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Welcome! Monthly Contractor Safety Meeting

April 2024

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Agenda

- Safety share
- Environmental share
- Safety Stats
- Freeport Safety Incidents- 7 high-risk incidents
Discussion
- PVB- Safety Processes and Improvements
- Metal Fume Policy
- Agency alerts

Environmental Share : Roll-Off Bin Management

Roll-Off Do's

- **Request Bins from Environmental**
- **Contact Environmental for Dump & Returns or Removal**
- **Place only the designated waste in the bin (Wood/Scrap Metal/Rubber etc.)**

Facts About Roll-Offs

- Property of Vista Recycling
- Managed by extensive collaboration Between Environmental, Vista, and GSC
- FMMI Pays for Damage!



Roll-Off Don'ts

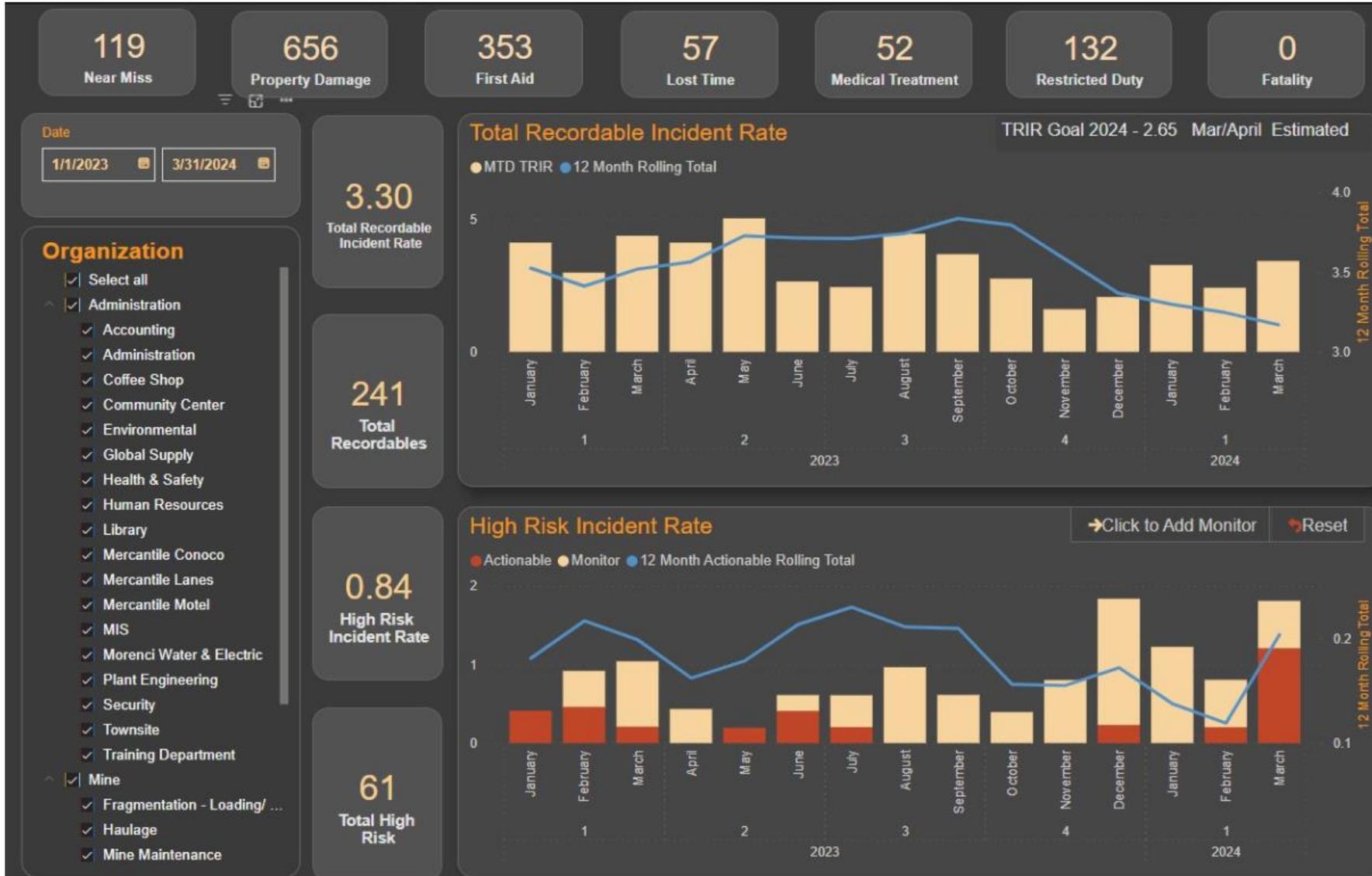
- Block access to bins from Vista**
- Mix Wastes**
- Relabel without Environmental approval**
- Fill bins over top/ overload bins**

Questions?

Contact Environmental
at 928-865-6000
or your representative

April 2024

Safety Stats 12 Month Rolling Avg



Safety Stats YTD



2024 Targets

- TRIR of 2.65 or lower
- 50% less for employees with less than 6 months of experience

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High Risk Events

April 2024

(Incidents and Communications from March 2024)

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High Risk Incidents at Morenci

Morenci has had **seven high-risk incidents** in less than two months. In each of these incidents, **one of our team members nearly lost their life**.

In some of these, our team member was **seriously injured**. We must turn this around!

One of our most important safety expectations for everyone at Freeport:

Speak up and stop work if it is unsafe or unclear!

- *Let's discuss these incidents*
- *For each incident, let's discuss how the people involved could have stopped work and prevented the incident*



We are requesting all department to tailgate these discussions. We want leaders to share learnings from employee feedback.

1. Are front line employees aware of recent incidents and their severity?
2. What are our teams saying about stopping work ? Lack of skill – culture- something else?
3. We seem to struggle in asking for help. Why?
4. What re we losing focus on the basics of safety?
5. What are the basics of safety? *Effective JRAs, reviewing policies, planning and engagement that lead to safe execution of work.*
6. What should we change?



Crush & Convey – Falling Rock

March 27, 2024

A chute plugged, resulting in significant muck spillage on an elevated conveyor.

A contractor crew was assigned to support clean-up, and was working on 1st level.

A second group was placing equipment above, to work on the belt. While this activity was taking place, a ~30lb rock came loose and rolled/slid down the structure.

One of the ground crew was struck in the head by the rock.



View from second level – showing spillage on edge of support beams over dribble chute.

Policy Violation- Health and Safety FCX-HS29

Standard Safety Requirements Policy

Health and Safety FCX-HS29 | Release Date 1/18/2019 | Rev 3/11/24

- Stop the job if critical controls are not in place, not effective, or conditions change that would affect safe work practices.
- Perform pre-shift inspections and workplace exams prior to starting a new task or activity.
- Consult required documents (SOPs, JSAs, SDS, Work Orders and Instructions) prior to performing tasks.
- Only use serviceable PPE that is free from modifications.
- Obey all posted warnings and instructions

Policy - Health and Safety FCX-HS02 |



Working at Heights Policy

Health and Safety FCX-HS02 | Release 03/2018 | Version 1

ACTIONS TO STAY SAFE

- Inspect fall protection equipment prior to using. Key items include:
 - Braids, webbing and stitching, fall/wear indicators
 - Condition of grommets, buckles and hardware, anchor points
- Have rescue plan and rescue capabilities available.
- **Complete risk assessment prior to work (i.e. JSA).**
- **Use fall protection systems work inside guardrails follow OEM requirements for mobile work platforms.**
- Secure tools and material when working above ground level.
- **Include areas above and below work area in workplace exams and inspections.**
- Prior to creating openings in walls or walking/working surfaces, install appropriate temporary barriers.
- **Flag lower levels, install fences and toe boards as necessary to guard against falling objects**
- Reference Flagging and Barricading, FCX-19.
- Permanently installed fall protection systems must be labeled to prevent being used as a lifting device.

