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

ACCIDENT INVESTIGATION REPORT

For Public Release

1. OCCURRED
   DATE: **22-OCT-2015** TIME: **0600** HOURS

2. OPERATOR: **Statoil Gulf of Mexico LLC**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Transocean Offshore**
   REPRESENTATIVE:
   TELEPHONE:

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

4. LEASE: **G34634**
   AREA: **WR** LATITUDE:
   BLOCK: **160** LONGITUDE:

5. PLATFORM:
   RIG NAME: **T.O. DISCOVERER AMERICAS**

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

7. TYPE:
- [ ] HISTORIC INJURY
  - [ ] REQUIRED EVACUATION
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [X] RW/JT (1-3 days) **1**
  - [ ] RW/JT (>3 days)
  - [X] Other Injury **1 Fractured Toe**
- [ ] FATALITY
- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION
- LWC
  - [ ] HISTORIC BLOWOUT
  - [ ] UNDERGROUND
  - [ ] SURFACE
  - [ ] DEVERTER
  - [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES
- COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K
- [ ] STRUCTURAL DAMAGE
- [ ] CRANE
- [X] OTHER LIFTING DEVICE **Sling-Core Barrel**
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [ ] PRODUCTION
- [X] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

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

9. WATER DEPTH: **5868** FT.

10. DISTANCE FROM SHORE: **158** MI.

11. WIND DIRECTION: **SW**
    SPEED: **22** M.P.H.

12. CURRENT DIRECTION:
    SPEED: **1** M.P.H.

13. SEA STATE: **5** FT.

17. INVESTIGATION FINDINGS:

On October 22, 2015, while performing drilling operations on Statoil's #002 well, Transocean's Discoverer Americas experienced an incident where an employee working on the drill floor was struck on the foot by a coring barrel while retrieving a sample from the wellbore.

At the time of the incident, the Discoverer Americas was working in Walker Ridge Block 160, Lease G34634. The crew had just finished taking a core sample from the well and was preparing to transfer the coring barrel to the transport rack to be analyzed. The coring barrel was hoisted from the well utilizing the rig's Top Drive as the transport rack for the barrel was moved into place utilizing an air hoist also located on the rig floor. Two taglines were attached to the coring barrel so that the Floorhands could guide the barrel into place as it was being lowered into the rack.

As the barrel was being lowered into place, the bottom of the barrel became hung up on one of the hang off pins on the rack, forming slack in the line the barrel was suspended from and allowing the barrel to shift to one side. Once the Floorhands noticed slack in the line, they signaled to the Driller to stop lowering the block and to pick up so the barrel could be readjusted. As the Driller began picking up on the block, the barrel shifted and came free from the rack, falling to the deck and striking one of the Floorhands on his left foot.

All operations on the drill floor were stopped following the incident. The Injured Party (IP) was sent to the onboard Medic for evaluation. At the time, immediately following the incident, the IP claimed he wasn't in any pain and it was thought that the steel toe of his boot had prevented any injury from occurring. It was only after the employee was sent in the following day, due to a family emergency, that some bruising and swelling of the IP's toe warranted further evaluation from an onshore Physician. It was at this time that it was determined the IP had sustained a fracture to one of the toes on his left foot. The IP was placed on Restricted Work duty and released to work by the Physician.

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

(1) Excessive slack in the line allowed the barrel to reach deck level, striking the IP's left foot, after falling from the transport rack.

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

(1) Poor Body Placement: The IP's body placement put him 'In the Line of Fire', regardless of taglines being utilized throughout the operation.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

N/A

NATURE OF DAMAGE:

N/A

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

The Houma District has no recommendations for the Regional Office 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:

29-OCT-2015

26. ONSITE TEAM MEMBERS:

James Richard /

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

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED DATE: **07-DEC-2015**