1. OCCURRED
   DATE: 13-MAR-2008   TIME: 0715   HOURS

2. OPERATOR: Chevron U.S.A. Inc.
   REPRESENTATIVE: Matthews, Justin
   TELEPHONE: (337) 989-3435

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

4. LEASE: G02318
   AREA: EI   LATITUDE:
   BLOCK: 339   LONGITUDE:

5. PLATFORM: C
   RIG NAME:

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

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

   PATALITY
   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: 268 FT.

10. DISTANCE FROM SHORE: 83 MI.

11. WIND DIRECTION: NE
    SPEED: 10 M.P.H.

12. CURRENT DIRECTION: NE
    SPEED: 10 M.P.H.

13. SEA STATE: 4 FT.
While utilizing the platform crane, a third party contractor improperly attached a two-part sling to a wireline lubricator in preparation for lifting a lubricator on well C-13. Contract Employee No.1 attached the lubricator sling D-ring to the fast line hook of the crane. Contract Employee No. 2 began to assist Employee No.1 with the rigging operations in preparation for making the lift. For unknown reasons a safety pin was inserted into the latch of the hook preventing the latch from opening allowing the D-ring to remain only on the tip of the crane hook. Employee No.1 placed the D-ring on the tip of the hook with the safety pin installed and both hand and verbal signals were used to notify the crane operator he was clear to proceed with the lift. Employee No.1 assisted in guiding the wireline lubricator while it was being lifted by the crane. Once the wireline lubricator reached the vertical position, approximately two to three feet above the deck, the the D-ring slipped off the crane hook. The lubricator fell to the platform deck, striking Employee No.1 on the back while he was trying to escape. Employee No. 1 sustained serious injuries including lacerations to the back of his head, injury to his left leg and pain to his upper back. A first responder was dispatched to the facility to access the injuries to Employee No.1 while accompanying him to the Lafayette General Hospital for treatment.

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

The probable cause of this incident is that the lessee and personnel engaged in the lifting operation failed to follow and adhere to safe rigging practices by removing the safety pin from the hook latch. Also, the lessee used careless practices and demonstrated complacency as apparent by ignoring signs of an unsafe condition by the improperly installed sling D-ring on the hook prior to making the lift.

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

While in the process of rigging the lubricator, personnel directly involved with the lift failed to ensure that the load was properly secured prior to conducting the lifting operation. In addition, other personnel observing the lift failed to recognize the hazard which could have prevented this occurrence.

20. LIST THE ADDITIONAL INFORMATION:
21. PROPERTY DAMAGED: No property damage
   NATURE OF DAMAGE: No property damage

   ESTIMATED AMOUNT (TOTAL): $

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:
   The MMS Lafayette District makes no recommendations to the MMS Regional Office of Safety Management (OSM).

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: YES

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:
   A G-110, Incident of Noncompliance was issued as an "After the Fact INC" to document that Chevron U.S.A. Inc. failed to protect health, safety and the environment by not performing operations in a safe and workmanlike manner as follows: Chevron U.S.A. Inc. failed to properly supervise crane lifting operations to prevent injury to personnel. The evidence provided by the onsite investigation clearly indicated that the lifting operations were not performed in a safe manner.

25. DATE OF ONSITE INVESTIGATION:
   13-MAR-2008

26. ONSITE TEAM MEMBERS:

   Johnny Serrette / Jason A. Abshire
   / Tom Basey /

29. ACCIDENT INVESTIGATION PANEL FORMED: NO

   OCS REPORT:

30. DISTRICT SUPERVISOR:

   Elliott S. Smith

   APPROVED

   DATE: 29-MAY-2008
<table>
<thead>
<tr>
<th>OPERATOR REPRESENTATIVE</th>
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**Unit Supervisor**

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**Coil Tubing Services**

**TOTAL OFFSHORE EXPERIENCE:** YEARS

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**MMS - FORM 2010**

**PAGE: 5 OF 6**

**EV2010R**

**14-AUG-2009**
STATE:
TOTAL OFFSHORE EXPERIENCE: YEARS

NAME:
HOME ADDRESS:
CITY: STATE:
WORK PHONE: TOTAL OFFSHORE EXPERIENCE: YEARS

EMPLOYED BY:
BUSINESS ADDRESS:
CITY: STATE:
ZIP CODE: