

# THE VALUE OF COPPER

## Freeport Safety Updates

June 2024

(Incidents and Communications from May 2024)

FCX  
LISTED  
NYSE



ICMM  
Member



**SAFE  
PRODUCTION  
MATTERS**

[fcx.com](http://fcx.com)

*All Operating Sites*

**FREEPORT**  
*FOREMOST IN COPPER*

# 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.

# THE VALUE OF COPPER

## Freeport Safety Incidents, Successes & Alerts

May 2024

FCX  
LISTED  
NYSE



ICMM  
Member



All Operating Sites

**SAFE  
PRODUCTION  
MATTERS**

[fcx.com](http://fcx.com)

**FREEPORT**  
FOREMOST IN COPPER





Exposure to Hazardous Substance - Acute

# Actionable Event: Railcar Acid Burns

## Preliminary Incident Details

<b>Operation</b>	Fort Madison
<b>Date / Time</b>	May 13, 2024 / 12:10 pm
<b>Event Type</b>	Injury – Medical Treatment
<b>Summary</b>	A contractor was depressurizing an acid railcar. While attempting to check the low side pressure valve tree, the employee was unable to maintain a tight seal on the valve and was sprayed with 93% sulfuric acid. The contractor was wearing chemical gloves, a suit, boots, face shield and goggles.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>Acid tank was not properly depressurized. <ul style="list-style-type: none"> <li>Operator deviated from depressurizing procedures.</li> <li>Improper depressurizing training.</li> </ul> </li> <li>Missing and improperly worn personal protection equipment.</li> <li>Failure to conduct periodic monitoring and assessment of contractor transload operations.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li><a href="#">FCX-HS28 – Sulfuric Acid Bulk Handling Policy</a></li> <li><a href="#">FCX-HS01 Administration Requirements Policy</a></li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>Contractor sustained second-degree burns.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>Michael Alsbrook, Manager-Health and Safety</li> <li>Sarah Johnson, Manager-Moly Operations</li> </ul>

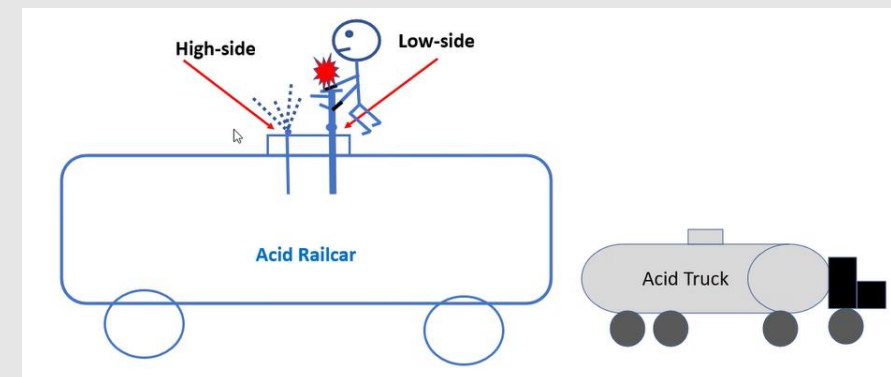
## Photos / Links



Re-enactment of valve assembly.



Contractor suit following acid exposure.



Railcar tank set up.



Vehicle Collision  
or Rollover

# Actionable Event: Tractor Slid Down Bench

## Preliminary Incident Details

<b>Operation</b>	Cerro Verde
<b>Date / Time</b>	May 25, 2024 / 11:17 p.m.
<b>Event Type</b>	Injury – First Aid
<b>Summary</b>	A dozer was tasked with pushing down a corniced overhang in fill material to two loaders below. The dozer used an existing ramp to access the top and decided to move a small windrow in the access; which wasn't part of the job. While doing so, the operator moved too close to the corniced crest and rolled one-and-a-quarter times down an 8-meter bank before stopping. A loader operator immediately issued a Mayday.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Dozer operator expanded access on the upper mining face.</li> <li>• The dozer was working parallel to the corniced ridge.</li> <li>• The weight of the dozer was not supported.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• Site-specific standard operating procedures.</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• Dozer operator was transported to the Cerro Verde medical center by emergency personnel.</li> <li>• Operator sustained multiple injuries.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• McKay Pugmire, Manager-Fragmentation and Loading</li> </ul>

## Photos / Links



• A CAT truck was leaving the loading front when the dozer fell. The loader operator activated the emergency button and activities were stopped.



