



July 2016 Contractor Safety Meeting

06/12/2016



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Weekly Safety Share – Open Hole

- What are the fatal risks for an open hole condition?
- How can we mitigate the hazards?





Overview

- TRIR
- PFE
- MSHA Citations







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Safety Performance

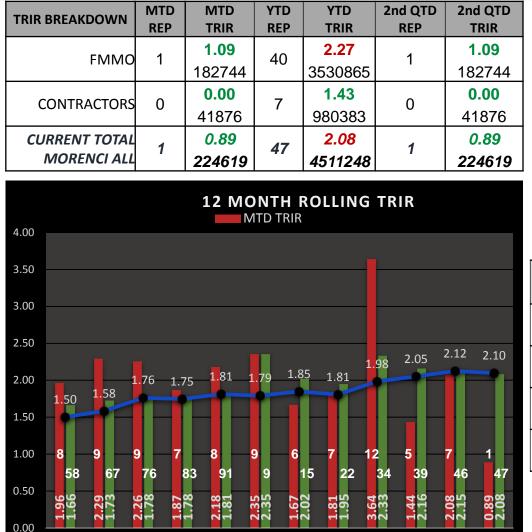
Day of	Employ	yees working	; Safely			INJURY RAT			LTIR		DRO	PERTY DAMA	IGE								
the Year	(Repo	ortable Injurie	s Only)				L		LIIN		FILU		IUL	MTD HEHI	YTD HEHI	YTD HEHI Rate	HEHI Target	DAYS W/O LTA	Hrs W/O LTA	Days W/O Rec.	Hrs W/O Rec.
192	TOTAL	MTD	YTD	MTD	YTD	QTD	Target	MTD	YTD	Target	MTD	YTD	Target								
Number	3104	3101	3014	1	47	1	1.70	0	11	0.45	20	310	11.70	1	16	0.71	0.54	01	466367	6	139264
Rate	5104	5101	JU 14	0.89	2.08	0.89	1.70	0.00	0.49	0.40	17.81	13.74	11.70	I	10	0.71	0.04	21	400007	0	109204

7/11/2016





Safety Dashboard 7/10/2016



Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16

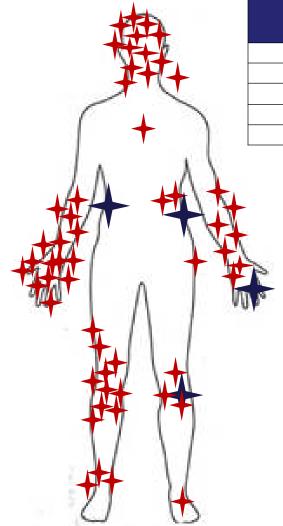


Incident Date	Incident Type	Organization/ Division	Short Description
7/1/2016	First Aid	Contractor General Contractor	The #50 Locomotive derailed and struck a Western Express Truck.
7/4/2016	Restricted Duty	Mine Frag-Loading/ Support	Employee was walking towards his truck and felt a pop in his knee.
7/1/2016	First Aid	Processing Hydromet	On 7/1/2016 an employee slipped and fell. On 7/4/2016, the employee reported pain in his lower back.
7/10/2016	First Aid	Processing Crush & Convey	An employee received a minor shock while adjusting the cable and pothead on the RP8 Ultra portable.





Injuries – Top 5



Nature of Injury	Total No. of Injuries	First Aid	Medical Treatment	Restricted Duty	Lost Time
Sprains & Strains	52	32	0	16	4
Bruise & Contusion	18	15	1	1	1
Irritation/ Burns (Chemical & Heat)	18	6	9	1	2
Cut/ Laceration/ Abrasion	16	12	2	2	0
Amputation/ Fracture / Crack/ Chip	6	0	3	1	2

- = Last week's injuries
- = Year to date injuries.

