Please Silence Your Cell Phones/Mute Your Microphone on Teams

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February Contractor Safety Meeting

2-13-24

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Attendance & Communications

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CONTACT LIST

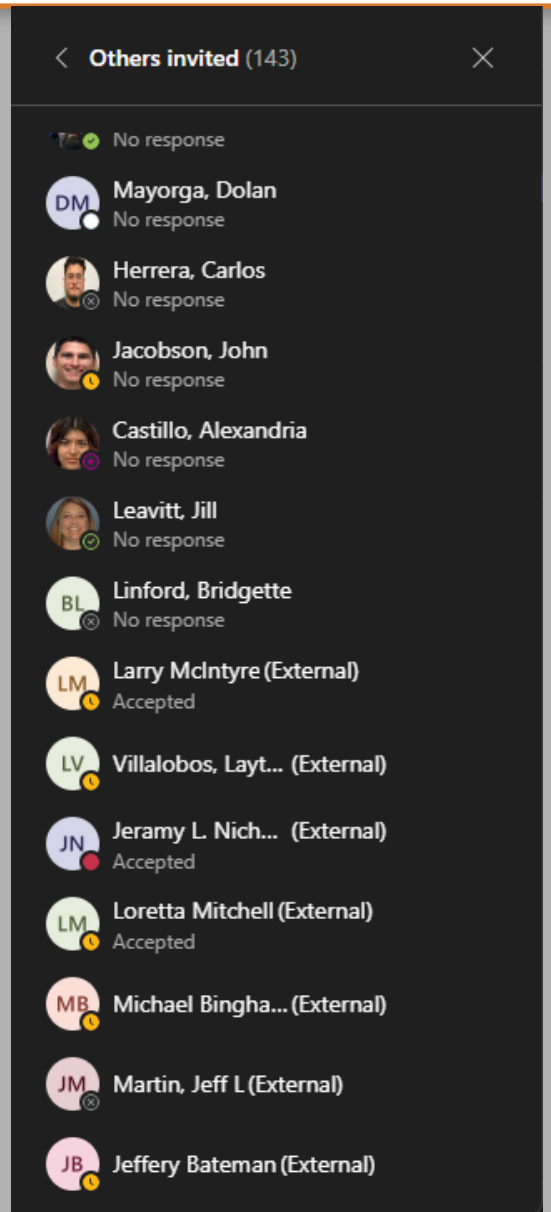
FREEPORT-McMoRan

Morenci Contractor Safety
Safe or Nothing

Please give the contact information for representatives of your company that need to be added to the communications emails from Morenci and the invitation to the Monthly Saftey Meeting

NO.	CONTACT NAME	COMPANY NAME	PHONE	EMAIL	JOB TITLE
01					
02					
03					
04					

MorenciContractorSafety@FCX365.onmicrosoft.com



Agenda

- Safety Share
- Environmental Share
- Safety Stats
- PFEs and Alerts
- Contractor Safety Manual - Reporting Incidents and Submission of Initial reports

Safety Share

Came out of mine and my NEW truck had trouble shifting into reverse. Hosed truck from bottom up- all good now,. RW garage posted pics for Morenci Morning Check In requesting regular cleaning of undercarriage. FYI- that mud hardens like concrete and can play havoc with park brakes and gear linkage.

Morenci Environmental Services

Environmental Share
Dust from Point Sources

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A point source is where emissions are produced from a single spot, such as a vent, lime silo, stack, chimney, opening or stockpile

- **Opacity limit for most point source emissions is only 20% which is very low!**
- **If you see emissions that look to be above this limit, please contact a member of the Air Team in Environmental or call the spill hotline at 928-865-7745.**

ISN System Updates

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To enhance contractor safety, the company has moved to ISNetworld as its primary contractor information management system, replacing Avetta effective immediately.

ISNetworld is a recognized leader in the field, with more than 77,000 contractor customers and over 750 Freeport-McMoRan contractor customers currently registered. ISN helps companies like ours reduce risk and strengthen relationships by qualifying and monitoring contractors through a subscription-based platform.