Morenci Mill – Head Pinned at Crusher

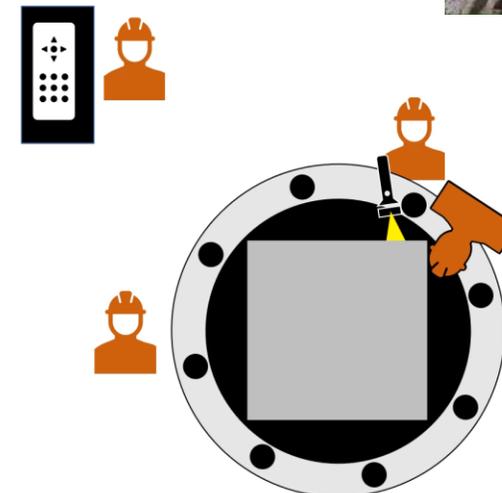
March 22, 2024

While attempting to clean out material in a shorthead crusher, a contractor was looking into the crusher to see the plug. Another operator rotated the structure to help un-jam the material.

The contractor's head became stuck between the mill locking post and discharge chute.

When the contractor realized they were stuck, they tapped a supervisor's shoulder, who then told the operator to stop. The equipment was backed off, and the contractor was released.

Any delay in communication would have resulted in a fatal head injury.



Project Support Contractor – Drive Assembly

March 12, 2024

Two contractor mechanics were replacing a 1600-pound final drive on a D8 dozer with the assistance of a forklift. It was partially secured with a 500-pound come-along, because their Cat-engineered tool was at another site. One mechanic was operating the forklift while the other mechanic was greasing the mounting seal.

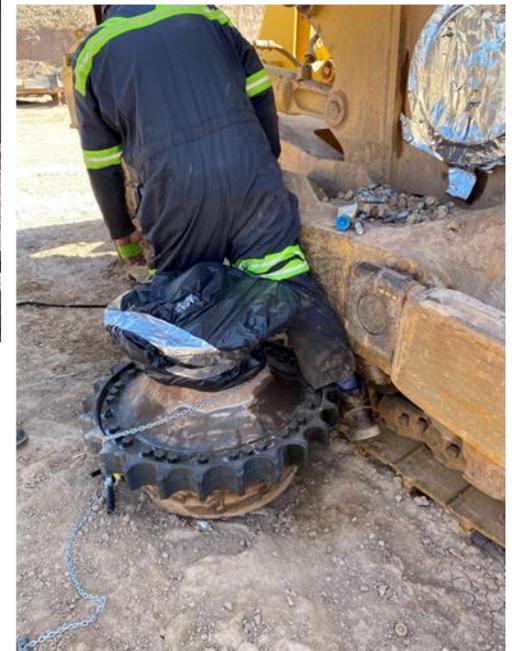
The loaded forklift, positioned 6 to 10 feet behind the mechanic, began to roll forward. The operator applied the brakes which caused the final drive to roll off the forklift.

The mechanic's inner thigh became pinned between a sharp edge of the drive assembly and the dozer, resulting in serious injuries near major arteries.



Final resting place of final drive after rotating off the forklift

Re-enactment of employee's leg pinned between final drive and D8



Global Action Item

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SAFE PRODUCTION MATTERS

Recap of PFE Incident

Incident Overview:
Two contractor mechanics were replacing a 1600lb final drive on a D8 dozer with the assistance of a forklift. One mechanic was operating the forklift while the other mechanic was greasing the mounting seal. The loaded forklift, positioned behind the mechanic, began to roll forward causing the operator to apply the brakes; this shifted the final drive causing it to roll off the forklift, pinning the mechanics leg between the final drive and the dozer. The mechanic sustained injuries to his knee while the forklift operator cut his hand helping to lift the final drive off the mechanic.

Key Findings During the Investigation:

- *Mechanics did not use the engineered tool for the task*
- *The forklift operator had the forklift in neutral, did not set the park brake, or lower the load while waiting for the mechanic, who was in the line of fire, to grease the mounting seal*
- *The forklift rolled forward and the mechanic was forced to step on the brake, causing the load to roll off the forks*
- *The final drive was not adequately secured to the forks to prevent the load from shifting forward*



Final resting place of final drive after rotating off the forklift



Re-enactment of en between fina

3. Evaluate contractor maintenance programs for equipment repairs on site, and establish minimum facility requirements
Owner with Title: Jerry Alvillar, Sr Sup H&S
Due Date: June 1, 2024

Global Action Item Proposal **Administrative**

- Identify companies performing equipment maintenance on property
- Develop minimum facility requirements
- Define audit processes
- Etc.

Crush & Convey – Fallen Idler

March 11, 2024

A contractor crew was assigned to clean buildup underneath the head end of a conveyor near the transfer tower. While on their lunch break and stationed across the street, the crew witnessed a return idler that fell 20 feet down from the conveyor. The idler landed close to the crew's working area.

The conveyor was running, the idler was mounted and in use at the time of the event.



Location where idler fell



Worn idler that fell from conveyor



Idler fell from section of conveyor circled in yellow

Mine – Water Truck On Berm

March 10, 2024

During a second run to water drills, a water truck was travelling on a ramp with 10,000 gallons of water in the tank.

At the top of the ramp, the operator identified that he couldn't safely turn around without running over drill holes.

The operator decided to back down the ramp to exit the work area. It was dark, visibility was poor, and the truck is not equipped with a camera. While backing down, the truck drove through a berm and was high centered at a 15-degree angle toward the slope. On the other side of the berm was an approximate 180-foot drop.



