



FREEPORT-McMoRAN

2016 April Contractor Safety Meeting



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Safety Share



Agenda

VALUE AT OUR CORE

- TRIR
- PFEA
- March incident overview
- Workplace Exam
- 2016 Safety Plan



TRIR

**“EXCELLENCE IS
NEVER AN ACCIDENT;
IT IS THE RESULT OF
HIGH INTENTION,
SINCERE EFFORT,
INTELLIGENT DIRECTION,
SKILLFUL EXECUTION
AND THE VISION TO SEE
OBSTACLES AS
OPPORTUNITIES.”**

ANONYMOUS



FREEPORT-McMoRAN

Day of the Year	Employees working Safely (FMMO Only, includes First Aids)			REPORTABLE INJURY RATE				LTIR			PROPERTY DAMAGE			DAYS W/O LTA	Hrs W/O LTA	Days W/O Rec.	Hrs W/O Rec.	MTD HEHI	YTD HEHI	YTD HEHI Rate	HEHI Target
101	TOTAL	MTD	YTD	MTD	YTD	QTD	Target	MTD	YTD	Target	MTD	YTD	Target								
Number	3243	3234	3188	5	27	5	1.70	0	6	0.45	10	163	11.70	15	122846	10	221124	2	10	0.81	0.54
Rate				4.07	2.19	4.07		0.00	0.49		8.14	13.20									

Safety Performance

4/11/2016



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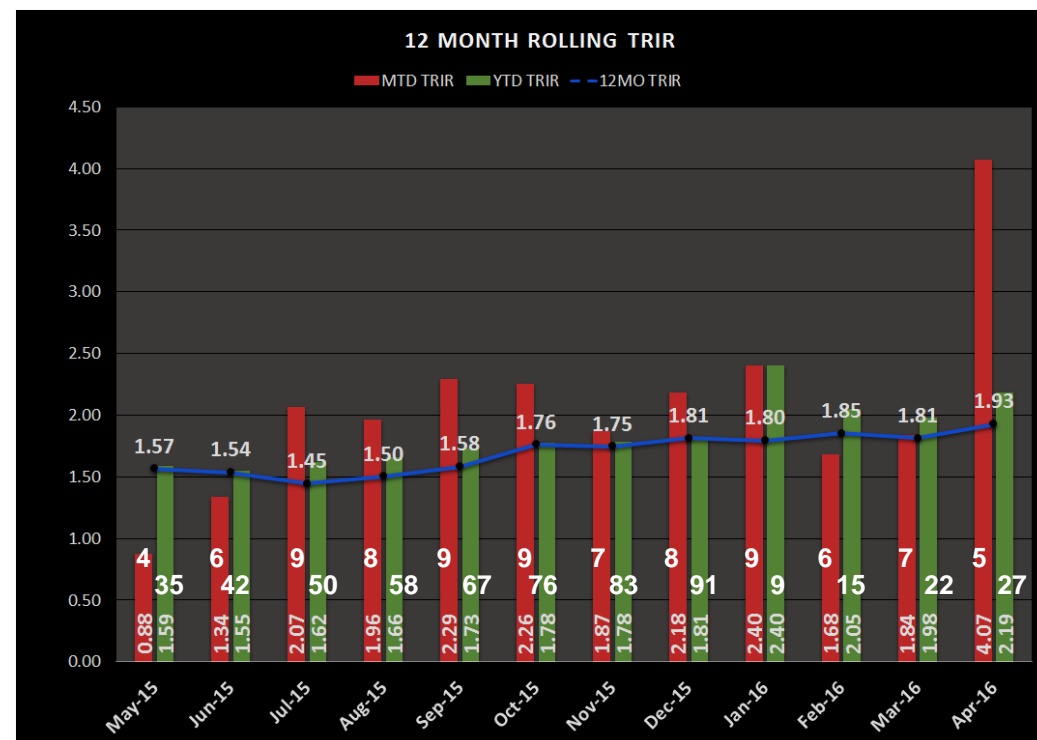
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Safety Dashboard 4/10/2016

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TRIR BREAKDOWN	MTD REP	MTD TRIR	YTD REP	YTD TRIR	QTD REP	QTD TRIR
FMMO	5	5.35 186754	23	2.45 1874362	5	5.35 186754
CONTRACTORS	0	0.00 58939	4	1.34 595284	0	0.00 58939
CURRENT TOTAL MORENCI ALL	5	4.07 245693	27	2.19 2469646	5	4.07 245693

