ACCIDENT INVESTIGATION REPORT

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: T.O. DISCOVERER AMERICAS

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

7. TYPE:
   HISTORIC INJURY 
   REQUIRED EVACUATION
   LTA (1-3 days) 
   LTA (>3 days) 
   RW/JT (1-3 days) 1 
   RW/JT (>3 days) 
   Other Injury 1 Fractured Toe
   FATALITY 
   POLLUTION 
   FIRE 
   EXPLOSION
   LWC HISTORIC BLOWOUT 
   UNDERGROUND 
   SURFACE 
   DEVERTER 
   SURFACE EQUIPMENT FAILURE OR PROCEDURES
   COLLISION HISTORIC $25K <=$25K

8. CAUSE:
   EQUIPMENT FAILURE
   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.
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 IF 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