MOBIL CHEMICAL COMPANY
INCIDENT DATA SYSTEM INFORMATION

INCIDENT SEVERITY TABLE

PLAINTIFF'S EXHIBIT
MBL-7

PLACE A CHARACTER TO THE LEFT OF THE TABLE CODE WHICH APPLIES TO THIS INCIDENT.

_	1	NEAR MISS
_	2	FIRST AID
X	3	MED TREATMENT
_	4	LOST TIME-RESTR
_	5	LOST TIME-AWAY
_	6	FATALITY

NUMBER OF DAYS RESTRICTED
NUMBER OF LOST WORKDAYS
FIRST DAY OUT
EXPECTED RETURN

EMPLOYEE'S NAME J D Dunn
REPORT LOCATION O/A Clinic
INCIDENT DATE 3-13-92

ACTUAL RETURN DATE
TIME OF RETURN

ACCIDENT CODE TABLE

_	10	STRUCK AGAINST
_	20	FALL FROM ELEVATION
_	22	FALL ON AGAINST OBJECT
_	30	CAUGHT BY/IN/UNDER/BETWEE
_	40	VIBRATING OBJECT
_	43	ABRASION/RUB/SCRATCH
_	45	VOLUNTARY MOTION/ACTION
_	60	EXPOSURE - ELECTRICITY
_	62	EXPOSURE - TEMP EXTREMES
_	64	EXPOSURE - RADIATION
_	66	EXPOSURE - ACIDS
_	68	EXPOSURE - FIRE/SMOKE/FUM
_	70	EXP - LIGHT/INFRARED/LASE
_	72	EXP - OTHER PHYSICAL AGEN
_	81	GENERAL HEAT
_	83	HOT OBJECT
_	99	OTHER

_	12	STRUCK BY
_	21	SLIP/TRIP/NO FALL
_	23	FALL FROM SAME LEVEL
_	35	ASPHYXIATE/DROWN/SMOTHER
X	41	FOREIGN MATERIAL IN EYE
_	44	INVOLUNTARY MOTION/ACTION
_	50	OVEREXERTION/STRAIN/STRES
_	61	EXPOSURE - CHEMICAL
_	63	EXPOSURE - NOISE/PRESSURE
_	65	EXPOSURE - HYDROCARBONS
_	67	EXPOSURE - DRUGS/ALCOHOL
_	69	EXPOSURE - DUST/PWDER/SAN
_	71	EXP - ANIMAL/INSECT/PLANT
_	75	MOTOR VEHICL
_	76	PUBLIC TRANSPORT
_	82	GENERAL COLD
_	84	COLD OBJECT

NATURE OF INJURY TABLE

_	10	AMPUTATION/ENUCLEATION
_	12	BURN - THERMAL/ELECTRICAL
_	14	CONCUSSION/UNCONSCIOUS
_	16	BRUISE/CONTUSION
_	18	SKIN DISORDERS/DERMATITIS
_	20	ELECTRIC SHOCK
_	22	HYPOTHERMA/FROSTBITE
_	24	HEAT STRESS/SUNSTROKE
_	26	INFLAMATION/INFECTION
_	28	LUNG DISEASE
_	30	SCRATCHES/ABRASIONS
_	32	RESPIRATORY - TOXIC AGENT
_	34	REPEATED TRAUMA
_	36	POISONING - CHRONIC
X	50	FOREIGN BODY IN EYE
_	80	OTHER

_	11	SUFFOCATE/DROWN/ASPHYXIAT
_	13	BURN - CHEMICAL
_	15	CONTAG/INFECT DISEASE
_	17	CUT/LACERATION
_	19	FRACTURE/CRUSH
_	21	DISLOCATION
_	23	HEARING LOSS/IMPAIRMENT
_	25	HERNIA/RUPTURE
_	27	POISONING-ACUTE
_	29	RADIATION
_	31	SPRAIN/STRAIN
_	33	PHYSICAL AGENTS
_	35	BITES/STINGS
_	37	HEART CONDIT
_	40	MULTIPLE INJURIES
_	70	OCCUPATIONAL DISEASE
_	99	UNDETERMINED

