

SAFETY ALERT NOTIFICATION

This is NOT an investigation report. It is a NOTIFICATION of a Significant Incident that has taken place at a Freeport-McMoRan location. The information below is a preliminary assessment and not a formal investigation.

OPERATION:	Chino Hydromet	Incident:	X				
ISSUED BY:	Brittany Varela, Chino Hydron	Injury:					
DATE:	10/3/14 & 10/7/14		Property Damage:				
TIME:			Process Loss:	x			
LOCATION/DEPARTMENT:	Chino Leach Stockpile - Lam	bright 7055 A-Lin	e				
INCIDENT DESCRIPTION:	On the morning of October 3, an FCX employee and three contractors were working around an HDPE drip line system on the Lampbright stockpile when they were exposed to a hazardous gas. All four were transported via mine rescue to the local emergency room, they were evaluated and ultimately released. Mine personnel immediately gathered up various air monitoring equipment and appropriate PPE to test for numerous gases (CO, H ₂ S, O ₂ , SO ₂) and LEL. Air monitoring in the immediate area of the event began approximately two hours after the incident occurred and throughout the day. In addition, air monitoring overnight into the next day. The results of this testing on October 3 rd through 4 th did not indicate levels immediately dangerous to human health. As a result, it was determined the stockpile could be accessed safely if personnel worked in pairs, wore personal air monitors (Bumble Bee) and carried two-way radios. In addition, the site delayed personnel access until any potential temperature inversion had dissipated. Over the next two days, Leach maintenance contractors and FCX personnel accessed the stockpile and began normal leach pad maintenance activities including drip-line repairs and pipeline flushing. Shortly after noon, two contractor employees complained of feeling ill, were transported to the emergency room for evaluation and were released later that day. Following this incident, mine personnel accessed the site and additional testing was conducted. Again, the air monitoring results were negative which led to a decision to shut-down the stockpile to all personnel.						
DETAILS OF INJURY TYPE:	From the descriptions of the personnel affected, it was evident, that the exposure was from inhalation. The evidence suggests the employees were exposed to NO ₂ gas from off-spec acid that was supplied to the mine from an external source.						
POTENTIAL FOR INJURY:	Fatality Lost Time	Permanent Disability	Other Potent	ial			
	1. The evidence of an 200 feet length ('dead leg') of 24 inch diameter LIDDE						
PROBABLE DIRECT CAUSES:	 The existence of an 800 foot length ('dead leg') of 24 inch diameter HDPE pipe at the highest point in the pipeline where gasses could collect in the system. It was confirmed that this configuration provided an opportunity for gas to collect in this area of the line and be released during the process of flushing or repairing the line. Acid quality – evidence suggests that poor quality or off-spec acid was received 						

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	and introduced into the mine leach system. A potential contaminant in sulfuric acid is nitrates, which can result in the generation of NO and NO ₂ when diluted below 70% strength. Although monitoring for NO ₂ was not conducted on October 3 rd or October 7 th , negative readings for CO were recorded on two air sampling monitors on October 3 rd . Per the air monitor manufacturer, negative readings for CO is an indication of sensor interference from the presence of NO ₂ . It was also confirmed that acid containing nitrates exceeding purchasing specifications was discovered at the Morenci mine on October 22 rd . Dilution testing of this acid at the FCX Central Analytical Services lab produced the evolution of NO _x gas. Based on this information and the addition of nine railcars of fertilizer grade acid being introduced into the system a few days prior to the October 3 rd event, it is highly probable that one or more of these rail cars contained high nitrate levels. When these nitrates were diluted into the raffinate, NO and NO ₂ gas was generated and trapped in the 800 feet of the HDPE pipeline. 3. Weather conditions – On the day of the event there was virtually no wind and an inversion existed which could have held gases in concentration at the surface where employees were working.		
IMMEDIATE CORRECTIVE ACTION:	 Employees were evacuated from stockpile, stockpile monitoring was conducted, stockpile operations were shutdown, investigation continued until causes determined. Multi-media sampling plan was developed and executed to include the various solutions, soils, and gases around the area where the exposure occurred. The 800-foot 'dead leg' was removed and an air relief valve (ARV) installed at the end of the pipeline. This allows any gas accumulated in the pipeline to be released as it is generated instead of building up over time and released when valves are flushed. Developed a process for monitoring incoming sulfuric acid to determine it meets internal specifications. This includes reviewing the certificate of analysis (COA) and visual observation of the color (Color Chart was developed and communicated to all FCX acid customers). A lab was set up to perform on-site NOx titration of all supplied acid. Acid that is cloudy or dark or assays ≥300 parts per million (ppm) (0.03%) NOx will be quarantined and quality confirmed at an outside lab. If the levels are >300ppm, the rail car may be rejected and returned to the acid supplier. Implemented a process and training to ensure that anyone working on the Lampbright stockpile is wearing a personal air monitor that will alarm for O₂, CO₂, NO₂, SO₂, and H₂S. In addition, all personnel carry an escape hood that will be deployed if alarm levels from the personal air monitoring dictate escape Strategically installed wind socks on the Leach stockpiles so personnel can visually determine wind direction and strength to plan evacuation routes. 		
REQUIRED ACTIONS:	 Tailgate incident with all personnel Install and continuously monitor for NO₂, SO₂, and H₂S at acid dilution areas. These areas will have an audible and visual alarm and will be tied into the SX control room. Communicate incident and findings to all FCX sites. 		