Some key benefits include:

- Reduced administrative costs
- Help with satisfying regulatory compliance and company-specific safety qualification requirements
- Support for more effective and efficient contractor management
- Access to contractor information, including company profile, health, safety and environmental policies and planning, safety performance (TRIR, MSHA/OHSA reporting), document submittals (insurance, HSEP, monthly forms), contractor employee rosters/training history, and more

All Freeport contractors must have an ISN subscription by **March 25, 2024**. (See timeline below.)

ISN Implementation Timeline:

- February 7 – ISN begins contacting Freeport contractors to begin the subscription process
- February/March – ISN holds training sessions for Freeport employees and contractors
- March 25 – Contractors must have an ISN account (compliance enforced)

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FCX Safety Updates

February 2024

(Incidents and Communications from January 2024)

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January TRIR & HRIR

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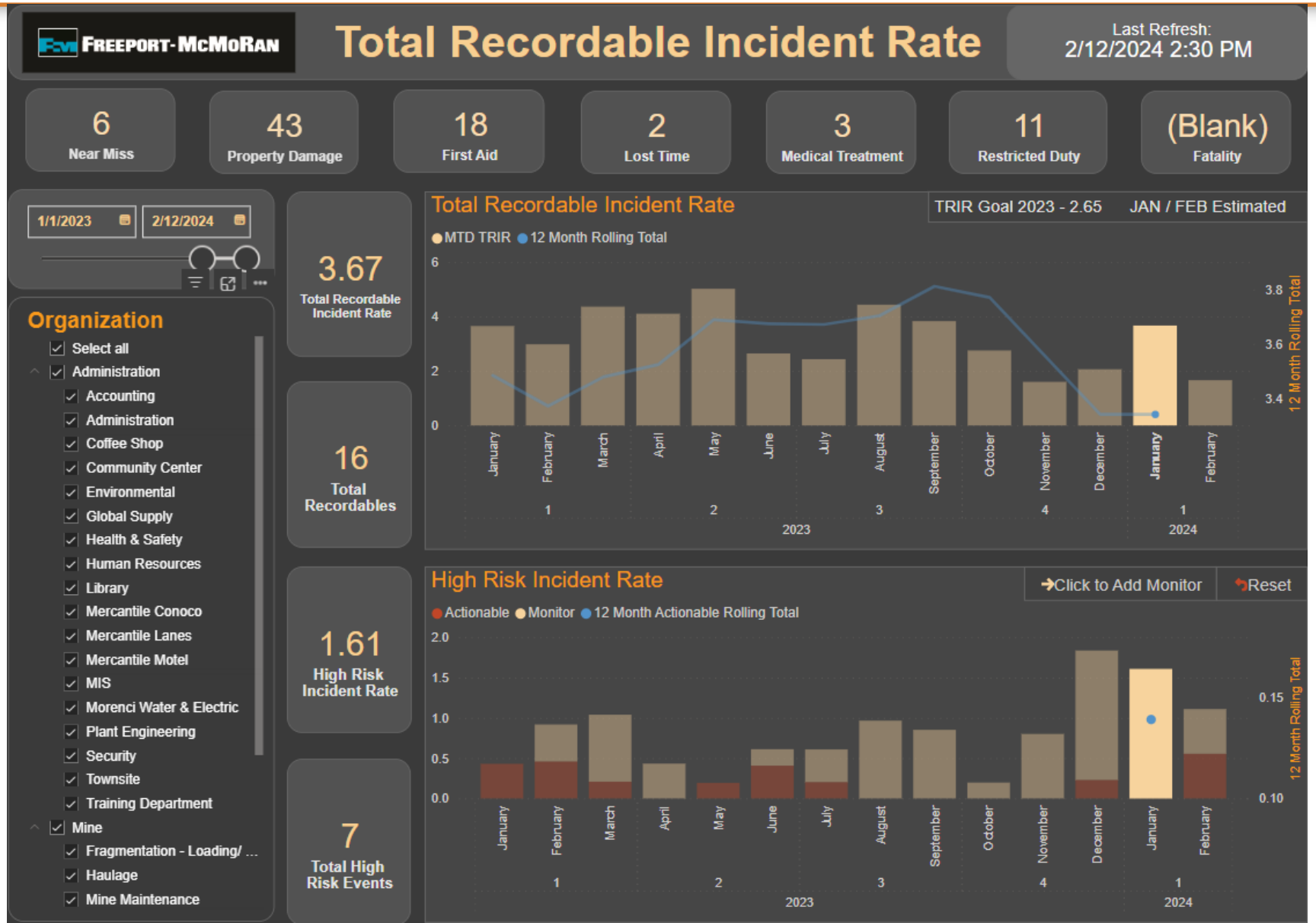

