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## Freeport Safety Updates

August 2024

(Incidents and Communications from July 2024)

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# Freeport Monthly Safety Content

The following slides have been provided to aid in compiling content for monthly Health & Safety meetings, tailgates, etc. with Freeport employees and contractors.

- Please keep in mind - some of this information is preliminary and may be pending complete investigations.

## Best Practices

- Be familiar with content prior to presenting.
- Hide/unhide incidents that are relevant to your team.
- Interact with your audience, relating information to your specific work.
- Update dashboards to share meaningful data ([Incident Summary - Power BI](#), [FRM - Power BI](#)). Contact your local Health and Safety staff for site-specific dashboards or external access.

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## Freeport Safety Incidents, Successes & Alerts

July 2024

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Exposure to  
Electrical Hazard

# Actionable Event: Breaker Arc Flash

## Preliminary Incident Details

<b>Operation</b>	El Paso
<b>Date / Time</b>	July 7, 2024 / 6:30 p.m.
<b>Event Type</b>	Near Miss
<b>Summary</b>	An electrician was called to reset an overloaded and tripped breaker at the coil collecting process of the Rod Plant. After the first reset, the table section of the conveying system did not respond. As the electrician returned to the breaker to troubleshoot, an arc occurred when a voltmeter contacted a contactor.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Faulty electrical equipment</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li><a href="#">FCX-HS03 Energized Electrical Work Technical Supplement</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>Employee was uninjured</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Roland Ruybe, Manager-Health and Safety</li> <li>Alejandro Valadez, Manager-Rod Mill Operations</li> </ul>

## Photos / Links



Arc flash label

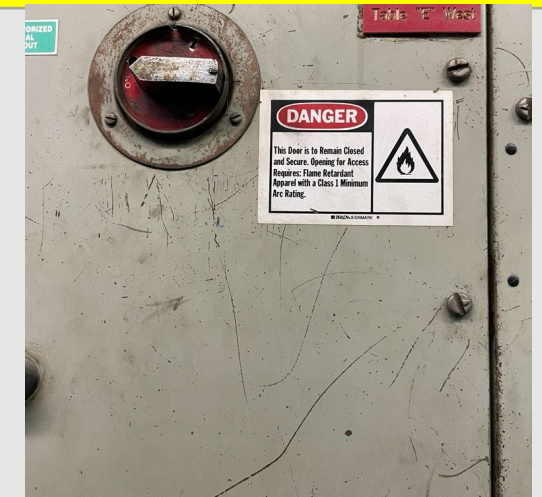


Table E conveyor door



Electrician inside of the motor control center when arc flash occurred



# Actionable Event: Haul Truck Steering Wheel Came Off

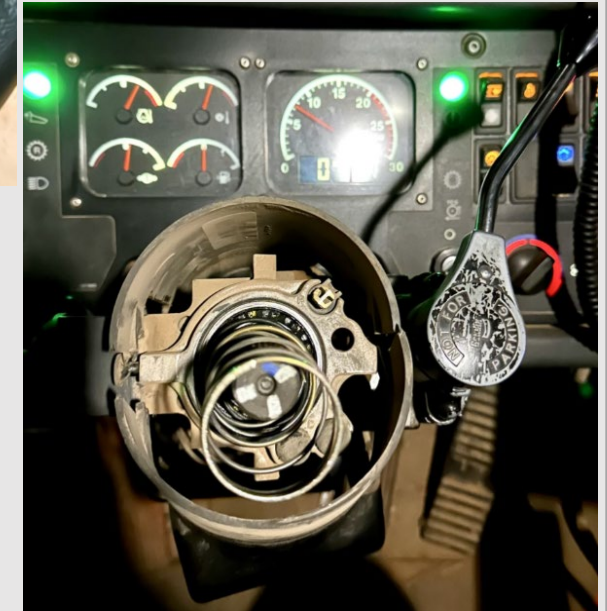
## Preliminary Incident Details

<b>Operation</b>	Morenci
<b>Date / Time</b>	July 11, 2024 / 7:20 a.m.
<b>Event Type</b>	Near Miss
<b>Summary</b>	A haul truck operator was traveling uphill, at low speed, on the haul road when the steering wheel fell off. The operator was able to stay in their traffic lane and stop the truck. There was no exposure to oncoming traffic.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Steering wheel locknut was not torqued to specified 60 lb./ft.</li> <li>Quality check to verify torque specifications was not applied by service contractor. The verification was to be conducted as part of the action plan following a previous PFE incident with a similar failure.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>Manufacturer (OEM) Caterpillar Steering Column Assembly (REN2535-16)</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>No injuries.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Gary Anderson, Manager-Mine Maintenance</li> <li>Rassie Ras, Manager-Health and Safety</li> </ul>