Water truck on berm



Water truck tire marks on ramp and impacted berm



Arrow points to location of water truck on berm



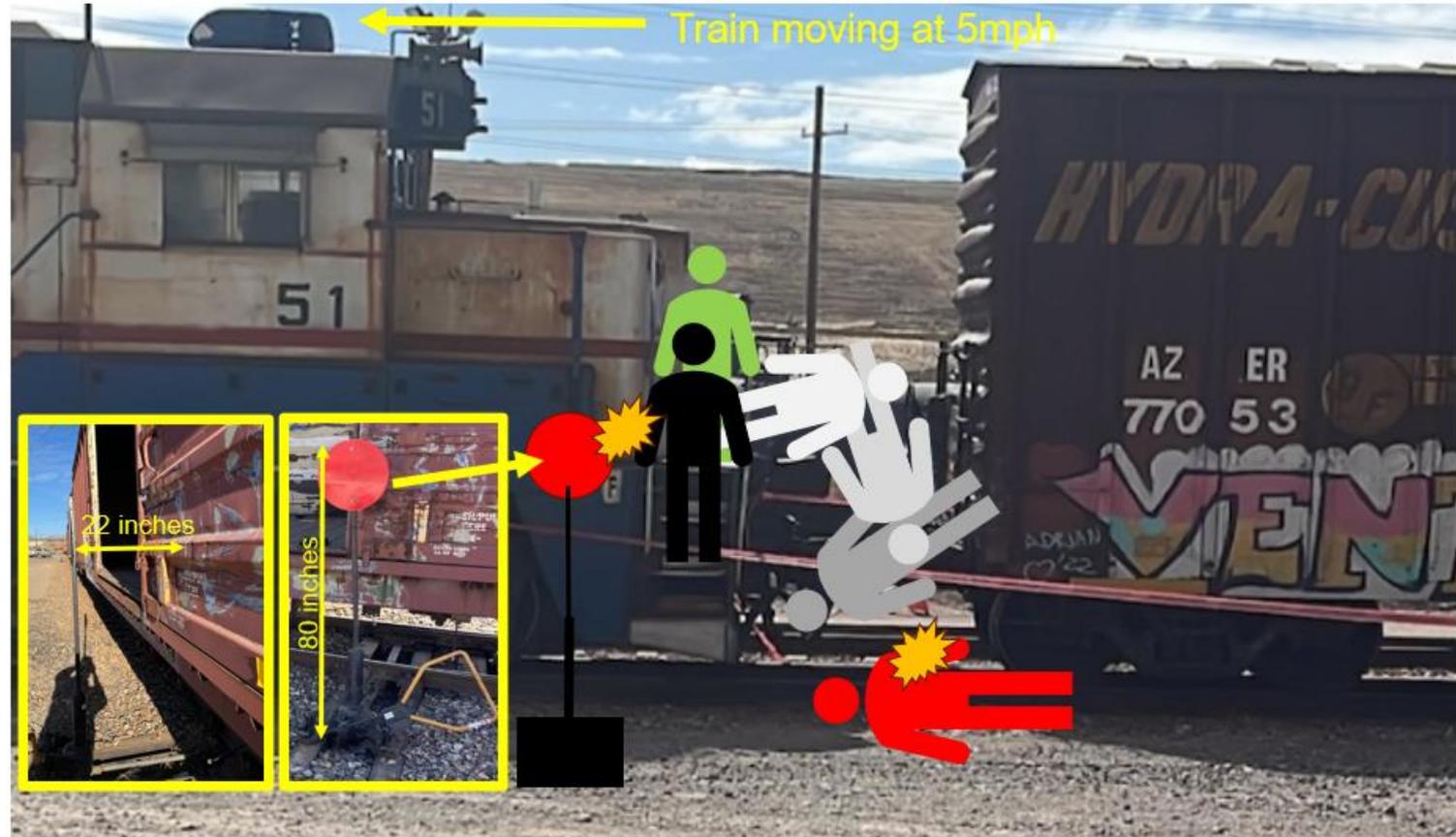
GSC Industrial Railroad – Operator Lost Arm

March 5, 2024

The Industrial Railroad crew was switching out boxcars at the south side of a copper dock.

The locomotive operator and a trainee were standing on the engine stairs and leaned out facing away from the direction of travel.

While doing so, the operator's body struck a rail switch guard sign. The operator flipped over the handrail, landing face down on the ground. The operator's right arm landed on the track and was severed. If the operator had fallen differently, he could easily have lost his life.





Rail Impact
to Person

Incident Overview

Morenci, March 5, 2024

The Industrial Railroad crew was switching out boxcars at the south side of a copper dock. The locomotive operator and a trainee were standing on the engine stairs and leaned out facing away from the direction of travel. While doing so, the operator's body struck a rail switch guard sign. The operator flipped over the handrail, landing face down on the ground. The operator's right arm landed on the track and was run over. A Mayday was called, and emergency services were dispatched to the area.



Railroad operators and employees working near railroads

- Be aware of the Industrial Rail Policy
- Do not ride on train stairs
- Complete site assessment to determine alternate means to minimize or eliminate the need for train ground crews to mount/dismount a train in motion
- Train crew may only ride on the platform of the leading end of railcars, if necessary to perform duties
- Switch personnel may only ride on leading end of railcars for spotting during pushing/shoving operations
- Do not work on or around rail or trains unless trained to do so



Morenci Leadership

- Review and audit critical components of Rail Fatal Risks according to the Industrial Rail Policy and Fatal Risk Management program.
- Reinforce execution of policies. Regularly check for understanding and adequate training.
 - Hold our employees and ourselves accountable when policies aren't followed.
- Ensure that site standard operating procedures are in line with corporate policy requirements



All of Us

- Review field training programs.
 - Confirm mentors fully understand policies and procedures. Mentors should reinforce correct behaviors while training in the field.
 - Utilize knowledge checks to regularly confirm understanding of training.
- Utilize stop work obligation when processes or procedures are not being followed, or control improvements are identified.