Mine Radio Changes

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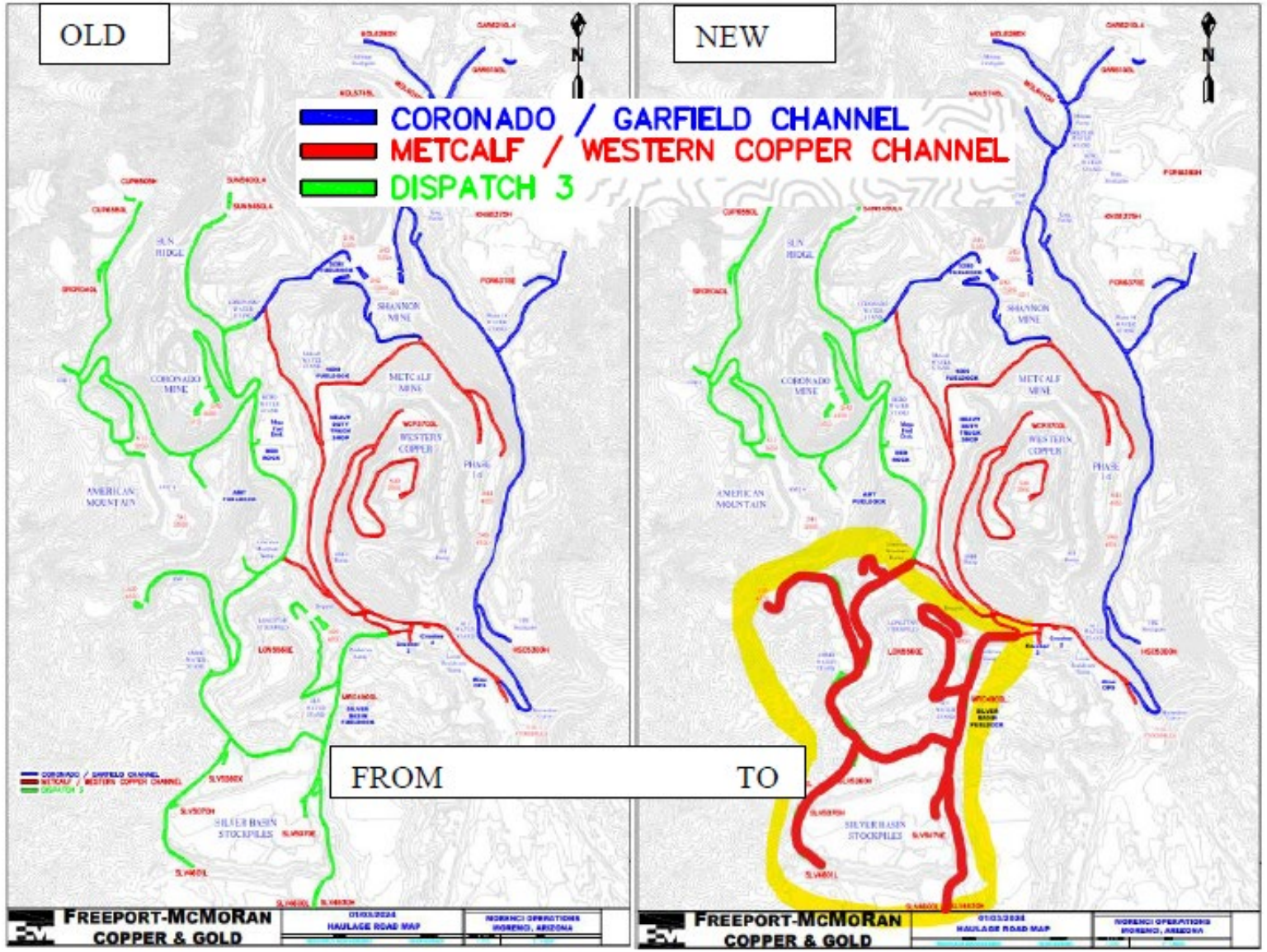

