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

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **02-JUN-2025** TIME: **2230** HOURS

2. OPERATOR: **Hess Corporation**
   REPRESENTATIVE:
   TELEPHONE:
   CONTRACTOR: **Transocean Offshore**
   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: **G07461**
   AREA: **GB** LATITUDE:
   BLOCK: **259** LONGITUDE:

5. PLATFORM:
   RIG NAME: **T.O. DEEPWATER ASGARD**

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: **1789** FT.

11. DISTANCE FROM SHORE: **96** 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:

Incident Summary:
On 02 June 2025, a hand injury occurred during drilling operations being conducted by Hess Corporation (Hess) at Garden Banks Block 259. The injury happened when a Transocean Second Engineer was checking the tension on an air handling unit (AHU) belt in the Mud Module Electrical Room (MMER).

Sequence of Events:
On 1 June 2025, a Transocean Second Engineer replaced the belt on an AHU located in the MMER. On 2 June 2025, while alone in the MMER performing another task, the Transocean Second Engineer heard a noise coming from AHU and decided to investigate. He shut off the power to the AHU and removed the guard over the AHU belt. When inspecting the tension of the AHU belt, he placed his left hand on the belt while the belt and pully were still in motion. His left hand was drawn up by the moving belt in between the belt and pulley that resulted in the partial amputation of the left hand middle and ring fingertips. Prior to checking the AHU belt, he did not communicate his change of plans to anyone about turning off power to the AHU equipment versus the required full isolation by lockout/tagout.

The Transocean Second Engineer reported to the Rig Medic for treatment. On 3 June 2025, he was evacuated by a medevac helicopter to East Jefferson Hospital located in Metairie, Louisiana for a medical evaluation and further treatment. His injuries included the amputation of distal ends of the left hand middle and ring finger with open non-displaced fractures of phalanges. He had minor surgery to close the wound as replantation which was not possible. After the surgery, the Transocean Second Engineer was released to work with light duty restrictions.

BSEE Investigation:
On 4 June 2025, the Bureau of Safety and Environmental Enforcement (BSEE) Lafayette District conducted an onsite Incident Follow-up Investigation. BSEE investigators met with Hess and Transocean representatives and gathered all available incident-related documents.

The BSEE Incident Investigation Team determined that the cause of the injury was improper hand placement. The Transocean Second Engineer placed his left hand on the moving AHU belt that caused his injury. The BSEE Incident Investigation Team reviewed the operator's report as well as the operator's policies and procedures. The BSEE Incident Investigation Team verified the operator's findings that the task of checking the tension on the AHU belt would have required a full energy isolation (LOTO) in place per the requirements of Transocean's Energy Isolation Process and would have required a supervisory approval process for the task. The Transocean Second Engineer did not isolate the energy to the AHU using the lockout/tagout system. The operator's report further stated the Transocean Second Engineer had no supervision at the time of the injury, nor did he communicate his decision to check the belt's tension to his supervisor as required by the Transocean policy for Lone Workers. The Transocean Second Engineer did not adhere to a Transocean Hazard Identification Prompt Card that was completed for identifying line of fire hazards where personnel could be caught by moving equipment.

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

Human Performance Error: The Transocean Second Engineer made the decision to check the AHU belt's tension by placing his left hand on a moving belt that drew up his hand between the belt and pulley causing his injury.

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

Work Environment:

• No lockout/tagout. The Transocean Second Engineer did not isolate the energy to the AHU using the lockout/tagout system.

Supervision:

• No supervision. The Transocean Second Engineer had no supervision at the time of the injury, nor did he communicate his decision to check the belt's tension to his supervisor.

Management Systems:

• Inadequate hazard analysis. A Transocean Hazard Identification Prompt Card was completed for identifying line of fire hazards where personnel could be caught by moving equipment but was not followed by the Transocean Second Engineer.

20. LIST THE ADDITIONAL INFORMATION:

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:

Based on the incident investigation findings, a G-110 (C) Incident of Noncompliance (INC) is issued to document that Hess Corporation (Hess) failed to perform operations in a safe and workmanlike manner during drilling operations on the Transocean (TO) Deepwater Asgard drillship located at Garden Banks Block 259.

On 02 June 2025, a Transocean Second Engineer injured his left hand while checking the tension on an air handling unit (AHU) belt that was not properly isolated before performing the work. The Transocean Second Engineer was evacuated from the drillship and was treated for the amputation of distal ends of the left hand middle and ring finger with open non-displaced fractures of phalanges.

A BSEE Incident Follow-up Investigation Team determined that the Transocean Second Engineer's left-hand injury was due to the following: 1) human performance error due to improper hand placement when he made the decision to check the AHU belt's tension by placing his left hand on a moving belt that drew up his hand between the belt and pulley causing his injury; 2) The Transocean Second Engineer did not isolate the energy to the AHU using the lockout/tagout system; 3) The Transocean Second Engineer had no supervision at the time of the injury, nor did he communicate his decision to check the belt's tension to his supervisor and 4) the Transocean Second Engineer did not adhere to a Transocean Hazard Identification Prompt Card that was completed for identifying line of fire hazards where personnel could be caught by moving equipment.

Hess must submit a letter of explanation within 14 days to the Lafayette District Well Operations Section Chief on the above Incident of Non-Compliance along with plans to

prevent future incidents of this nature.

25. DATE OF ONSITE INVESTIGATION:

04-JUN-2025

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:

Mark Malbrue

APPROVED DATE: **04-SEP-2025**