Metcalf Mill – Feed Chute Rolled Onto Contractor

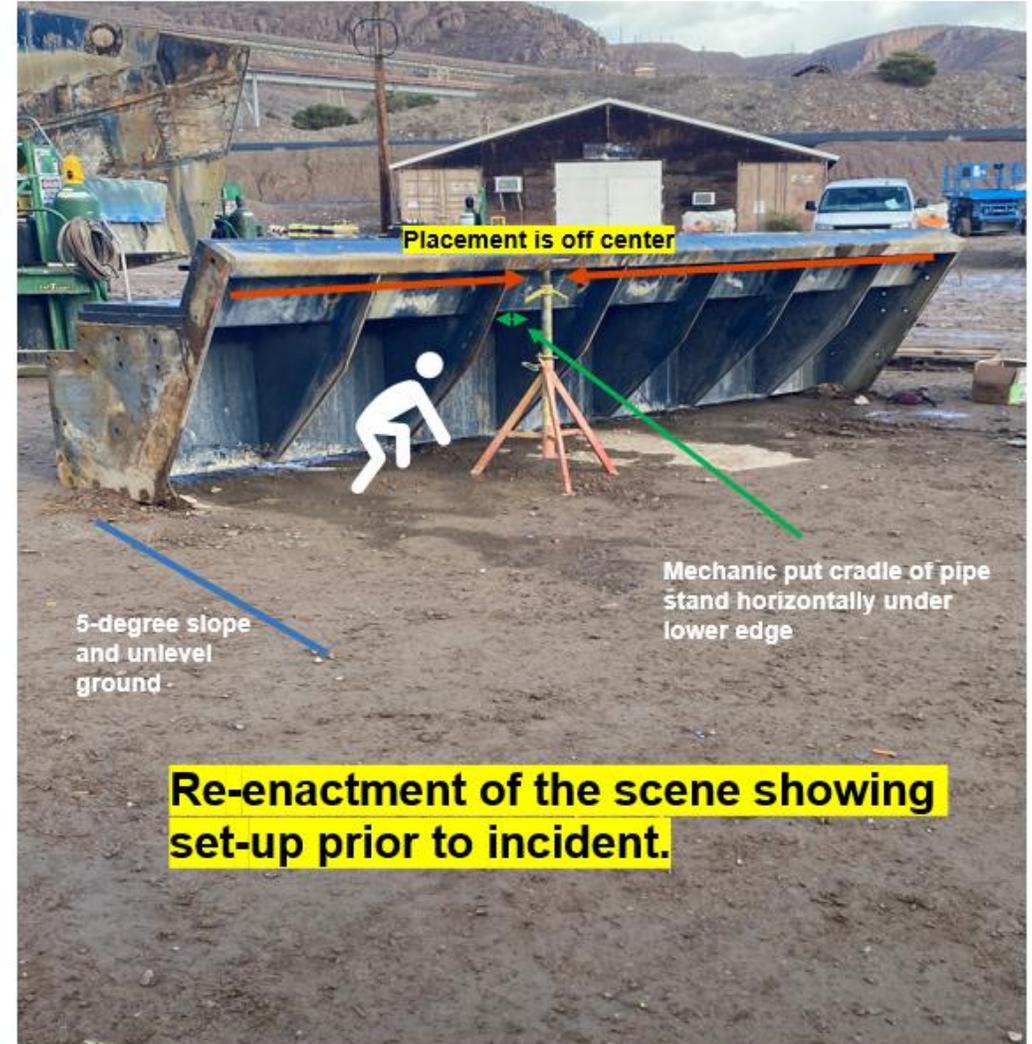
February 6, 2024

A contractor was installing liners on a wet screen feed box that had been placed on the ground for maintenance. He was working from below one side of the assembly, using inadequate supports.

As the liners were added, the two-ton box rolled over onto the worker, who was trapped underneath.

After unsuccessful attempts to move the box by hand, a forklift was used to free the worker.

If he had not seen it rolling and tried to get out, the screen could have caused fatal injuries.



What does “Stop the work” really look like?

Some common themes:

- If you're operating equipment and can't see well, get a spotter.
- If you don't have the proper tool, take the time to get it.
- If there are overhead hazards (build-up, or questionable structure/equipment) get it checked out before entering.
- If you are doing elevated work, flag the area below you; keep people out.
- If people are working above you, stop until they're finished.
- If you're operating machinery and there are people nearby, make sure they're clear before you begin.
- If “we've always done it this way”, but we'd never plan a *new* job this way, stop and question our procedure.
- If we are unsure if the work we are doing follows policy, take some time to review
- **What else??**

“Speak up and stop work if it’s unsafe or unclear.”

What does that mean?

In many cases, a quick and easy “time out” can prevent a major incident:

- “I’m not sure what to do here. I’d appreciate your advice.”
- “I can’t clearly see where I’m going. Please spot for me.”
- “Gimme some time to get the right tool.” (There’s always some housekeeping or prep work to do while you wait...)

Sometimes it might take more time, and/or involve more people

- Safety incidents end up taking up *a lot* more time, in addition to the impact on our people
- *Water truck incident: Missed opportunity. 1 hour for a spotter to avoid an incident, or 36 hours with the truck and drill down after the incident.*

Sometimes we stop, and through discussion we find that there are no problems. All OK; we should still challenge the status quo from time to time!



How We Put Safety First	All Employees
	<ul style="list-style-type: none">• Report fit for duty• Take responsibility for my own and others' safety• Assess risk and eliminate hazards using specified controls• Follow all standard operating procedures• Speak up and stop work if it's not safe or unclear• Promptly act on unsafe conditions
SAFE PRODUCTION MATTERS	All Leaders
	<ul style="list-style-type: none">• Set clear safety and work expectations• Ensure certifications/trainings are current for assigned work• Support, demonstrate and teach safe work practices• Coach to safety standards and confirm understanding• Prioritize time in the field and engage in safety conversations• Listen to employees and follow up on concerns• Reinforce the expectation to stop work

Routine / Non-routine Matrix

Routine vs. Non-Routine Work Matrix v.2024.1

FREQUENCY	CREW EXPERIENCE				
	5 or more	3-4 Times	2 Times	1 Time	None
OCCURS 2+ YEARS	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE
OCCURS 1 – 2 YEARS	ROUTINE	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE
OCCURS 6-12 MONTHS	ROUTINE	ROUTINE	NON-ROUTINE	NON-ROUTINE	NON-ROUTINE
OCCURS 1-6 MONTHS	ROUTINE	ROUTINE	ROUTINE	NON-ROUTINE	NON-ROUTINE

ROUTINE

- Standing risk assessment associated with SOP/Work Instructions
 - Formal risk assessment to develop field risk assessments

NON-ROUTINE

- Requires FRM Risk Assessment in planning phases and JRAs throughout execution
 - Involve FMI supervision & Contractor leadership

*****CONSIDERATIONS WHEN CLASSIFYING**

- 🕒 Median level of experience of crew performing job-
- 🕒 Supervisor experience = higher influence
- 🕒 High risk work can influence classification
- 🕒 Reassess when multiple fatal risks are present
- 🕒 Same or substantially similar tasks can factor into experience
- 🕒 Reevaluate when different equipment is used for the task

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PVB Safety

Safety Systems and
Process Improvements

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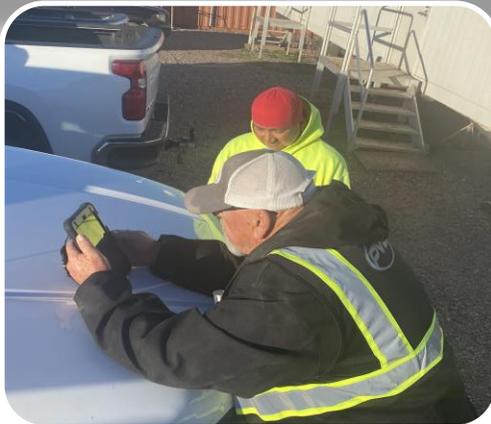
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PVB 2024 Focus Roadmap



Knowledge

- Leadership Training Classes
- Employee handbook provided
- Standardized mobile equipment and role-based training curriculum
- Completion of safety professionals (All blue cards)
- Hands on training demos
- Improving training techniques and curriculum
- Improved incident reporting / RCA form

Systems

- Root cause analysis tool improvements
- Change to electronic filing structure
- Improved risk assessment processes and communication
- Improvements in "Safety Culture" electronic Audit tool
- Hazard Identification Improvements

Culture

- Accountability to safety standards
- Consistent communication across sites (flash reports)
- Corrective action follow up / periodic audits
- One-on-one hazard identification reviews
- Safety team with specific goals



Company Flash Report



Preliminary Flash Report - Communication

Preliminary Incident Details	
Job Site	Chino
Date / Time	3/17/24 @ 08:30 AM
Type of Incident	Property Damage
Summary	Forklift was unloading Super Sacs from the Flat bed of a delivery truck. There were two more pallets to go at the end of the trailer but was unable to unload them because the Rolling Coil Tarp was situated at the end of the trailer too close to the super sacs. The tarp rolled back unexpectedly after it had been moved for safe offloading just as the forklift moved in causing a tear in the tarp.
Risk	low
Risk Category	Chemical Exposure
	Low
Findings / Missing Contr	Unexpected movement Control was added- but was ineffective
Applicable Procedures	Securing materials Allow for room for error when possible
Employee Condition	No Injuries- Minor damage to tarp
Contact	Teresa Reyes- (520) 633-7260

Photos / Links	
	
Above / Below Right: Shows damage to tarp. Tarp was rolled back accordion style, and moved unexpectedly (below)	
	
	

Company Wide Flash Report

Goals:

- Quickly communicate to all sites
- Discuss immediate learning
- Look at similar work scopes
- Maintain active crew comms.