To improve Radio Communication Traffic Management, and considering the mining sequence currently and going forward, we will make changes on Radio Channel Management **effective Feb 1, 2024**.

1. **Ponderosa/AMT01 (from BEBO intersection South) along with all of the Silver Basin dumps** will be switched from DISPATCH-3 over to Metcalf/Western Copper channel **effective Feb 1, 2024.**

2. Please use the correct Radio Channel by following the updated Driver Map.

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FCX Safety Incidents, Successes, & Alerts

January 2024

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Actionable Event: Atlantic Copper – Overhead Filter Presses

FREEPORT-McMoRan

Event ID # 20012570

SAFE PRODUCTION MATTERS

Incident Details	
Operation	Atlantic Copper
Date / Time	January 4, 2024 / 12:43 p.m.
Type	Injury
Summary	When an operator was carrying out the cake discharger operation from the overhead filter presses, he detected a failure in the plate system. While looking for possible causes, the employee tried to check the pulley of the plate transport system. During the inspection, he tripped and rested his right hand between the pulley and cable of the transport system, which trapped his fingers, resulting in amputation of the 2nd and 3rd fingers on his right hand.
Fatal Risk	Entanglement and Crushing
Risk Category	Actionable
Pre / Post Rating	Significant (3), Likely (3)
Absent / Insufficient Controls	Engineering Controls: Moving Machinery not guarded
Applicable Policies / Procedures	Control of Hazardous Energy Sources (LOTOTO)
Employee Condition	Amputation of 2nd and 3rd fingers on employee's right hand
Contact	Ignacio Romero Martin, H&S Manager

Photos / Links

Actionable Event: Miami Smelter – Slag Launder

FREEPORT-McMoRan

Event ID # 20012772

SAFE PRODUCTION MATTERS

Incident Details	
Operation	Miami Smelter
Date / Time	January 14, 2024 / 12:43 p.m.
Type	Near Miss
Summary	Smelter Operator Trainee gave clearance to the slag hauler operator to set the pot in place to receive slag from the east slag launder. Without confirming that the pot was in place, the operator opened the launder and it spilled on the ground and slag hauler. The slag hauler operator quickly moved the hauler and pot away from the pouring slag. No damage to the hauler was reported.
Fatal Risk	Contact with Molten Material
Risk Category	Actionable
Pre / Post Rating	Significant (3), Likely (3)
Absent / Insufficient Controls	Communication between slag skimmer and hauler operator Visual verification
Applicable Policies / Procedures	Slag Skimming SOP Communication expectations
Employee Condition	No injuries
Contact	Justin Taylor, H&S Manager

Photos / Links

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PFE Events

January 2024

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Fatal Risk – 32B Confined Space 10-3-2023

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What did we miss?

- 32B belt was overloaded at 2:43 AM, job was turned over to dayshift
- Confined space paperwork and ECC was started
- An employee was found to be inside the confined space without the completion permit paperwork or attendant in place

What did we learn?

- Training was outdated for the employee involved
- Planning and execution of work failed to define clear roles & establish leaders
- Fill-in supervisors not aware of responsibilities

What changed or Plan to Change?