Reportable Injuries per Quarter			
Q1	Q2	Q3	Q4
22	5		



Incident Date	Incident Type	Organization/ Division	Short Description
4/1/2016	Restricted Duty	Mine Haulage	On 4/1/2016, an employee fell and struck his elbow against the base of a cable tower causing a bruise. Reported on 4/8/2016
4/5/2016	First Aid	Processing Maint. Services	An employee was shoveling material when the shovel made contact with the belt causing pain in her wrist.
4/5/2016	Restricted Duty	Mine Mine Maint.	Employees were aligning bearing on the 78 Cat when one employee swung the hammer and struck the other employee's hand.
4/4/2016	First Aid	Contractor Townsite	A Jay's Construction employee was installing flooring when he lost his balance and reached out causing pain in his wrist.
4/7/2016	Medical Treatment	Processing Hydromet	An employee cut his wrist on unit strut when he slipped on a pipe that was covered in slippery organic and water.
4/7/2016	**Medical Treatment	Processing Crush & Convey	Employees were in the process of moving a strongback into place when an employee's finger was pinched.
4/9/2016	First Aid	Mine Maint. Services	Employees were moving empty lockers when it tipped over and fell on an employee's leg causing a bruise.

<i>Division</i>	<i>Date of Last Rep. Injury (FMMO)</i>	<i># of Days w/o Rep. Injury (FMMO)</i>	<i>Date of Last Rep. Injury (Contractors)</i>	<i># of Days w/o Rep. Injury (Contractors)</i>	<i>Date of Last HEHI Event</i>	<i># of Days w/o a HEHI Event</i>
MAINTENANCE SERVICES	1/24/2015	77	9/14/15	209	3/3/2016	38
HYDROMET & CLP	4/7/2016	3	3/27/15	380	6/10/2015	3
LEACHING	11/17/2015	145	3/17/16	24	2/25/2015	349
MORENCI CONCENTRATOR	11/18/2015	144	8/25/15	229	2/10/2015	443
METCALF CONCENTRATOR	11/5/2015	157	8/8/15	246	3/12/2016	29
CRUSH & CONVEY	4/7/2016	3	11/10/15	152	4/1/2016	9
MINE MAINTENANCE	4/5/2016	3	3/10/16	31	3/19/2016	22
FRAGMENTATION/LOADING/SUPPORT	1/14/2016	87	4/19/12	1459	2/15/2016	55
HAULAGE	4/1/2016	9	8/1/2008	3021	5/7/2015	339
RESOURCE MANAGEMENT	11/17/2014	510	2/17/16	53	1/5/2016	96
ADMINISTRATION	2/10/2015	443	9/15/15	208	1/1/2014	831
MERCANTILE	12/28/2015	104	3/3/15	404	1/1/2014	831
CONTRACTORS	3/17/2016	24	3/17/16	24	2/17/2016	53



PFEA

Norwich Rod Mill PREA

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A roofing contractor working on roof replacement partially fell through the roof over the Rod Mill, up to his thigh. His leg went through a section of decking after the rubber roofing membrane was peeled back, and the underlying insulation had not yet been removed. The insulation prevented the contractor from seeing the corroded condition of the decking underneath. The contractor was able to crawl out, leaving a 12" hole behind. Some debris fell to the mill floor ~40 feet below, inside the taped-off area.

Prior to the event, a JSA and HazOps evaluation had been conducted with the contractor for this project. The contractor was following the existing work instruction for the task as the policy only required the contractors to don fall protection prior to creating an open hole by removing corroded decking material.

All work on the job was stopped to understand what led to the event. The policy was modified immediately to require the use of fall protection at any time the rubber membrane is being removed, and flagging and taping must be verified prior to the removal of membrane. Health and Safety as well as Engineering held a tailgate with the contractors to make sure they understood the plan going forward. The contractor will provide a safety watch on the floor below to ensure the flagging is effective, and there is no traffic in the area.