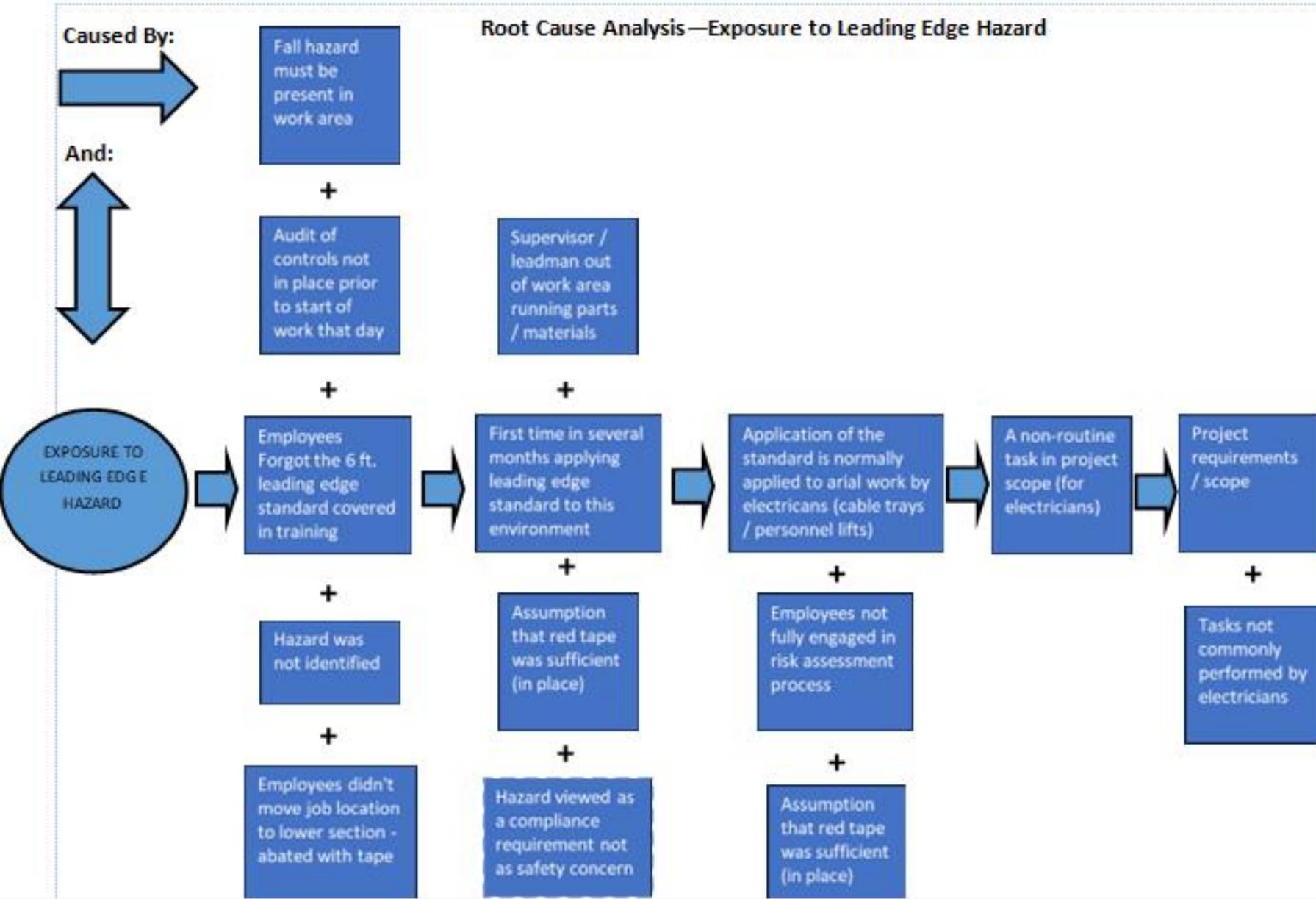
***Marker flags used for in-field hazard identification as a visual to crew and visitors, actively identifying hazards (hands on) to avoid complacency, and reducing paperwork (pencil-whipping) for crew buy in.**



Root Cause / Incident Analysis



Root Cause Analysis—Exposure to Leading Edge Hazard



***Look up “spilled milk video”**
Sologic Root Cause Analysis
Methodology to learn more.
[Root Cause and Effect Charting Video | Sologic](#)

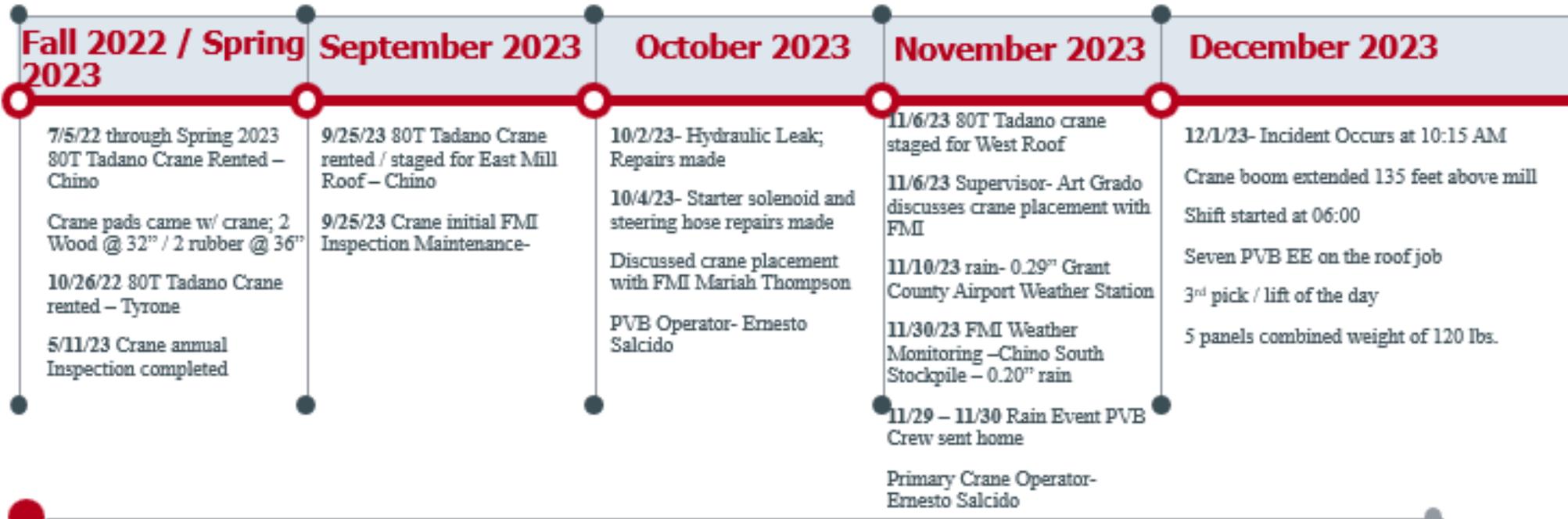


Root Cause / Incident Analysis



West Roof Crane Incident

12/01/2023





“Safety Culture” App Implementation



SafetyCulture

- Home
- Search
- Notifications
- Templates**
- Inspections
- Schedule
- Actions

[Try Premium for free](#)