- Build onboarding and selection process for fill-in supervisors
- Formalize training/transfer process to ensure employees have required training before starting work
- Create work instructions for routine jobs that have a fatal risk

H&S Field Services, Inc.

Welding & Mechanical Repairs

Upper Feed Box Incident

H&S Field Service

Employees were working on rebuilding the wet screen. One of the task is to install new liners on upper feed box. As employee was installing bolts on the back side of the feedbox the jack stand fell, causing the feed box to tipped backwards smashing jack stand and employees left side of his lower body.

After Further investigation jack stand was not installed in proper location to keep feedbox from tipping backwards. Blanket JSA was created, not for specific task of relining the upper feedbox.

Potential Fatal Event: Feed Box Rollover Onto Contract Worker

FREEPORT-MCMORAN

PFE # PFE-2024-2
Event ID #20013230

SAFE PRODUCTION MATTERS

Preliminary Incident Details	
Operation	Morenci
Date / Time	February 6, 2024 / Noon
Type	Injury
Summary	A contractor was installing liners on a wet screen feed box that had been placed on the ground for maintenance. 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.
Fatal Risk	Uncontrolled Release of Energy
Risk Category	Actionable
Risk Rating	Significant (3) Likely (3)
Findings / Missing Controls	Blocking for maintenance work and energy isolation • Inadequate risk assessment • Pipe stands were BO and not intended for this use • Pipe stands were used instead of cribbing or engineered cradle • Placement of the stand cradle was not secure to the feed box • Ground was not level/potentially soft
Applicable Policies / Procedures	Control of Hazardous Energy
Employee Condition	Minor injuries resulting in restricted duty
Contact	Chris Seick, Metcalf Mill Manager Jacob Sweet, Health and Safety Manager

Photos / Links

Position of employee, placement of pipe stands and direction the feed box tipped.

Learnings

- Method – set-up is common practice for ground repairs
- Balance can become unstable as liners are installed- this is why pipe jack is used.
- JRA was for Screen repair- energy dynamics changed as job scope changed
- Pipe jack was not properly set up- potential slack in adjustment or saddle not placed properly
- Low experience
- Work instruction is for feedbox repair while mounted on screen

Gaps

- Risk assessment
- Rigging ineffective – insufficient cribbing
- Routine work – no yellow flags
- Work instruction-SOP
- Lack of feedback process for JRA

Miami 2014.

The PFE occurred when a 12 ton jack stand broke in half after weight placed on jacks exceeded capacity of jack stand and the jack stands were improperly used (side loaded). The Morenci light duty garage was targeted for inspection as a primary user of jack stands.

ACTION PLAN

- Inventory jacks stands and other secondary blocking apparatus in shop
- Inspect and audit items on inventory monthly.
- Commission Reliability Centered Maintenance services to perform Magnesium Particle Testing to test stands for structural defects where visual inspection would be unable to detect.
- Provide training/ refresher training for use of jack stands and importance of knowing weights of equipment being lifted or supported
- Require field examinations of blocking apparatus before each use.
- Work with Globe sourcing to ensure jack stands are no longer purchased when manufactured in China. Develop process to purchase stands made in America.

- Visual inspections identified several defective stands/ removed from service.
- MPT testing discovered conditions such as incomplete penetration, overlap, undercutting of welds plus cracking on support structures.
- Chinese stands were discovered to be defective (at a ratio of about 2 to 1).
- ASME PALD Standard 2009, American Society of Mechanical Engineers / Portable Automotive Lifting Devices. Requires jack stands to meet 200% of advertised load capacity for a specified time without impacting function or components. Performance requirements have evolved from 125% to the current 200% of advertised capacity.