003117

249169

INCIDENT CAUSE TABLE SELECTIONS

10	PHYSICAL LIMITATION
11	DEFICIENT SKILL/ABILITY/KNOWLEDGE
12	INFLUENCE OF DRUGS/ALCOHOL
13	NOT ALERT/INATTENTIVE
14	MENTAL PROBLEMS
15	WILLFUL RISK TAKEN
16	FATIGUE
X 17	FAILURE TO RECOGNIZE HAZARD
18	MAKE SAFETY DEVICE INOPERABLE
19	REPETITIVE MOTION
20	WRITTEN PROCS/INSTR NOT FOLLOWED
21	SPACE ENTRY PROCEDURE NOT FOLLOWED
22	HOT WORK PROCEDURE NOT FOLLOWED
23	LINE BREAK PROCEDURE NOT FOLLOWED
24	LOCKOUT/TAGOUT PROCEDURE NOT FOLLOWED
25	PRESSURIZED EQUIP/LINE PROC NOT FOLLOWED
26	SAFETY PERMIT PROCEDURE NOT FOLLOWED
30	FAILURE TO FOLLOW ORAL INSTRUCTIONS
31	IMPROPER LIFTING
32	IMPROPER LOAD/PLACEMENT
33	HORSEPLAY
35	UNSUITABLE CLOTHING
40	PROTECTIVE EQUIPMENT NOT USED
41	OPERATING WITHOUT AUTHORITY
42	TAKING AN UNSAFE POSITION
43	UNSAFE SPEED/HASTE
44	IMPROPER USE OF TOOLS/EQUIP/MATERIALS
45	USE OF INCORRECT TOOLS/EQUIP/MATERIALS
46	IMPROPER HANDLING OF EQUIPMENT
50	INCORRECT/INCOMPLETE PROCS/INSTRUCTIONS
51	RULES/PROCEDURES/POLICIES NOT ENFORCED
52	INADEQUATE/INCOMPLETE TRAINING
53	PROPER TOOLS/EQUIPMENT NOT PROVIDED
54	DEFICIENT MATERIAL HANDLING PRACTICES
55	INADEQUATE HOUSEKEEPING/INSPECTION
56	UNWARRENTED HASTE BY SUPERVISOR
57	HAZARD NOT PROPERLY IDENTIFIED
58	FAILURE TO WARN/SECURE
59	INADEQUATE EVALUATION OF ABILITY
60	DEFECTIVE EQUIPMENT/TOOL/MATERIALS
61	INADEQUATE/MISSING GUARD/PROTECTION
62	INADEQUATE/BYPASSED SAFETY DEVICES
63	INADEQUATE MAINTENANCE/INSPECTIONS
64	INADEQUATE LIGHTING
65	INADEQUATE VENTILATION
66	INADEQUATE DESIGN/INSUFFICIENT SPACE
67	INADEQUATE FABRICATION/INSTALLATION
68	INADEQUATE WARNING SYSTEM
70	HORSEPLAY/DISTRACTION BY 3RD PARTY
71	ERROR BY 3RD PARTY
72	UNSAFE 3RD PARTY EQUIP/MATERIAL/ACTION
73	UPSET CONDITIONS - FIRE/EXPLOSION SPILL
74	EXPOSURE TO PHYS/CHEM/BIO AGENTS
75	WEATHER
76	EXCESSIVE NOISE
77	FIRE/EXPLOSION HAZARD
78	EXPOSURE TO RADIATION
80	UNDETERMINED
99	OTHER