Part of Body by Classification of Injury	Total No. of Injuries	First Aid	Medical Treatment	Restricted Duty	Lost Time
Hand/ Finger/ Wrist	33	18	8	3	4
Leg/ Knee/ Hip	25	14	0	8	3
Back/ Neck	21	16	0	4	1
Arm & Shoulder	19	10	2	6	1
Head/Face/ Eye/ Mouth	14	7	5	0	2

Freeport-McMoRan



Division	Date of Last Rep. Injury (FMMO)	# of Days w/o Rep. Injury (FMMO)	Date of Last Rep. Injury (Contractors)	# of Days w/o Rep. Injury (Contractors)	Date of Last HEHI Event	# of Days w/o a HEHI Event
MAINTENANCE SERVICES	6/15/2016	25	9/14/15	300	7/1/2016	9
HYDROMET & CLP	6/11/2016	29	3/27/15	471	6/10/2015	384
LEACHING	11/17/2015	236	3/17/16	115	2/25/2015	440
MORENCI CONCENTRATOR	6/17/2016	23	8/25/15	320	6/17/2016	23
METCALF CONCENTRATOR	6/11/2016	29	8/8/15	337	6/12/2016	28
CRUSH & CONVEY	5/31/2016	40	5/18/16	53	5/18/2016	53
MINE MAINTENANCE	4/5/2016	96	4/18/16	83	3/19/2016	113
FRAGMENTATION/LOADING/SUPPORT	7/4/2016	6	4/19/12	1550	5/6/2016	65
HAULAGE	6/19/2016	21	8/1/2008	3112	1/24/2016	168
RESOURCE MANAGEMENT	6/1/2016	39	2/17/16	144	1/5/2016	187
ADMINISTRATION	2/10/2015	534	9/15/15	299	1/1/2014	922
MERCANTILE	5/31/2016	40	3/3/15	495	1/1/2014	922
CONTRACTORS	5/18/2016	53	5/18/16	53	2/17/2016	56





MSHA Inspection Summary

TOTAL BY DIVISIONS			
DIVISION	S&S	NON S&S	TOTAL
MAINTENANCE SERVICES	2	1	3
HYDROMET	1	2	3
LEACHING	0	0	0
MORENCI CONCENTRATOR	15	26	41
METCALF CONCENTRATOR	2	7	9
CRUSH & CONVEY	4	6	10
PROCESSING ORGANIZATION TOTAL	24	42	66
MINE MAINTENANCE	2	3	5
FRAGMENTATION/ LOADING/ SUPPORT	0	0	0
HAULAGE	1	1	2
MINE ORGANIZATION TOTAL	3	4	7
ADMINISTRATION	0	0	0
CONTRACTORS	2	1	3
INSPECTION TOTAL	29	47	76



Near Miss

	Incident Detail								
Date	06.02.2016								
Organization	Mine	Mine							
Division	Fragmentation-Loading	Fragmentation-Loading/ Support							
Potential	3	2	6						
Risk	Consequence	Likelihood	Potential Risk						
Brief Description	Layne Drilling Contractors	s were left inside the 1500ft blast a	zone for the shots.						

Best Practices

1. Conduct a thorough risk assessment, to include line of fire, prior to starting work.

- 2. Ensure communication between departments
- 3. Areas should be double checked when clearing for blasts.





Property Damage

	Incident Detail									
Date	06.06.2016									
Organization	Mine									
Division	Division Haulage									
Potential	3	2	6							
Risk	Consequence	Likelihood	Potential Risk							
Description	reduced speed causing when the retarder and s	it to go into a slide. The 623HT service brakes were applied. The	2HT slowed down in front of it and was going approximately 18MPH e 623HT slid 180 ft. and the bed d 571HT that was traveling up the							

made contact with the non-cab side guard rail of the loaded 571HT that was traveling up the

Best Practices

- 1. Drive to road conditions
- 2. Follow roadway watering procedures

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ramp. The 801 ramp was heavily watered.