Potential Fatal Event: Drill Rig Cable Failed

FREEPORT-MCMORAN

PFE # 2023 - 45
Event ID # 20012538

SAFE PRODUCTION MATTERS

Preliminary Incident Details

Operation	Whitlock Valley Test Well-Land and Water
Date / Time	December 28, 2023 / 6:10 a.m.
Type	Near Miss
Summary	A contractor had successfully completed the drilling and construction of one of three test production wells southeast of Safford and was installing a gravel filter pack using a 3-inch tremie pipe. Throughout the process, there was clogging in the pipe. The contractor lifted the pipe with a crane to clear debris when the main cable snapped, causing a 100-pound steel ball to fall approximately 12 feet to the drilling platform below, where a driller and helper had been working moments earlier.
Fatal Risk	Falling Objects
Risk Category	Medium
Risk Rating	Significant (3), Possible (2)
Findings / Missing Controls	• Flagging and Barricading • Equipment Inspections • Manufacturer Specifications for Replacement
Applicable Policies / Procedures	• Flagging and Barricading • Drill Rig Pre-use Inspections
Employee Condition	N/A
Contact	Michael Lacey, Manager-Hydrogeology. Bill Schneider, Health & Safety Manager

Photos / Links

The drill rig cables used during the pipe installation process.

Discovered Sheave on top of mast was pinching auxiliary line

Circled in red is the 100-pound steel ball that fell 13 feet to the drilling platform where two contractor employees had been working.

Potential Fatal Event: Employee Struck By Forklift

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PFE # 2023-43
Event ID # 20012496

SAFE PRODUCTION MATTERS

Preliminary Incident Details	
Operation	Miami Smelter
Date / Time	December 30, 2023 / 3:30 p.m.
Type	Injury
Summary	An employee stepped from behind a converter into an aisle and was struck by a forklift. The employee was knocked to the ground.
Fatal Risk	Vehicle Impact on Person
Risk Category	Monitor
Pre / Post Rating	Significant (3) Possible (3)
Findings / Missing Controls	• Forklift operator did not sound horn when traveling past openings in structure • Pedestrian did not yield when entering roadway • Operating speed
Applicable Policies / Procedures	• Equipment Interaction SOPs
Employee Condition	• First aid – Released back to work on full duty
Contact	Louie Barreras, Senior Supervisor-Health and Safety / Michael Cross, Manager – Downstream Ops

Photos / Links

The red X marks where the forklift struck the employee.

Potential Fatal Event: Slag Poured on Hauler

FREEPORT-McMoRan

PFE # 2023-44
Event ID # 20012503

SAFE PRODUCTION MATTERS

Preliminary Incident Details

Operation	Miami Smelter
Date / Time	December 31, 2023 / 12:15 p.m.
Type	Injury
Summary	An employee who was opening the slag tap hole requested the slag hauler operator move the pot from the east hole to the west hole. While the hauler operator was picking up the pot from the east hole, the tapper, thinking the pot was already in place, opened the west hole. Molten material flowed out onto the slag hauler. The operator moved the slag hauler forward away from the slag and immediately pulled the pin to activate the fire suppression system, and safely escaped without injury. The slag hauler caught fire and was damaged.
Fatal Risk	Contact With Molten Material
Risk Category	Monitor
Pre / Post Rating	Significant (3) Possible (3)
Findings / Missing Controls	• Failure to follow SOP • Lack of communication between operators
Applicable Policies / Procedures	• Slag Tapping SOPs
Employee Condition	No Injury
Contact	Louie Barreras, Senior Supervisor-Health and Safety/ Michael Cross, Manager-Downstream Ops

Photos / Links

The slag hauler caught fire after molten material flowed onto it.

Damage to the slag hauler.