			Fixed Mon	itors fo	or NO2, SC	02, H2S				
Manufacture	r Model	Model		Description		Measuring Range		larm Set	Calibration	
Mine Safety Appliance Company	A-Ultima E1M300002 110000	A-Ultima X3 E1M3000025119 110000		Mine Safety Appliances Company-Ultima X3 Technology Sensors H ₂ S		H ₂ S: 0 - 100 ppm		ppm	Monthly	
Mine Safety Appliance Company	A-Ultima E1M300002 110000	X3 25119)	Mine Sa Applian Company-U X3 Techno Sensor S	ie Safety pliances any-Ultima echnology isor SO ₂		0 ppm 2 ppm		pm	Monthly	
Mine Safety Appliance Company	A-Ultima E1M300002 110000	X3 01121)	Mine Safety Appliances Company-Ultima X3 Technology Sensor NO ₂		NO ₂ : 0 - 10 ppm		3 ppm		Monthly	
Initial alarm set points (OEL).	s are set in accordance to	o FCX Ha	zardous Gas Mon	itoring Sys	stems and Appu	rtenances w	hich are at/or	below the Occu	pationa	l Exposure Limits
		Mobi	le Monitors	s for H2	2S, SO2, C	02, NO	2, O2			
Manufacturer	Model	De	escription	Measu	ring Range	Initial A Po	Alarm Set	Calibrati	on	Bump Test
Industrial Scientific	MX6 iBrid	In Scie iBrid	ndustrial ntific MX6 Sensor H ₂ S	H ₂ S: 0	- 500 ppm	10 ppm		Monthly		Daily
Industrial Scientific	MX6 iBrid	In Scie iBrid	Industrial Scientific MX6 iBrid Sensor SO ₂		SO ₂ : 0 - 150 ppm		2 ppm		у	Daily
Industrial Scientific	MX6 iBrid	In Scie iBrid	ndustrial ntific MX6 Sensor CO ₂	CO ₂ : 0 - 5% Vol.		0.5% Vol.		Monthly		Daily
Industrial Scientific	MX6 iBrid	Ii Scie iBrid	ndustrial ntific MX6 Sensor NO ₂	NO ₂ : 0 - 150 ppm		3 ppm		Monthly		Daily
Industrial Scientific	MX6 iBrid	In Scie iBrio	ndustrial ntific MX6 1 Sensor O ₂	O ₂ : 0 -	O ₂ : 0 - 30% Vol.		19.5 % Month 'ol.(Low) or 23.5% Vol. (High) (High)		у	Daily

al Scientific which are afor below the Occupational Exposure Limits (OEL).

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This is NOT an investigation report. It is a NOTIFICATION of a Significant Incident that has taken place at a Freeport-McMoRan operation and is being communicated to enhance safety awareness should a similar situation exist. The information above is a preliminary assessment of the event and is not a formal investigation.