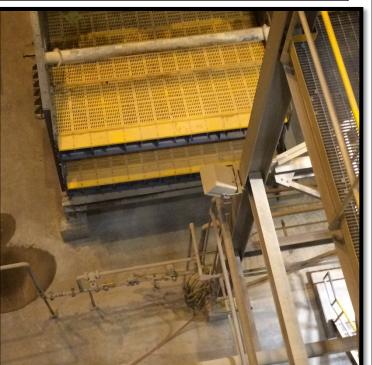




Near Miss

		Incident Detail	
Date	06.12.2016		
Organization	Processing		
Division	Metcalf Concentrator		
Potential	4	2	8
Risk	Consequence	Likelihood	Potential Risk
D : <i>i</i>	Employee reported that	the #2 Wet screen drive shaft	(Weighing approximately 30 lbs)

Brief
DescriptionEmployee reported that the #2 Wet screen drive shaft (Weighing approximately 30 lbs)
broke off and landed approximately 60 feet to the ground. No employees were in the area.
Safety will be investigating it further to classify the event.



Best Practices

1. Ensure adequate workplace exams are conducted.

- 2. Update PM process to identify potential failures
- 3. Identify and Implement controls to prevent reoccurrence of failure







First Aid

	Incident Detail							
Date	9 06.17.2016							
Organization	Processing							
Division	Morenci Concentrator							
Potential	4	2	8					
Risk	Consequence	Likelihood	Potential Risk					
Brief Description	they can place a switch were waiting on the ope valve if needed to. Emp employees turned and employee was running h he water that was comi was down he couldn't se they were able to see th	to control the valve. They went a rator to come so they could show loyees then heard a loud pop ar started to run as they didn't kno e still had his welding shield on. H ng down had pushed it down. Em e). Co-worker then helped guide e at the #2 train discharge sweep b	s onto the frame for the cylinoid so and shut the valve off. Employees v him how to open and close the nd were soaked with water. Both bow what had happened. As one lis shield had been down because ployee ran into something (shield employee. Once out of area safely lown off just above them hanging ng below. Investigation is ongoing.					



1. Conduct a thorough JSA prior to starting task

- 2. Review SOP and identify procedures and sequences for denergizing
- 3. Train employees on system operations







First Aid

	Incident Detail									
Date	07.01.2016									
Organization	Processing									
Division	Maintenance Services	3								
Potential	4	3	12							
Risk	Consequence	Likelihood	Potential Risk							
Brief Description	shop to travel up to M the locomotive lost his and it went unmanned	a.m. a single locomotive, #50 orenci Mill. After pulling away s brakes. He was not able to d towards the Columbine Gate columbine gate. The train tipp ni truck head on.	from the shop the operator of gain control of the locomotive . The locomotive went off the							

Best Practices

1. Complete a pre-shift inspection prior to operation.

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2. Upon completion of maintenance, ensure equipment is operational ready.







received a shock

First Aid

	Incident Detail						
Date	07.10.2016						
Organization	Processing						
Division	Crush & Convey						
Potential	2	3	6				
Risk	Consequence	Likelihood	Potential Risk				
Description		a a i	ortable RP8 and was adjusting zontal feed conveyor when he				

Best Practices

1. Always complete a thorough pre-shift inspection/ Workplace Exam/ JSA

- 2. Ensure personnel receive the proper training for the task.
- 3. Utilize the Stop Work Authority





PFE







The A-side primary crusher was undergoing a scheduled mantle change. Typically schedule crusher maintenance is communicated to Mine Ops in the morning tailgate meeting; however, it did not occur on this day.

Three mechanics were assigned to work in the dump pocket. At the time of the event the rock breaker was staged in front of the dump pocket and the crane hook was lowered into the crusher. The critical control of hard barricading in front of the bay was not in place, while the administrative control of a flashing red strobe light used to indicate to haultruck operators that the crusher is not accepting haultrucks was active.

While the mechanics were performing work in the dump pocket a fully loaded Caterpillar 793 Haultruck began backing into the A-side crusher bay. When the 3 mechanics heard the haul truck backing up and saw the loaded truck was in position to dump they hurried to exit out of the dump pocket via the stairs.

After fully backing into the bay and striking the rock hammer, the truck driver heard an alarm sounded by the crusher operator causing him to stop. At that time he noticed that the red strobe light was on, indicating that dump pocket was down. He pulled out and proceeded to move to the B primary crusher (bay #4) to dump out.