Exploration-Steam Crossing

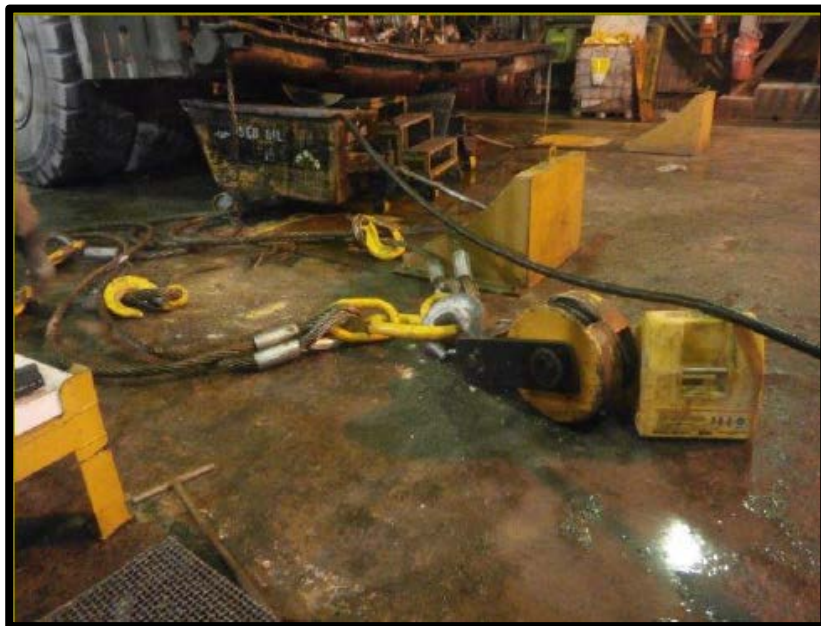
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Several kilometers into a hike en route to a prospect in the Estero Las Animas, in the central Chilean Andes Mountains near the town of Linares, the local guide leading two of our employees crossed a primitive log bridge over a steep, narrow drainage without incident. Our employee (Field Assistant Claudio Salas), was next in line and he put his foot on a log to test it and it seemed secure. However when he attempted to cross it, the log broke and the “bridge” collapsed. This resulted in his falling approximately 3 meters onto an area of rocks, logs, and debris below and sliding an additional 5 meters before finally coming to a stop, laying on his back on one side of the drainage.

The Supervisor (trained in First Aid) and the guide made sure the employee stayed immobile afterwards, examined him for back, spine or other serious injuries and administered First Aid. Once back at camp, the employee’s pain continued in his thigh and buttocks area. The employee was evacuated the next day to the city of Linares, and taken to the hospital for diagnosis and care. X-ray and CT scans revealed no fractures, only a contusion (strong bruise) of the tailbone. Employee is at his home resting.

PTFI Overhead Crane

On Sunday 31 January 2016 at approximately 00.30 Local Time (WIT), an electrician carried out a repair on Overhead Crane #079 (40-ton capacity) at Bandung Shop to replace 42AC Volt contactor with 110AC Volt contactor. During the function test of the contactor, the electrician performed the test from the top position on OHC platform. The electrician switched on the pendant control and pushed the hoist up switch to move up the hoist. The electrician didn't recognize that the limit switch failed and caused the hoist rope to continue winding to the drum. The electrician didn't observe that the OHC hook block already contacted the OHC drum, as a result, excessive tension was created and the hoist rope snapped and the Hook Block (150 kg) fell from 18-meter elevation to the floor right behind HT#115. No one was working under OHC area when the incident occurred. No injuries were sustained during the incident



KPI Logistics Transport

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On Tuesday February 09, 2016, a Cargo Transport Tractor Truck and Single Trailer were transporting a 25 ton load at Mile Post 62 along the main supply route (MSR) incline. The operator maneuvered the truck to a stop at a location of road heading in an upward position on a +15% incline. He had decided to take a personal rest at this point, placing the truck in neutral, setting the parking brake and then exiting the unit's cab. As he stepped out the door, the tractor trailer began rolling backward down the incline and out of control with the operator on the outside of cabin for a distance of approximately 25 meters. The truck and trailer struck the berm; the trailer flipped to one side while the tractor jack-knifed pointing upward.