• Dozer position following the roll. The operator exited the machine without assistance.



• Trajectory of the tractor, to the point where it slid and rolled down an 8-meter bank.



# THE VALUE OF COPPER

## Potential Fatal Events

May 2024

FCX  
LISTED  
NYSE



ICMM  
Member



**SAFE  
PRODUCTION  
MATTERS**

[fcx.com](http://fcx.com)

*All Operating Sites*

**FREEPORT**  
*FOREMOST IN COPPER*



# Potential Fatal Event: Loader Hit Light Vehicle in GBC Mine

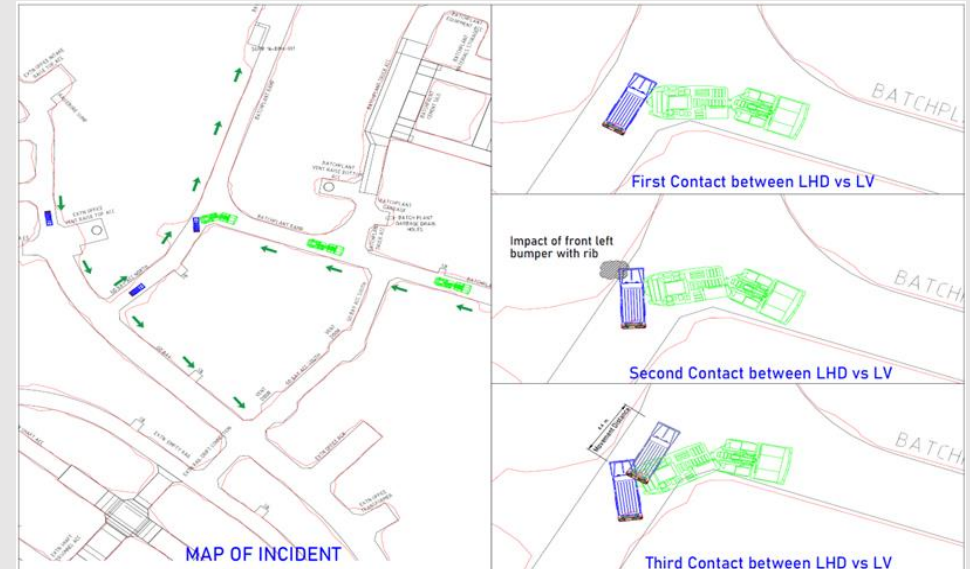
## Preliminary Incident Details

<b>Operation</b>	PTFI – Underground Mines Division, GBC Mine
<b>Date / Time</b>	May 8, 2024 / 2:55 a.m.
<b>Event Type</b>	Property Damage
<b>Summary</b>	A loader (LHD) was travelling up a ramp in reverse toward an intersection to turn left. Before entering the intersection, the operator stopped, sounded the horn four times and flashed the lights. A light vehicle (LV) – unaware of the LHD and stop sign – approached the intersection in third gear, slowed and sounded the horn about 4 meters before entering the area. Upon doing so, the LV was struck by the LHD’s rear tow hook and cabin side wings. The LV was pushed into the rib and then back about 4.4 meters, resulting in significant damage to the driver's side door and front, righthand-side quarter panel. In addition, the driver's side window and windshield were broken, and both tires on the passenger side were pulled off the rim.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Failure by LV to follow procedure for approaching and safely passing through intersection.</li> <li>• Failure by LHD to follow the Traffic Management Plan – the area is listed as one-way.</li> <li>• The reverse camera was not functioning, which increased the LHD blind-spot while reversing.</li> <li>• The reverse camera is a critical component on pre-start inspection, but the operator used an outdated pre-start checklist without the camera listed.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• SOP-6.01-UG-J01 LHD Operation Procedure</li> <li>• SOP-4.04-PTFI-002 Light Vehicle Operation</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• No employees were injured.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• Anthony Hall, Manager-GBC Development</li> <li>• Andri Abdullah, Manager-Health &amp; Safety UG Division</li> </ul>

## Photos / Links



Damage to light vehicle.



Incident sketch.