## Photos / Links



*Detached haul truck steering wheel.*



*A photo showing the unsecure haul truck steering wheel locknut.*





Vehicle Collision  
or Rollover

# Actionable Event: Haul Truck Steering Wheel Falls Off



Preliminary Incident Details	
Operation	Bagdad
Date / Time	July 15, 2024 / 6:49 a.m.
Event Type	Near Miss
Summary	<p>A haul truck operator was preparing to reverse to a shovel when the steering wheel came off. The operator used the secondary brake to stop, put the truck in neutral and set the parking brake. There was exposure to oncoming traffic.</p>
Risk Category	Actionable – Significant (3) Likely (3)
Findings / Missing Controls	<ul style="list-style-type: none"> <li>Steering wheel keeper nut was not torqued to proper specifications.</li> <li>Quality check to verify torque specifications was not applied by service contractor.</li> </ul>
Applicable Policies / Procedures	<ul style="list-style-type: none"> <li>Manufacturer (OEM) Caterpillar Steering Column Assembly (REN2535-16)</li> </ul>
Employee Condition	<ul style="list-style-type: none"> <li>No injuries.</li> </ul>
Contact	<ul style="list-style-type: none"> <li>Danielle Murphey, Sr. Supervisor-Industrial Hygiene</li> <li>Benny Corbell, Manager-Mine</li> </ul>

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Photos / Links	
 <p><i>Detached steering wheel.</i></p>	 <p><i>Steering wheel assembly after wheel was detached.</i></p>





# Actionable Event: Lowboy Fender Falls

## Preliminary Incident Details

<b>Operation</b>	Bagdad
<b>Date / Time</b>	July 25, 2024 / 7:30 a.m.
<b>Event Type</b>	Near Miss
<b>Summary</b>	<p>Contractor technicians were replacing a lowboy rear fender. The night crew positioned the fender with a crane but did not tack weld it in place before removing the crane and leaving site. The next morning, the fender fell to the ground as the day crew was preparing for work approximately 45 feet away.</p>
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Failure to follow standard operating procedure.</li> <li>• A welder was unavailable during the evening shift.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• Contractor standard work practice</li> <li>• <a href="#">FCX-HS32 Crane and Rigging Policy</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• No injuries.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• Danielle Murphey, Sr. Supervisor-Industrial Hygiene</li> <li>• Benny Corbell, Manager-Mine</li> </ul>

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## Photos / Links



Lowboy fender after falling to ground (approximately 45 feet to crew members gathered at truck).

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## Potential Fatal Events

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# Potential Fatal Event: Grader Hits Light Vehicle

## Preliminary Incident Details

<b>Operation</b>	PTFI
<b>Date / Time</b>	July 1, 2024 / 8:40 a.m.
<b>Event Type</b>	Property Damage
<b>Summary</b>	A light vehicle (LV) stopped on the left side of the road, giving the right of way to a reversing grader approximately 40 meters ahead. As the grader approached the LV, it changed direction, first contacting the LV with the right rear tire against the LV side and then the grader blade against the right front. The grader dragged the LV approximately 10 meters. There were three people inside the LV including the driver. All occupants exited the LV without injury.
<b>Risk Category</b>	Monitor – Significant (3) Likely (2)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Grader operator did not respond to warning horns from LV operator.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li><a href="#">GDL-4.04.10-PTFI-001 Operational Safety Mobile Assets</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>All employees were uninjured.</li> </ul>
<b>Contact</b>	Jim Dellinger, VP Operations Support

## Photos / Links



• Damaged light vehicle following collision with grader.