The operator was outside the cabin during the event, he held on to the door while standing on the running board for the +25 meters the unit descended until the unit came to a stop. He then jumped down to ground. He suffered minor abrasions and bruising due to this event. When tested for alcohol consumption the result was negative. The operator was a senior driver. The location of the accident is one of the steepest sections of the MSR and is a location of several previous cargo accidents that have been reviewed and used to educate the drivers in annual refresher(s) and toolbox meetings; these last two issues demonstrate the extreme poor judgement and lack of caution exercised by the driver.



KPI Logistics Transport

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Haul Truck Lost Control

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On Thursday, 11 February 2016 at approximately 12:43 local time, an empty Komatsu 930E haul truck traveling from Bali Dump to shovel #22 was involved in an accident at the junction of Kitamani 2 – Kintamani 1 – D4 (Pinang).

The haul truck was being operated by a Cat 793 operator that was training to operate the 930 class truck, he was accompanied by a qualified trainer. While coming down an inclined section of haul road the operator lost control of the truck and it slipped into the wall on the right side of the haul road. The truck continued traveling down the haul road to an intersection where the operator and trainer tried to steer the truck to the right and stay on the haul road. The operator and trainer again lost control of the truck and it traveled over a two meter high berm falling two benches below the intersection, about 30 meters.

The operator of the truck was uninjured but the trainer, who was not wearing a seat belt, sustained minor injuries.



Light Vehicle hit by Dozer

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A Mine Maintenance Light Vehicle (LV) was struck by a dozer while both vehicles were inside of a shovel loading area. The LV had parked behind the dozer with two occupants inside and the dozer backed up into the LV. No injuries were reported.

The Maintenance LV notified the dispatcher that it was entering the shovel loading area to facilitate refueling of the shovel. With the shovel parked the dozer was in the process of clearing off the loading pad. As The LV entered the loading area and parked the dozer reversed into the LV.



Uncontrolled Pneumatic Energy

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A drilling company was in the process of drilling a dewatering well with an RD-20 rotary drill rig. Prior to reaching bedrock, the hole was being drilled in an old stockpile through approximately 185 feet of fill material. In this type of drilling, a 10 foot length of 16" casing (conductor) is attached to a casing bit, which pulls the casing down with it during drilling. Every 10 feet of depth, an additional 10 foot section is welded on at the surface, so the entire hole is cased to within approximately 1 foot from the bottom as it is being drilled.

At the time of the incident, the hole was 150 feet deep, and the drill pipe was being tripped out of the hole. Prior to tripping out of the hole, the casing bit was at the bottom of the hole, with the casing hammer on top of it with both being suspended by five-30 foot lengths of drill pipe. The pipe was pulled out of the hole as each 30 foot section was removed. When four sections (120 feet) of pipe had been removed, the bit became stuck at a depth of 30 feet due to stockpile material/cuttings wedging between the bit and the casing. Efforts to dislodge the bit resulted in the casing being drawn up to within a half a foot of the bottom of the deck.

Air was being used in an effort to dislodge the material jammed between the bit and the casing. The bit did not move and the air pressure continued to build up between the bit and the bottom of the hole, essentially becoming a 120 foot X 16" compressed air cylinder.

The pressure eventually released and blew past the bit and out of the hole, ejecting both the inner and outer split bushings at the collar. The driller quickly turned away to avoid being hit in the face by cuttings and was struck in the back of his hard hat by the 60 lb. inner bushing. The hard hat absorbed most of the force of the impact and was severely damaged. The driller received medical treatment for a laceration and was given a full duty release back to work.



Uncontrolled Pneumatic Energy

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Climax Dozer Overturn

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On the morning of March 7th at approximately 8:20 am, DZ03 was pushing material to LD01 on 12160 bench. The dozer was working parallel to the crest of 12200 when material below gave way. This caused DZ03 to roll one full rotation and land on its tracks on 12160. The operator was able to exit once the dozer stopped and was examined by site medical personnel. The operator was wearing his seatbelt and there were no sustained injuries.



Drill Rig Unload

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On March 17th, 2016, at about 2:15 PM, a drill rig was being unloaded from a lowboy trailer at the east laydown area of the Bagdad Mine. Two employees from the haulage company crew were removing tie-down chains as two others were separating the front and rear parts of the trailer.

Air lines from the tractor to the rear part of the trailer were disconnected so that loss of air pressure to the rear trailer brakes would lock the brakes. No wheel chocks were put in place at the wheels of the rear part of the trailer. The central portion of the trailer was lowered to rest on the ground, and the fasteners holding the two parts of the trailer together were removed.