- Help >
- Tyler's Team >
Tyler Vincent

Templates Responses Public Library Archive

<input type="checkbox"/>	Critical Hazard Competency Assessment Competency assessment for use with employees in the field to check / document levels of understanding for critical hazards and controls. This assessment should be...	15 Jan 2024
<input type="checkbox"/>	Continuity and Resistance Checks (Ground Checks) MSHA requires that electrical equipment receive an annual test to ensure the resistance in Ohms is within acceptable limits. An increase in resistance means that...	10 Jan 2024
<input type="checkbox"/>	(Use After MSHA Training) Spanish Comprehension Quiz Use this form after required MSHA training to ensure any primary Spanish speaking employees understood the material presented with this comprehension quiz.	4 Jan 2024
<input type="checkbox"/>	Incident Report Template Download and use this free general incident report template to capture photo evidence of the incident and injury, capture signatures of the parties involved. You...	20 Dec 2023
<input type="checkbox"/>	(Daily) Safety Audit Job site Safety Inspections focused on conditions and behaviors. Action must be initiated for any unsafe conditions or behaviors. Use this audit to document...	19 Dec 2023

Current Functionality: (Mobile & Desktop Access)

- Vehicle Pre-op Inspections
- Knowledge Assessments
- Task Training Checklists
- Daily Safety Audits
- Corrective Action Tracking
- Workplace Exams
- Continuity & Resistance Checks
- Training Modules
- Action Reminders



“Safety Culture” App Implementation



AREA CONDITIONS / BEHAVIORS

Have fire extinguishers been inspected for monthly and annual



Annual inspections out of date



Photo 6



Photo 7

Done | Assignee: Bruce Pope | Priority: Low | Due: 10 Apr 2024 09:59 MST | Created by: Bruce Pope

fire extinguishers

replaced with current dated extinguishers

Done | Assignee: Bruce Pope | Priority: Low | Due: 10 Apr 2024 09:55 MST | Created by: Bruce Pope

Private & confidential

2/10

Currently implemented with Safety Team across PVB

Permits in place for CSE, Working at Height, Excavations, Hot Work, or others	N/A
Workplace exam completed for each working area	Safe
FMI electrical test done before entry	
Photo 4	Photo 5
Pre-op inspections completed for all mobile equipment in use	N/A
Safe Access / Housekeeping	
Housekeeping to PVB standards	Safe
Pallets with any exposed nails have been removed	
Safe access provided to working locations	Safe
Guarding	
All guarding for moving machine components are in place	N/A
Hand tools have been checked with no homemade tools	N/A
Are emergency stops and pull cords in working condition	N/A
Grinders and other powered hand tools have no trigger locks	N/A
BEHAVIORS	1 flagged, 2 actions
Is work pace acceptable to prevent "hurry" injuries	Safe

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Freeport Safety Updates

April 2024

(Incidents and Communications from March 2024)

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Metal Fume Policy



Metal Fume Control Policy

Health and Safety FCX-HS33 | Release Date: April 7, 2021

POTENTIAL FATAL RISKS

Exposure to Hazardous Substances – Chronic
Exposure to Hazardous Substances – Acute

CRITICAL CONTROLS

Engineered Controls
Local Exhaust Ventilation (LEV)

PPE
Respiratory Protective Equipment (RPE)
Half/Full-Face Respirators
Powered Air-Purifying Respirator (PAPR)
Supplied Air Respirator (SAR)
Assigned Protection Factor (APF)

Handling Requirements
Surface Preparation
Process & Equipment Selection

TRAINING REQUIREMENTS

Hot Work, annual and refresher
Respiratory Protection and Fit Testing
Task and Technical Training

OCCUPATIONAL EXPOSURE LIMITS (OEL)

Substance	OEL (mg/m ³)
Antimony	0.5
Beryllium	0.00005
Cadmium	0.005
Chromium	0.003
Hexavalent Chromium	0.0002
Cobalt	0.02
Copper	0.1
Iron	5.0
Lead	0.05
Manganese	0.02
Molybdenum	0.5
Nickel	0.1
Vanadium	0.05
Zinc Oxide	2.0

POLICY

OVERVIEW
This policy outlines the requirements for protection from chronic and acute health hazards associated with metal fumes from hot work including welding, cutting, brazing, air arcing, and other processes that create metal fumes. Employees must consider the process, consumable, base metal, backing material and any surface coatings that may be present.

CONTROL REQUIREMENTS: REFERENCE CHART BELOW

- Stainless steel, high manganese alloys, galvanized or cadmium-containing material, and arc air gouging require more protective RPE, or a combination of LEV and RPE.
- Welding or cutting in confined spaces requires LEV and appropriate RPE, or RPE with an APF of 1000.
- Fume ventilation is distinct from confined space ventilation.
- Control requirements for specific tasks may be relaxed, if documented and cleared by Industrial Hygiene sampling.

ACTIONS TO STAY SAFE

- Complete a pre-task review for non-routine work.
- Position yourself to avoid the pathway of the plume.
- Consider others' exposure in the area, e.g. fire watch.
- Position LEV hoods close to fume source to capture maximum amount of fume.
- Remove surface contaminants and other hazardous materials (e.g. concentrate, solvents, lead, zinc, chromate paints, adhesives, etc.) before welding or cutting to prevent additional exposures.

CONTROL LEVEL CHART

Minimum requirements to meet OELs

	GTAW (TIG) Cutting	GMAW (MIG)	FCAW (Flux Core)	SMAW (Stick)	CAC/PAC (Carbon/plasma arc)
Carbon	Elective	Half Mask (P100 or Equivalent) (APF 10)			
Galvanized Cadmium	PAPR (APF 25)				PAPR with Shroud/SA (APF 1000)
Manganese Stainless	PAPR (APF 25)	PAPR with Shroud/Supplied Air (APF 1000)			
Enclosed or Confined	Local Exhaust Ventilation and RPE specified above - or - PAPR with Shroud/Supplied Air (APF 1000)				

Refer to site Respiratory Protection Program for additional information

CRITICAL CONTROLS

Engineered Controls - Local Exhaust Ventilation (LEV)

PPE

Respiratory Protective Equipment (RPE)
Half/Full-Face Respirators
Powered Air-Purifying Respirator (PAPR)
Supplied Air Respirator (SAR)
Assigned Protection Factor (APF)

Exposure varies with material involved
Any type of welding requires RPE-
exception is use of TIG