Potential Fatal Event: Contact with Energized Cable

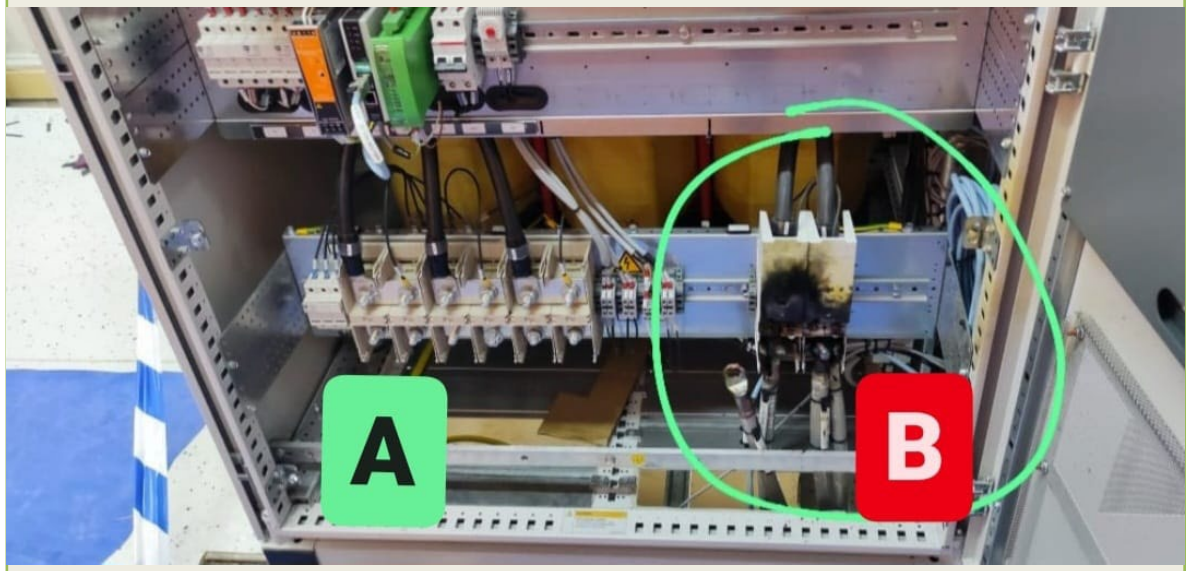
FREEPORT-McMoRan

PFE # 2024 - 1
Event ID # 20012857

SAFE PRODUCTION MATTERS

Preliminary Incident Details	
Operation	Manyar Smelter Project – Slag Concentrator Substation 2
Date / Time	January 17, 2024 / 10:30 a.m.
Type	Injury
Summary	Contractors were working on the left side of an electrical panel, which had been de-energized. Without testing for current, a worker removed a 400-volt cable from the right side, which remained energized, and contacted another cable, causing a spark.
Fatal Risk	Exposure to Electrical Hazard
Risk Category	Monitor
Risk Rating	Significant (3) Possible (2)
Findings / Missing Controls	• Failure to isolate energy with LOTOTO procedure • Wrong tool for the job • Inadequate training; worker was not authorized to perform this work
Applicable Policies / Procedures	• LOTOTO • Isolation/De-Isolation Certification Process • Energy Isolation Survey Form
Employee Condition	Worker sustained minor burns, was evaluated and released back to work.
Contact	Zach Scrivner, Manager-Corporate Project Engineering Safety

Photos / Links



The de-energized portion of the panel (A) and the energized portion (B), which shows damage.

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Agency Shares

January 2024

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MSHA Fatality Alert – Bison No.1