At this point, the driver attempted to separate the two trailer parts by pulling the front part forward, away from the rear part that had the drill rig on it. A spotter was on the right side of the truck cab where the driver could see him. One employee was crouching in front of a set of dual tires on the right side of the rear part of the trailer, attempting to remove a tie-down chain. The driver sounded the truck's horn once and without a pause drove forward. The rear part of the trailer failed to separate immediately and began to move forward with the rest of the truck, for a distance of about one foot. The rear trailer brakes did not prevent the movement. The employee who was endangered by the rear duals jumped clear as the spotter called to the driver to stop.

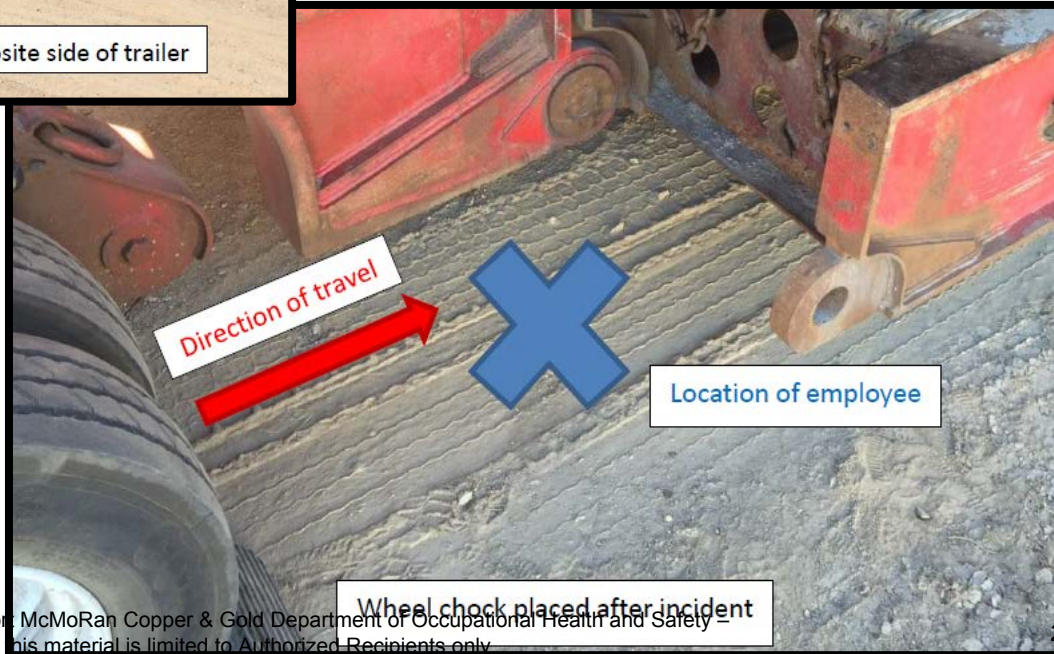


Drill Rig Unload

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Employee was crouching in front of dual tires on opposite side of trailer