CONTROL LEVEL CHART

Minimum requirements to meet OELs

	GTAW (TIG) Cutting	GMAW (MIG)	FCAW (Flux Core)	SMAW (Stick)	CAC/PAC (Carbon/plasma arc)
Carbon	Elective	Half Mask (P100 or Equivalent) (APF 10)			
Galvanized Cadmium	PAPR (APF 25)				PAPR with Shroud/SA (APF 1000)
Manganese Stainless	PAPR (APF 25)	PAPR with Shroud/Supplied Air (APF 1000)			
Enclosed or Confined	Local Exhaust Ventilation and RPE specified above - or - PAPR with Shroud/Supplied Air (APF 1000)				

Refer to site Respiratory Protection Program for additional information

- Some groups have been sampled to modify restrictions.
- Not a blanket application- any deviation from policy is only authorized by a variance.
- Variance approval requires project specific sampling

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Freeport Safety Incidents, Successes, & Alerts

March 2024

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Actionable Event: Operator Electrical Shock

Exposure to Electrical Hazards

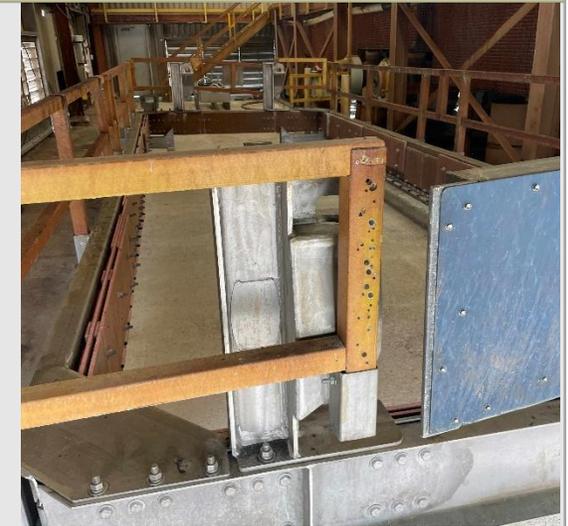
Preliminary Incident Details

Operation	Chino
Date / Time	March 6, 2024 / 12:30 p.m.
Event Type	Injury, first aid – electrical shock
Summary	A crane operator was harvesting cathodes from cell 8 inside a jumper frame. The employee was removing the second pull when a wet pantleg came into contact with the jumper frame above the boot. The operator sustained a minor shock.
Risk Category	Actionable – Significant (3) Likely (3)
Findings / Missing Controls	<ul style="list-style-type: none"> • The insulator on the crane hook was wet and offered no insulating value (showed no resistance) • The insulating material on the strongback was worn
Applicable Policies / Procedures	FCX Policy - EW ER Electrical Safety Rev. 2.pdf
Employee Condition	Employee was evaluated and released to full duty.
Contact	Jim Cook, Manager-Health and Safety

Photos / Links



Strongback handle



Area the operator's leg contacted the jumper frame



Handle with replaced insulation



Actionable Event: Forklift and Truck Collision

Preliminary Incident Details

Operation	El Paso
Date / Time	March 22, 2024 / 1:32 p.m.
Event Type	Property Damage
Summary	A forklift operator was weighing a cathode bundle at the scale. When complete, the operator reversed and struck a travelling pickup truck. Both operators failed to look in the direction of travel and identify other mobile equipment in the area. Both continued work without stopping.
Risk Category	Actionable – Significant (3) Likely (3)
Findings / Missing Controls	<ul style="list-style-type: none"> • Failure to make eye contact with equipment operators • Failure to yield to moving equipment • Failure to look in direction of travel • Failure to utilize horn signals for movement notification
Applicable Policies / Procedures	<ul style="list-style-type: none"> • SAF-0220 Powered industrial equipment operations
Employee Condition	No employees were injured.
Contact	Roland Ruybe, Manager-Health & Safety

Photos / Links



Position of forklift and truck upon collision.

Actionable Event: Invalid Motor Lockout

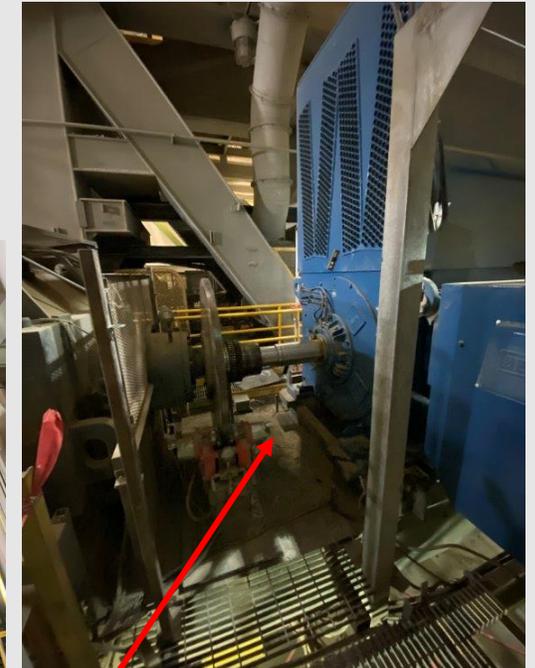
Preliminary Incident Details

Operation	Henderson
Date / Time	March 22, 2024 / 8:20 a.m.
Event Type	Near Miss
Summary	Four contractor employees were working to align a belt system motor next to a gear box and break disk with removed guarding. The energy control coordinator (ECC) released the belt brake to initiate the lock out process which caused the belt to move one foot. Contractor employees recognized the system was not locked out and notified site supervision.
Risk Category	Actionable – Significant (3) Likely (3)
Findings / Missing Controls	<ul style="list-style-type: none"> Lack of lock out, tag out, try out (LOTOTO) Contractor missed ECC radio notification
Applicable Policies / Procedures	<ul style="list-style-type: none"> Henderson Operations LOTOTO Program FCX HS04 Control of Hazardous Energy
Employee Condition	No employees were injured.
Contact	Benjamin Goertz, Manager-Health & Safety

Photos / Links



Operations lock box. Contractor was locked on this box without the ECC lock.