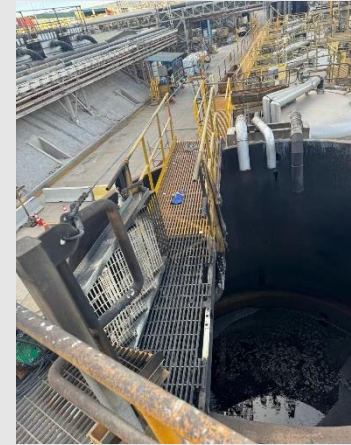
Fire

# Potential Fatal Event: Hydromet Tank Fire

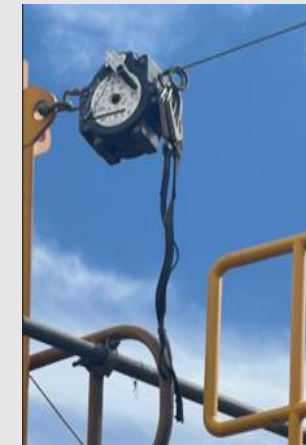
## Preliminary Incident Details

<b>Operation</b>	El Abra
<b>Date / Time</b>	May 13, 2024 / 4:05 p.m.
<b>Event Type</b>	Injury – First Aid
<b>Summary</b>	Three contractors were performing hot work on a platform at the tank farm. A failure in the undersized extension cord caused a fire at the welding machine, which subsequently spread to the fire blanket. One employee who was tied-off was unable to get free from the harness until the lanyard was completely burned through by the fire. The other employee attempted to suppress the fire with a portable fire extinguisher but was unsuccessful. The emergency response team was notified and quickly arrived on scene to extinguish the fire.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Improper selection of appropriately rated extension cord.</li> <li>• Improper evaluation of fire risk and exposure to electrolyte backwash tank.</li> <li>• Improper use of fire blanket – the blanket was left in place for a week and was subsequently contaminated with organic.</li> <li>• Standard operating procedures was not developed for hot work around the tank farm.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• <a href="#">FCX-HS06 Hot Work Policy</a></li> <li>• <a href="#">FCX-HS02 Working at Heights Policy</a></li> <li>• GAre0012 El Abra Hot Work Regulation</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• One employee sustained superficial burns to right ear.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• Mack Rojas, Manager-Safety, Health and Technical Training</li> <li>• José Guzman, Senior Manager-Engineering and Services</li> </ul>

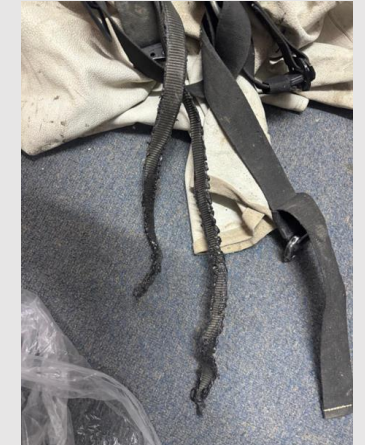
## Photos / Links



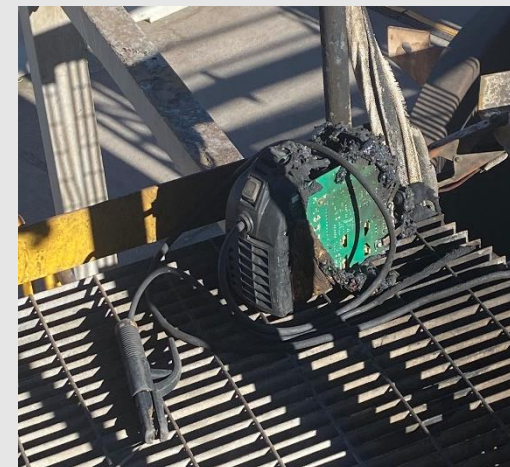
Platform where fire started.



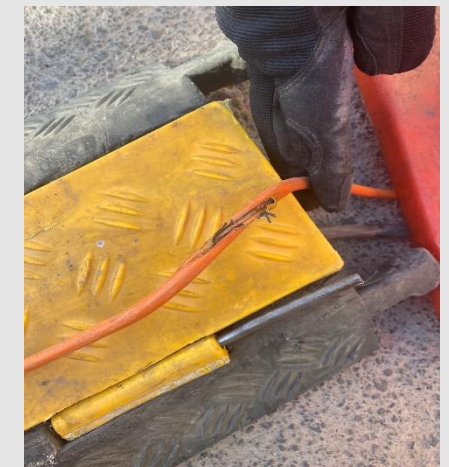
Reactor and burned lanyard.



Burned lanyard.



Burned welding machine.



Failed extension cord.