OTHER SIGNFICANT RISK (specific to site or task not categorized as global)

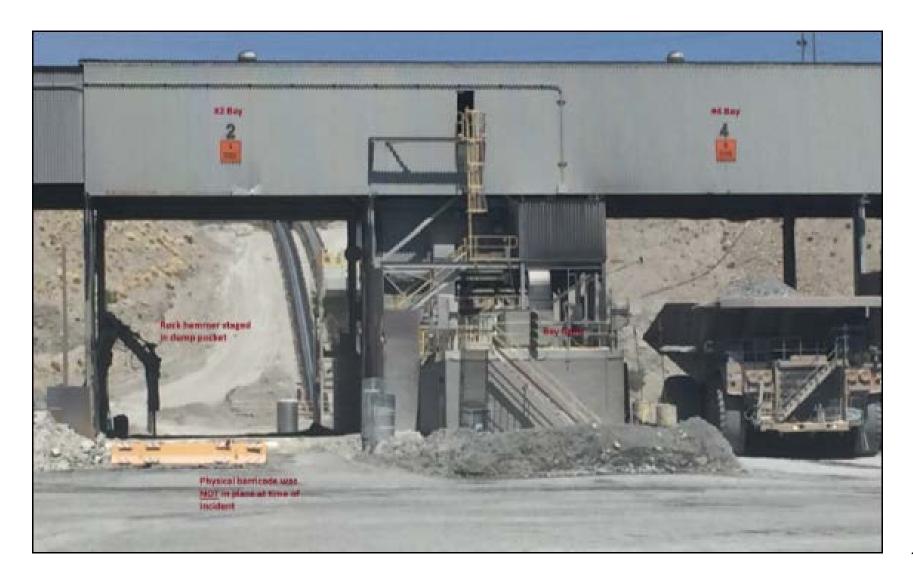
- Flagging and Barricading. During maintenance activity inside the crusher dump pocket, dumping of haul trucks is prohibited. Access by haul trucks is controlled by a hard barricade that was not in place at the time of the event.
- 2. Failure to follow a SOP.
 - A physical barricade must always be placed prior to personnel entering the dump pocket.
 - A red strobe light indicates Haul Trucks are not to back into the crusher bay.

ABSENT / INSUFFICIENT CONTROLS CONTRIBUTING TO THE EVENT

- Critical controls not in place or ineffective
 - Failure to place physical barricade.
 - Flashing strobe light was not noticed by the haul truck operator.
- A-side maintenance was not communicated in the morning tailgate meeting.
- The pre-job JSA did not indicate the need for the hard barricading.
- The SOP for the job had not been updated with the current method of hard barricading (jersey barrier).



















Morenci Runaway Locomotive

DESCRIPTION / DETAILS OF ADVISORY

A locomotive pulled out of the repair bay approximately 100 yards to be returned into service after preventative maintenance. As the locomotive was approaching an area where the tracks descend on a 3% grade, the engineer noticed the brakes were not functional. Engineer asked the groundsman walking beside the locomotive to check the position of the brake pistons. It was identified the brakes were not engaged and the locomotive continued to gain speed. He further attempted to stop the locomotive with the emergency and dynamic brakes. When the operator realized he had lost control of the locomotive, he called a Mayday on the radio and dismounted off the stairway.

The locomotive traveled approximately half a mile gaining speed towards the railroad crossing at the mill site security gate, where traffic and delivery trucks enter/exit the property. When the locomotive reached a curve near the truck crossing the weight and momentum caused the locomotive the lay over on its left side. It slid approximately 130 feet and impacted a semi-tractor that was stopped at the crossing waiting to enter the mine in the inbound lane. The locomotive's trucks separated from the body when it laid on its side. The leading locomotive-truck rolled approximately 300 feet until it impacted a metal power pole, where it came to a stop. Another semi coming on property had just crossed the tracks.

Initial investigation revealed the air for the braking system was not valved in after maintenance was performed and this was not identified during the pre-shift examination. The sole injury was a sprain/strain experienced by the semi-truck operator.

ABSENT / INSUFFICIENT CONTROLS CONTRIBUTING TO THE EVENT

Post equipment check for placing equipment back in service Placement of derailers **PROVING OUR**

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Freeport-McMoRan

Morenci Runaway Locomotive





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Morenci Runaway Locomotive

Locomotive









MSHA Citations