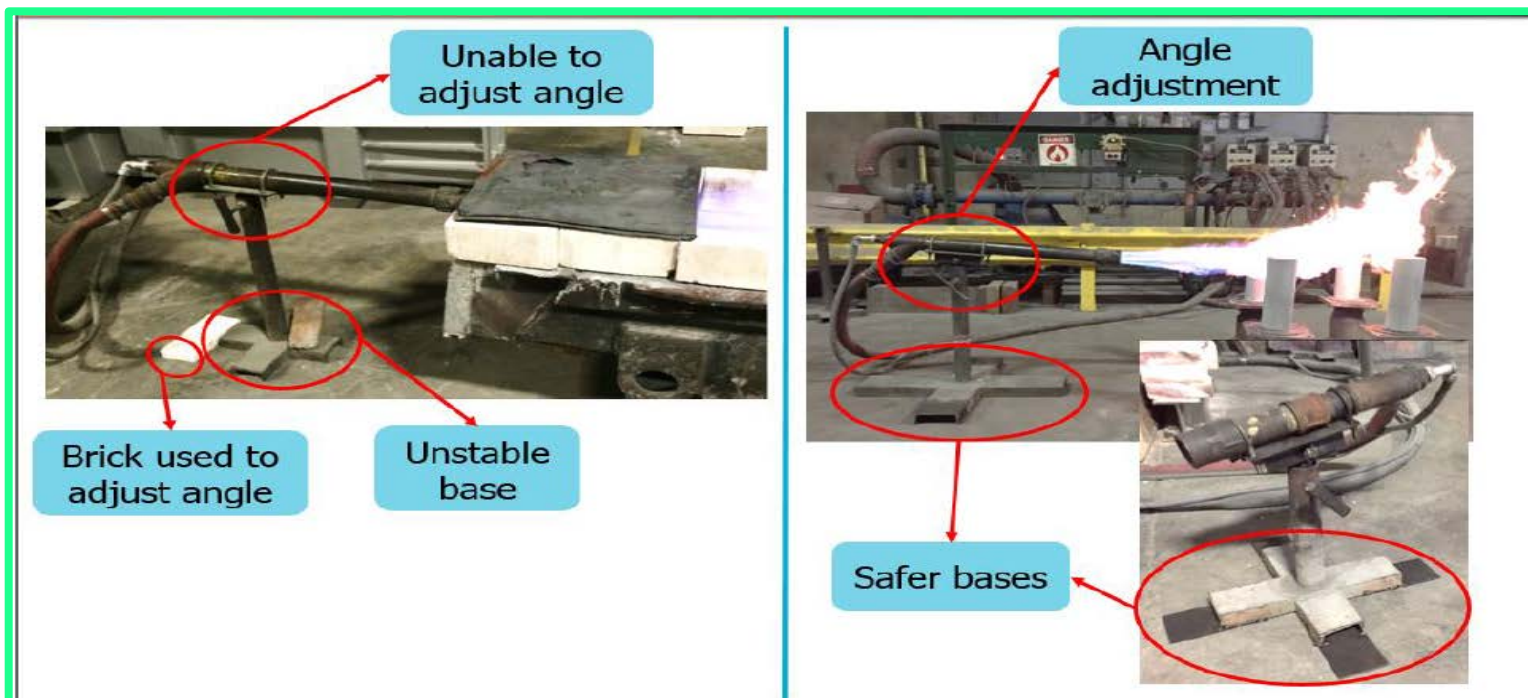
Wheel chock placed after incident



Safety Success

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As part of the Safety Focus Group the Refractory Room in Norwich was analyzed for improvement opportunities, the Operator stated that the torch did not have a stable base and he needed a way to adjust the torch since he works with different angles when curing materials. He used bricks to tilt the torch and get the work done. An opportunity to redesign the torch was identified.





Workplace Exam



Form

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FREEPORT-McMoRAN
WORK PLACE EXAMINATION

HS-SPS-1.9-001 – Rev. January 2016

EXAMINER: _____ DATE: _____ SHIFT: _____

AREA: _____

CONDITIONS NOTED:

CORRECTIONS NEEDED:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



Workplace Exam Standard

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This standard applies to all Freeport-McMoRan Morenci employees and contractors who conduct work on FMMO property. Areas excluded from requiring a workplace examination each shift include: office buildings, off-sites, laydown yards and other non-working areas in which personnel are not stationed or do not normally visit to perform work. These areas require workplace examination by a competent person when work is performed at the location or on a routine basis (according to a schedule established by the area) to ensure hazardous conditions are identified and corrected.

4.2 Contractors: are responsible for inspecting areas where work is being undertaken by their employees in accordance with this standard. Where conditions exist that affect health and safety matters not under the direct control of the contractor, an FMMO management representative shall be contacted to assist with mitigating the hazard.

Workplace Exam

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- Contractor enters site area.
- Contractor makes contact with workplace exam area owner.
- Contractor asks owner if the workplace exam has been completed in the area of work.
- If workplace exam has NOT been completed, contractor is to do a workplace exam for the area that they are working.
 - Workplace exams are to be completed regardless of whether a defect is found.
- If a workplace exam HAS been completed, the contractor is to review the workplace exam, and report any additional hazards to the area owner.



Workplace Exam

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- Questions.



2016 Safety Plan



Prevent Fatalities

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1

Improve Fatality Prevention through employee engagement at every level of the organization.