Vehicle Impact  
to Person

# Potential Fatal Event: Lowboy Runs Over Employee's Foot

Preliminary Incident Details	
<b>Operation</b>	PTFI Technical Services – Maintenance Support Division
<b>Date / Time</b>	May 29, 2024 / 7:59 a.m.
<b>Event Type</b>	Injury – Medical Treatment
<b>Summary</b>	A lowboy was moving out of the trailer shop at 5km/h (3 mph) with a spotter on the right side. Another employee approached the moving equipment from the left side to move a welding screen that had potential to be hit. The employee was positioned facing the welding screen. The left rear tire of the lowboy ran over the employee's right foot, resulting in major leg and foot injuries.
<b>Risk Category</b>	Actionable – Significant (3) Likely (3)
<b>Findings / Missing Controls</b>	<ul style="list-style-type: none"> <li>• Failure to maintain safe distance from moving vehicles.</li> <li>• Failure to maintain safe visibility (victim unseen by spotter).</li> <li>• Failure to maintain positive communication between operator, spotter and offsideers.</li> </ul>
<b>Applicable Policies / Procedures</b>	<ul style="list-style-type: none"> <li>• Site standard operating procedure 4.04.10-KPI-MTCLL-32TRL-011, Entering and Exiting Unit</li> </ul>
<b>Employee Condition</b>	<ul style="list-style-type: none"> <li>• Employee sustained a crushing injury to the right foot and multiple fractures below the knee.</li> <li>• Employee is under medical observation.</li> </ul>
<b>Contact</b>	<ul style="list-style-type: none"> <li>• Lucky Hermawan, Vice President-Maintenance Support Division</li> </ul>

Photos / Links	
	
<ul style="list-style-type: none"> <li>• Incident reenactment. Position of employee to moving equipment.</li> </ul>	<ul style="list-style-type: none"> <li>• Incident reenactment. Position of employee's right foot and the welding screen. The lowboy was moving 5km/h (3 mph).</li> </ul>

# THE VALUE OF COPPER

## Agency Shares

May 2024

FCX  
LISTED  
NYSE



ICMM  
Member



*All Operating Sites*

**SAFE  
PRODUCTION  
MATTERS**

[fcx.com](http://fcx.com)

**FREEPORT**  
*FOREMOST IN COPPER*



# MSHA Health Locator Tool

## MSHA Health Locator Tool for Miners

The Health Resource Locator Tool provides miners with a single accessible place where they can obtain real-time information on healthcare facilities, services and specialists tailored to their unique health needs.



- ASSISTANT SECRETARY OF LABOR  
FOR MINE SAFETY AND HEALTH

**Chris Williamson**



The MSHA Health Locator Tool for Miners was developed to address your unique health needs as a miner and connect you with essential healthcare services. You can use this Locator to quickly and easily access a diverse range of health information and care resources such as medical support, specialized services, and helpful information, based on your selected location and search distance.

[Find more info here](#)

# Safety Share – Lock Out Tag Out Try Out



## Lock Out/Tag out/Try out (LOTOTO)

Protects miners by preventing others from turning on equipment or from a release of energy while working on or servicing equipment & machinery. Using LOTOTO controls hazardous energy.

### Steps to use LOTOTO

- Identify the equipment/ machinery that needs to be shut down and ALL its energy sources
- Determine if there are any stored energy sources
- Notify all affected workers about the shutdown
- Properly shut down equipment and machines
- Properly shut off the power sources at the source. Emergency shut off switches should not be used as a power source.

### Lock Out / Tag Out

- Each person must apply their own locks & tags to the power sources to ensure that the machine or equipment being worked on cannot be started. In some instances, the equipment directly before or after the machinery or equipment you are working on may need

### Try Out

- Test to see if the equipment is properly locked out by trying to start it.



# MSHA Fatality Alert

**MINE FATALITY** – On May 16, 2024, a miner died when the excavator he was operating traveled over a 200-foot highwall.



## Eliminate hazards and prevent injuries:

- Reduce fall hazard exposure by limiting the distance equipment can safely operate near the edge of highwalls.
- Examine benches to identify hazards related to insufficient bench width, locations of other equipment, loose material, etc.
- Discuss highwall hazards with miners and train miners to recognize these hazards.
- Address hazards in the mine's Surface Mobile Equipment Safety Program. Include safe work practices for weather conditions (fog, heavy rain, or snow) that could reduce visibility.

[PDF LINK](#)