## Preliminary Incident Details

<b>Operation</b>	Cerro Verde
<b>Date / Time</b>	July 2, 2024 / 12 a.m.
<b>Event Type</b>	Property Damage
<b>Summary</b>	A haul truck was travelling down a ramp behind a light vehicle towing a solar repeater on a trailer and other haul trucks. As traffic slowed, the haul truck drove over the trailer and contacted the rear of the light vehicle with the left front tire. On impact, the haul truck operator veered right. The two workers inside the light vehicle were able to exit the vehicle without injury.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Driver fatigue based on initial review of Driver Safety System data and video footage</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• <a href="#">FCX-23 Interaction with Heavy Mobile Equipment – Surface</a></li> <li>• CV procedure - SApr100 Material Hauling</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• No injuries</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• David Vasquez Merino, Hauling Manager</li> </ul>

## Photos / Links



*Trailer damage following impact*



*Incident location*





Fall from Height

# Potential Fatal Event: Employee Falls from Fixed Ladder

## Preliminary Incident Details

<b>Operation</b>	Miami
<b>Date / Time</b>	July 10, 2024 / 4:55 p.m.
<b>Event Type</b>	Injury – Medical Treatment
<b>Summary</b>	An employee was climbing a fixed ladder after cleaning hoppers. Approximately 12 feet up from the landing, the employee lost their grip and fell to the grating at the base of the ladder. The employee landed on their left arm and struck their head.
<b>Risk Category</b>	Monitor – Significant (3) Possible (2)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Fall protection was not required</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li><a href="#">FCX-HS02 Working at Heights</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>Employee broke thumb</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Justin Taylor, Manager-Health and Safety</li> </ul>

## Photos / Links



Location of ladder and fall.





Falling Objects

# Potential Fatal Event: Objects Fall From Stack

## Preliminary Incident Details

<b>Operation</b>	Atlantic Copper
<b>Date / Time</b>	July 12, 2024 / 11 a.m.
<b>Event Type</b>	Near Miss
<b>Summary</b>	<p>Two contractors were lifting measuring equipment up the stack for environmental samples. Worker #1 was operating the electric winch on the stack's upper platform. Worker #2 put the equipment in a lifting bag and flagged the intermediate platform, then proceeded to walk down to the lower platform.</p> <p>When the lifting bag reached the upper platform, the hoist steel cable broke. The bag, weighing approximately 132 lbs (60 kgs), fell and hit the intermediate platform, releasing the equipment. The equipment continued to fall to the lower platform and stopped near Worker #2.</p>
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>The lifting cable was rusty and deteriorated.</li> <li>The area immediately below the winch was flagged, but the lower platform was not barricaded.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>Site Work Permit Procedure</li> <li>Site Work at Heights Procedure</li> <li><a href="#">Flagging and Barricading Policy</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>No injuries</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Ignacio Romero, Health and Safety Manager-Atlantic Copper</li> </ul>