Contractor work area



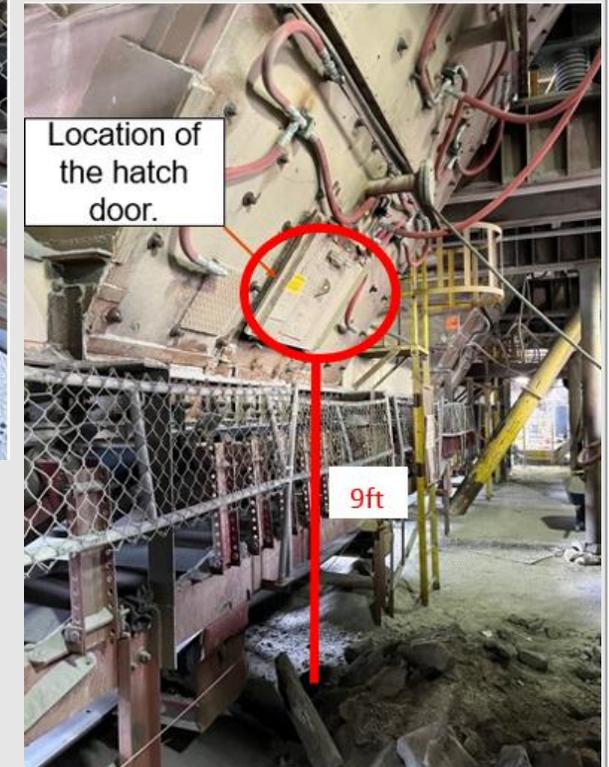
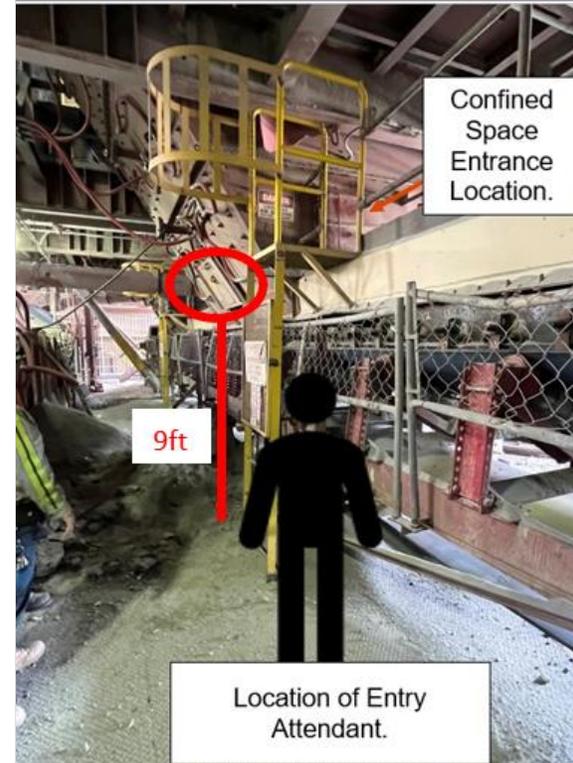
Actionable Event: Fall from Height in Chute Hatch

Fall from Heights

Preliminary Incident Details

Operation	Sierrita
Date / Time	March 28, 2024 / 8:30 a.m.
Event Type	Near Miss
Summary	Three employees were clearing deadbed material stuck on catch bars in the secondary chute. The confined space attendant opened a hatch on the north side of the chute to help improve access to the material. An employee inside the chute, unaware of the opened hatch, stepped on deadbed material covering the hatch, pushing one foot through the opening, and was exposed to a nine-foot fall.
Risk Category	Actionable – Significant (3) Likely (3)
Findings / Missing Controls	<ul style="list-style-type: none"> Lack of risk assessment Failure to communicate Failure to initiate stop work authority
Applicable Policies / Procedures	<ul style="list-style-type: none"> FCX-HS05 Confined Space FCX-HS02 Working at Heights FCX-HS04 Control of Hazardous Energy
Employee Condition	<ul style="list-style-type: none"> No injuries
Contact	<ul style="list-style-type: none"> Procopio Gonzales, Superintendent-Crush/Convey Cara Forbregd, Manager-Health and Safety

Photos / Links



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Safety Share



Overexertion in the Workplace

Employees who do physically demanding work may be working too hard and putting themselves at risk of injuries from overexertion. Overexertion injuries are costly because there are so many of them and because they often involve days away from work. Estimates place the total cost to employers at over \$10 billion annually. Another important fact about overexertion injuries is that they are preventable. It takes training, policies, procedures, and employee involvement to make an overexertion prevention program work.

- **IDENTIFY OVEREXERTION RISKS** - Once you have pinpointed the risks, you can modify workstations, job procedures, and the work environment to minimize the risks. Storing heavy items low to avoid excessive reaching and strain; reducing the depth of shelves to reduce overreaching; and modifying the work environment to reduce the need for twisting, bending, and other awkward postures.
- **PROVIDE LIFTING AIDS** - Manual and powered lifting aids reduce the strain on human bodies and greatly reduce the risk of overexertion in many material handling tasks. Examples would be forklifts.
- **PROHIBIT SOLO LIFTING OF HEAVY LOADS** - Recommend a 50-pound limit for solo lifting. More than that and employees should be required to get help or use a lifting aid. Lifting or carrying loads that weigh 50 pounds or more increases a person's risk for a serious back injury.
- **INCLUDE LIFTING POLICIES IN JOB DESCRIPTIONS** - Include lifting requirements in the job description so that these requirements will be taken into account when hiring new workers.
- **REQUIRE FREQUENT SHORT BREAKS** - A study conducted by NIOSH indicates that workers who do a lot of lifting should take frequent breaks to relax tired, tense muscles and reduce the risk of injury, particularly back injury.
- **PERFORM REGULAR AUDITS** - Studies show that frequent and unannounced audits by management and supervisors will greatly reduce safety issues like overexertion. Review audit results with team supervisors and create a "Critical Risk Assessment" document for high-risk jobs and tasks

MSHA Fatality Alert

MINE FATALITY – On November 13, 2023, a rotating drill steel of a roof bolting machine entangled a miner, causing fatal injuries.



Eliminate hazards and prevent injuries:

- Always follow manufacturer recommendations when conducting maintenance on equipment, including:
 - Turn off or de-energize the machine.
 - Secure the equipment against hazardous motion.
- Never touch or hold the drill steel, wrench, or bolt while it is rotating.
- Do not wear loose-fitting or bulky clothing when working around any machinery with rotating parts.

MSHA Fatality Alert

MINE FATALITY – On August 5, 2023, a piece of granite fell, striking two miners, killing one and seriously injuring the other.



Eliminate hazards and prevent injuries:

- Examine work areas to identify loose ground or unstable conditions before work begins and as conditions change. Report hazards and do not work in unsafe conditions.
- Correct unsafe conditions or barricade areas to prevent access before beginning work.
- Consider mining methods that do not require miners to work or travel near the base of a highwall.

MSHA Fatality Alert

MINE FATALITY – On March 1, 2024, a miner died after a metal slurry pipe struck him. The miner was removing the last bolt connecting two metal slurry pipes when the pipe broke free and swung in his direction.



Eliminate hazards and prevent injuries:

- Prevent miners from positioning themselves in a manner that will expose them to hazards while performing a task.
- Examine work areas before and during the shift for hazards.
- Ensure that blocking material is competent, substantial, and adequate to stabilize the load.
- Train miners in safe work procedures and hazard recognition. Monitor personnel routinely to ensure they follow safe work procedures.

MSHA Fatality Alert

MINE FATALITY – On August 21, 2023 a crusher lid that was being moved into place struck a miner when the rigging broke. The miner died from his injuries on August 23, 2023.



Eliminate hazards and prevent injuries:

- Do not work under suspended loads.
- Use properly rated lifting equipment and ensure that the load is well secured.
- Attach tag lines to suspended loads to steady or guide the load.
- Communicate lift plans to all persons working in the lift zone. Follow manufacturer's recommended work procedures.

Industry Fatality Alert – Codelco

MINE FATALITY – On March 8, 2024, a haul truck driver was killed after the vehicle caught fire. The driver was unable to evacuate the truck and could not activate the manual fire suppression equipment.



Eliminate hazards and prevent injuries:

- Inspect and maintain fire suppression equipment
- Know procedures for fire suppression activation
- Perform fire drills on equipment
- Practice equipment evacuations
- Check for leaks
- Take equipment out of service if needing repair