I top two copies of this form to:
CAS WORKERS' COMPENSATION COMMISSION
tral Office. 4000 South IH-35. Southfield Building
tin. Texas 78704

d the specified copies to your Workers' Compensation
rier and the injured employee. Please read instruction
t CAREFULLY, giving special attention to items marked
an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

ame (Last, First, M.I.) | 2. Sex F ☐ M ☒ | 15. Date of Injury (m-d-y) 3-14-92 | 16. Time of Injury 7:00 am ☐ pm ☒ | 17. Date Lost Time Began (m-d-y)

cial Security Number 433-29-9678 | 4. Home Phone (409) 722-0000 | 5. Date of Birth (m-d-y)

oes the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

ace White ☒ Black ☐ Asian ☐ | 8. Ethnicity Hispanic ☐ Native American ☒ Other ☐

18. Nature of Injury* Eye - Foreign Body | 19. Part of Body Injured or Exposed* Eye

20. How and Why Injury/Illness Occurred*
Employee was using a grinder to grind a piece of metal when a piece flew into his eye.

ailing Address
et or P.O. Box 3130 Eastex Fwy

State TX | ZIP Code | County Jefferson

21. Was employee doing his regular job? YES ☒ NO ☐ | 22. Worksite Location of Injury (stairs, dock, etc.)* Eastex Fwy

Marital Status
Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site
Street or P.O. Box 3130 Eastex Fwy | County Jefferson

Number of Dependent Children | 12. Spouse's Name

City Beaumont | State TX | ZIP Code 77704

Doctor's Name
St. Elizabeth Hospital (E.C.)

24. Cause of Injury (fall, tool, machine, etc.)*
Employee was using a grinder

Doctor's Mailing Address (Street or P.O. Box)
2830 Calder Ave

State Texas | ZIP Code 77702

25. List Witnesses
None

26. Return to work date/or expected (m-d-y) 3-15-92 | 27. Did employee die? YES ☐ NO ☒ | 28. Supervisor's Name Ewing | 29. Date Reported (m-d-y) 3-14-92

Date of Hire (m-d-y) | 31. Was employee hired or recruited in Texas? YES ☒ NO ☐

32. Length of Service in Current Position Months ____ Years 11 | 33. Length of Service in Occupation Months 1 Years 11

Employee Payroll Classification Code 61

35. Occupation of Injured Worker Precision Operator

Rate of Pay at this Job $ ____ Hourly $ ____ Weekly | 37. Full Work Week is: 40 Hours ____ Days

38. Last Paycheck was: $ ____ for ____ Hours or ____ Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☒

Name and Title of Person Completing Form
J. Bruce SK

41. Name of Business
Mid-County Machine Co

Business Mailing Address and Telephone Number
Street or P.O. Box | Telephone 409-729-1231

43. Business Location (If different from mailing address)
Number and Street 3614 3862

City | State | ZIP Code
Beaumont TX 77704

City Beaumont | State TX | ZIP Code 77704

Federal Tax Identification Number 75-1770 | 45. Primary Standard Industrial Classification (SIC) Code* (4 digit) 3599 | 46. Specific SIC Code* (4 digit) 3599 | 47. Texas Comptroller Taxpayer No.

Workers' Compensation Insurance Company | 49. Policy Number

Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X J. Bruce SK | Date

WCC-1 (2-91)
13/91

EMPLOYEE/EMPLOYER REPORT

249171

Rule 120.2

MOBIL OIL CORPORATION
MEDICAL DEPARTMENT
MEDICAL TREATMENT REPORT

FCO-429B (9/87)

☒ INITIAL VISIT ☐ FOLLOW-UP VISIT

Beaumont Mobil Chemical OA.	3/19/92	3/14/92
T NAME AND ADDRESS	DATE OF THIS VISIT	DATE OF ONSET OR CASE NUMBER

M. SECURITY NO. 3-28-9676	NAME Duncan, James Donald	JOB CLASSIFICATION Operator	AGE	SEX ☒ MALE ☐ FEMALE
DENCE 2 10½ Street Nederland Tx.	TELEPHONE 722-4828	SUPERVISOR D.D. Forrest Don Rogers	EXTENSION 1225	DEPARTMENT Pro-1 Ethylene
T 3/14/92 TIME 5pm.	LOCATION (BUILDING, FLOOR, SECTION, ETC.) Area #8 & #9	PHYSICAL WORK LOCATION CODE	FIRST REPORTED TO MEDICAL DATE 3/19/92 TIME 9:07 AM	

OSITION ☒ RETURNED TO WORK ☒ MEDICAL RESTRICTIONS EXPLAIN BELOW

NOT RETURNED TO WORK ☐ HOME ☐ CONSULTANT DETAIL BELOW ☐ HOSPITAL DETAIL BELOW ☐ OTHER DETAIL BELOW

No activities other than sedentary work.