Establish employee review teams in each division

Define and communicate roles and responsibilities for each team

Employee review teams monitor Morenci Fatality Prevention efforts

Employee review teams provide feedback and recommendations to Management

Verify teams have been established

Verify roles and responsibilities have been defined and communicated

Evaluate whether intended outcomes are being produced

Evaluate feedback and implement action items

2

Leaders observe the use of Critical Safety Controls and take action where necessary to Prevent Fatalities and/or improve upon existing controls

Leaders will define which high risk tasks need to be audited by Managers, Superintendents, and Supervisors through utilization of the "category" feature in the HIRA Matrix.

Perform monthly Fatal Risk audits
Managers - 1
Superintendents - 2
Supervisors - 1

The OHSMS Leadership Team Coordinators track audit completion.

The Safety Steering Committee verifies the audits performed.

Review audit records to determine whether categories were used to prioritize

General Managers address performance within their organization.

Communicate critical control upgrades



Prevent Fatalities

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3	All levels of the organization use the HIRA Matrix for Fatality Prevention activities.	Differentiate between controls and critical controls	Employees participate in HIRA work sessions		
		Use HIRA Matrix to plan for Critical Control audits	Employees implement field version of HIRA Matrix	Review of Divisional HIRA for documentation of critical controls and upgrades. (Cross divisional reviews)	TBD based on results of Check processes
		Plan HIRA Work sessions	Use in-field evaluations to update HIRA Matrix		
		Schedule cross divisional reviews	Use HIRA for audit criteria		

4	Improved collaboration to make Fatality Prevention live through cross divisional interaction		Employees participate in cross-divisional/ departmental audits, safety meetings, tailgate meetings, and OHSMS meetings	Monitor participation and solicit feedback.	TBD based on feedback.
		Schedule cross divisional meetings			



Continual Improvement

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1

Regulatory compliance is improved with focus on the Workplace Examination process.

The Health & Safety Department will analyze and disseminate past noncompliance trends to site leaders.

Divisions will identify Workplace Examiners.

Divisions will identify areas to be examined each shift.

The Training Department in cooperation with the Health & Safety Department will provide training and mentoring to those with responsibility for workplace examinations.

Internal & Regulatory Compliance Audits

Health & Safety Department will conduct periodic internal audits to determine the effectiveness of examinations.

TBD based on performance results.

2

Employee noise and respirable dust over exposures are reduced.

Establish 2015 baselines for noise and dust.

Set 2016 targets based on 5% reduction from the 2015 baseline

Employee working in high risk exposure areas will be targeted for full shift sampling. Employees will be trained on hearing conservation and dust exposure prevention

Health & Safety Department will analyze sampling results. Compare results to established OEL's and/or PEL's

TBD based on results monitoring progress



*Quarterly Updates are
due*



Contact Sheet

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Contractor Contact Information Sheet (Provide to Safety Department)						
Company Name/ MSHA ID						
Street			City		State	Zip Code
Corporate Physical Address:						
Corporate Mailing Address:						
Project #	Contract #	Type of Work	Area Working	FMI Contact		
Company MSHA TNG Plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approved instructor	Name(s)/Organization	Instructor's	MIN. Number	
Corporate Contacts						
Title	Name (First, MI, Last)	Phone #	Cell Phone#	E-mail Address		
Owner/President						
Safety Contact						
Office Contact						
On Site Management						
Local Office Location(s)						
Title	Name (First, MI, Last)	Phone #	Cell Phone#	E-mail Address		
Expected number of Employees Coming on Site:						



Updated Training Matrix

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Contractor Task Training Inventory UPDATE Quarterly																
Activities requiring completion of FMMO delivered training																
Please enter the dates task training is completed. MSHA columns are for dates when new MSHA compliance training is completed.																
Company :																
Employee		FMMO Delivered				MSHA				Other training completed by Contractor						
Last name	First Name	LOTO	Restricted Area Access	Confined space	Fall Protection/open hole	Blue stake	New Miner	Annual Refresher	Experienced Miner	Hazard Recognition Compliance						
1																
2																
3																
4																
5																
6																
7																
8																

TRIR

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- Just a reminder that TRIR reports are due by the 5th to BOTH:
 - Amy_Sammito@fmi.com
 - Sophia_jinbo-doran@fmi.com