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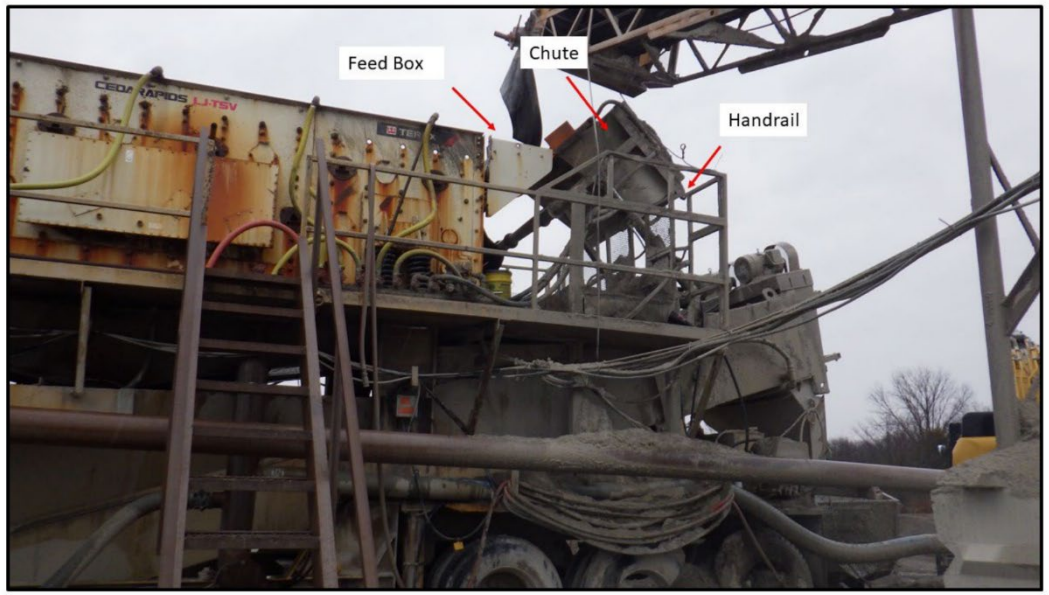
MINE FATALITY – On December 14, 2023, a miner died while preparing to repair flanges on the feed box. In the process of lowering the chute into the maintenance position, the chute pinned the miner between the chute and the handrail.



Best Practices

- Block machinery components against motion before beginning maintenance or repairs and verify miners are in a safe location before moving equipment and components.
- Examine work areas during the shift for hazards that could be created while performing the work.
- When conducting a non-routine task, review safe procedures before starting work and ensure all safety components are in place.
- Do not work under suspended loads.

This is the 39th fatality reported in 2023, and the 15th classified as "Machinery."

PDF LINK

MSHA Fatality Alert – Beck Street

MINE FATALITY – On December 14, 2023, a contractor died while delivering parts to the mine when an all-terrain telehandler pulling cable, tipped over, striking him.

Best Practices

- Do not exceed the load radius and load limits of lifting equipment.
- Ensure miners position themselves in a safe manner while working around equipment.
- Barricade and sign affected areas in case equipment or loads fail or tip.
- Ensure visitors entering the mine receive site specific hazard awareness training.
- Maintain good communication between co-workers.

This is the 40th fatality reported in 2023, and the 16th classified as "Machinery."

PDF LINK

7.0 Emergency Action and Incident Reporting

Emergency telephone numbers/radio channels will be posted in areas accessible to Contractor employees. In the event of a serious incident or injury, immediately activate the project emergency response/notification system, maintain scene safety and trained Contractor personnel should render first aid to any incident victims..

If an incident requires immediate notification to government agencies, the area will be secured, and nothing disturbed or removed after evacuation of the injured employee until approval from all government agencies and FCX representatives is received. FCX will address any media inquiries or announcements and make other decisions critical to the overall site and project

7.1 Incident Reporting

Incidents of a serious nature may require “immediate” notification to government agencies. Contractors are responsible for this notification in the time limits set in regulation. Once time sensitive reports are made, the FCX Health and Safety Representative will also be notified.

Incident Reporting – Submission of Initial Reports

- All incidents will be reported to the FCX Health and Safety Department immediately with the initial written report to be submitted by shift end. Initial reports will include, at minimum:
  - Location of incident
  - Name of persons involved
  - Equipment involved
  - Time/date of incident
  - Nature of incident: occupational injury, occupational illness, near miss, property damage
  - Brief description of incident
  - Where injured (body part)
  - Complete Logbook

- Written final report is due to the Health and Safety Department within 48 hours of the incident, unless otherwise extended based on severity of incident.
- Each incident will be reviewed immediately to determine if it had the potential to result in a fatality. In such instances, the event will be investigated with the same rigor as if a fatality had occurred.
- Contractors may be required to conduct or participate in any investigations and/or root cause analysis (RCA).
- Action plans may be developed and implemented to prevent reoccurrence.