## Photos / Links

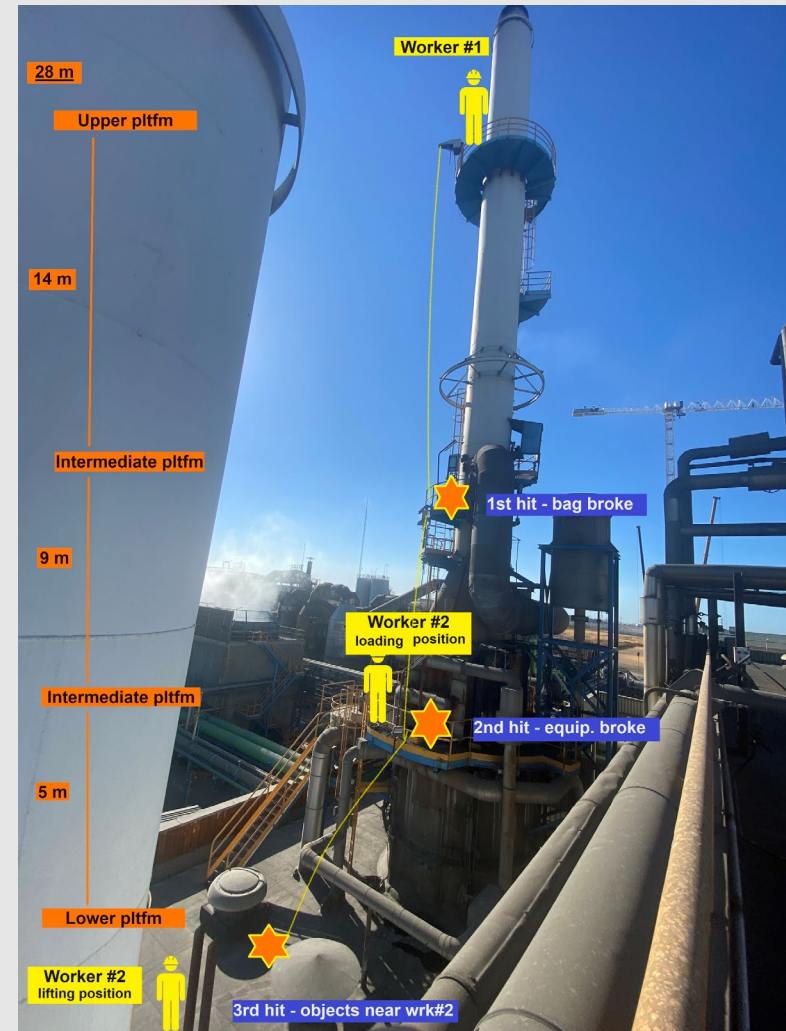


Diagram of the dropped object path, contact points and elevations.



Fall from Height

# Potential Fatal Event: Employee Jumps from Crane Counterweight

## Preliminary Incident Details

<b>Operation</b>	PT Freeport Indonesia
<b>Date / Time</b>	July 17, 2024 / 8 a.m.
<b>Event Type</b>	Injury – Medical Treatment
<b>Summary</b>	During crane disassembly, the team was working on removing the last section of the main boom. The crane operator was outside the cab using a remote control to adjust the super lift mast within the 75-degree safe working limit, so that a second 100-ton crane could access and lift the last main boom section away. As the super lift mast was adjusted, it started moving backward and collapsed over the rear of the car body. When the rigger saw the mast moving backward, they jumped to the counterweight and then approximately 3 meters (10 feet) to the ground, sustaining injuries to the head, face, and upper body.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Current crane procedure does not consider disassembly as a critical activity.</li> <li>Failure to discuss safe exit points with crew in case of emergency.</li> <li>Critical evaluation of using remote control unit versus cabin operation during crane dismantlement was not done.</li> <li>Remote control should be turned off when not in use to prevent unexpected crane movements.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>Superkrane SOP SCC6000A – Dismantlement, Installation and Transport of Crawler Crane</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>The rigger received five stiches above the eye and was admitted to the hospital for 24-hour observation.</li> </ul>
<b>Contacts</b>	<ul style="list-style-type: none"> <li>Marie Donna Cristina Coronel, FPJO Project Manager-Copper Cleaner Construction Project</li> <li>Zainuddin Hassan, Safety Lead-Mill Optimization Construction Highland Area</li> </ul>

## Photos / Links



*Super lift mast collapsed backward over car body.*



1 – Position of rigger on platform. 2 – Rigger jumped to counterweight. 3 – Location rigger landed after jump.





Uncontrolled  
Release of Energy

# Potential Fatal Event: Mechanic Struck with Metal Wedge



## Preliminary Incident Details

<b>Operation</b>	Morenci
<b>Date / Time</b>	July 23, 2024 / 9 a.m.
<b>Event Type</b>	Injury – Lost Time
<b>Summary</b>	Mechanics were replacing a bit sub on a worn drill pipe. Metal wedges were used to separate the pipe. As the drill operator turned the breakout wrench on the pipe, a metal wedge, approximately three pounds, popped out of place and struck a mechanic on the chin. The wedge landed approximately 51 feet from the drill.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Diagnostic mechanic had two years of experience.</li> <li>Struck mechanic was an apprentice 1, in the role for nine months.</li> <li>Failure to segregate the employee from fatal energy. No barricading or guard to control energy.</li> <li>Improper tool (steel wedges) was used to secure the stuck drill pipe.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>Operation manual for removing stabilizer.</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>Employee underwent surgery, was discharged and is expected to recover.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Rassie Ras, Manager-Health and Safety</li> <li>Gary Anderson, Manager-Mine Maintenance</li> </ul>

