MEMBERS:

Earl Roy /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

30. DISTRICT SUPERVISOR:

David Trocquet
<table>
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**NAME:**

**HOME ADDRESS:**

**CITY:**

**STATE:**

**WORK PHONE:**

**TOTAL OFFSHORE EXPERIENCE:**

**EMPLOYED BY:** Seadrill Limited / 20814

**BUSINESS ADDRESS:** 11210 Equity Drive, Suite 150

**CITY:** Houston

**STATE:** TX

**ZIP CODE:** 77041

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