IF REFERRED TO CONSULTANT OR HOSPITAL, PLEASE RECORD: NAME AND ADDRESS OF M.D. OR HOSPITAL

Dr Mae E. Wesson M.D
2900 North Street - #103
Beaumont, Tx

OTHER—PLEASE EXPLAIN

URN FOR ADDITIONAL TREATMENT YES ☐ NO DATE 3/20/92

D INITIALS MN

DISCHARGE DATE

INITIAL—HISTORY OF COMPLAINTS (IN PATIENT'S OWN WORDS—WHAT, HOW, WHY, WITNESSES—IF ANY)
FOLLOW-UP—CURRENT STATUS

Filling 18 wheeler from F2310 Drum. was under 500 lb. nitrogen pressure. Hose jerked back and I closed the hatch but it wouldn't hold and the liquid from the hose grayed face and hit left eye knocking lens out of safety glasses. Went to shower & washed eye and taken to St. Eliz. Hosp. by McC O/A ambulance - Seen by Dr Mae Wesson M.D. Was treated & eye patched, seen 3/15, 3/16, 3/17. Will see today @ 10AM. Now - having discomfort from abrasions & contusions - both lower legs and discomfort to scrotum.

ICAL FINDINGS:

(L) eye - conjunctiva injected Scrotum - excoriated
& erythematous anteriorly Skin - excoriated

X-RAY DATE ☐ MOBIL ☐ OTHER

ESSION:

Isolated lesions on LE
1) Corneal abrasion & chemical conjunctivitis
2) Acute chemical burn with possible early 2° infection - scrotum
3) Excoriated lesions - LE

ATMENT:

1) F/U Dr Wesson - Optho
2) Cont topical antibiotics - scrotum / lesions
3) Start Eye C 250 qid x 10d
4) RTC daily

ARKS:

IF DETERMINED ...
WORK-RELATED ...

RN
MD

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MOBIL OIL CORPORATION
MEDICAL DEPARTMENT

FCO-429B (9/87)

MEDICAL TREATMENT REPORT

☒ INITIAL VISIT ☐ FOLLOW-UP VISIT

IT NAME AND ADDRESS | DATE OF THIS VISIT | DATE OF ONSET OR CASE NUMBER

IAL SECURITY NO.	NAME	JOB CLASSIFICATION	AGE	SEX ☐ MALE ☐ FEMALE
DENCE	TELEPHONE	SUPERVISOR	EXTENSION	DEPARTMENT
ET TIME	LOCATION (BUILDING, FLOOR, SECTION, ETC.)	PHYSICAL WORK LOCATION CODE		FIRST REPORTED TO MEDICAL DATE TIME

POSITION ☐ RETURNED TO WORK ☐ MEDICAL RESTRICTIONS EXPLAIN BELOW | NOT RETURNED TO WORK ☐ HOME ☐ CONSULTANT DETAIL BELOW ☐ HOSPITAL DETAIL BELOW ☐ OTHER DETAIL BELOW

IF REFERRED TO CONSULTANT OR HOSPITAL, PLEASE RECORD:
NAME AND ADDRESS OF M.D. OR HOSPITAL

OTHER—PLEASE EXPLAIN

URN FOR ADDITIONAL TREATMENT
YES ☐ NO DATE

AD INITIALS | DISCHARGE DATE

F INITIAL—HISTORY OF COMPLAINTS *(IN PATIENT'S OWN WORDS—WHAT, HOW, WHY, WITNESSES—IF ANY)*
F FOLLOW-UP—CURRENT STATUS

ICAL FINDINGS:

X-RAY DATE ☐ MOBIL ☐ OTHER

ESSION:

ATMENT:

ARKS:

RN
MD

249173

To File

Don came back to work on 3-15-92 without restriction did normal sof task

[illegible]

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