## Photos / Links



*Position where steel wedge was installed and later dislodged.*



*Top view where steel wedge was installed and later dislodged.*



*Position where the mechanic was standing at the time of the event.*



*Steel wedge (3 lbs) landed 51ft from the drill.*





Fall from Heights

# Potential Fatal Event: Employee Falls From Crossover

## Preliminary Incident Details

<b>Operation</b>	Bagdad
<b>Date / Time</b>	July 29, 2024 / 9:15 a.m.
<b>Event Type</b>	Injury – Medical Treatment
<b>Summary</b>	<p>A mill employee was standing on top of a rougher flotation crossover approximately four feet from the floor. The employee fell backwards, hit their ribs on a pipe and fell to the floor.</p> <p style="font-size: 48px; color: cyan; opacity: 0.5; transform: rotate(-15deg); position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%);">DRAFT</p>
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>No fall protection was being used above four feet.</li> <li>Employee should not have been on top of crossover.</li> <li>No field verification by supervision that employees were working safely.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li><a href="#">FCX-HS02 Working at Heights Policy</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>Employee was transported off-site for medical treatment.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Danielle Murphey, Senior Supervisor-Industrial Hygiene</li> <li>Ryan Fidler, Manager-Mill</li> </ul>

## Photos / Links

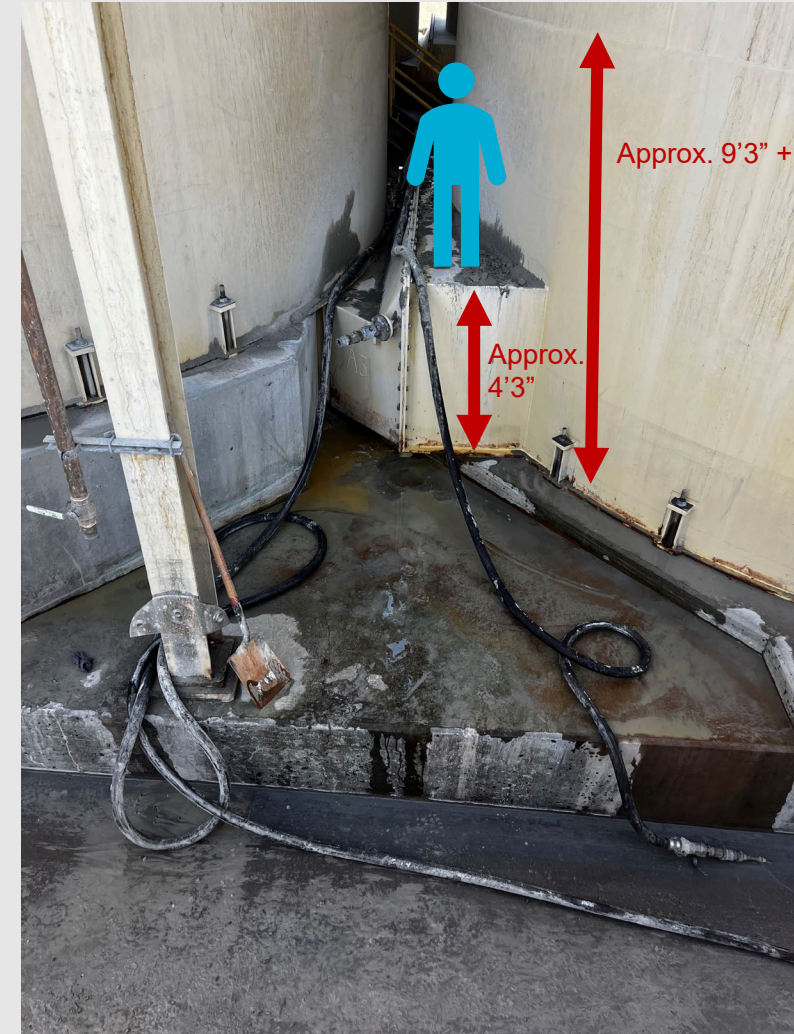


Diagram of employee location prior to fall and approximate heights.

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