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## 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:	Henderson Mill			Incident:	
ISSUED BY:	Phil Lawlor			Injury:	
DATE:	2/11/2015		Property Damage:	X	
TIME:	1:05 a.m.		Process Loss:	X	
LOCATION/DEPARTMENT:	Nokes Building Caustic Transfer - Operations				
INCIDENT DESCRIPTION:	At the end of dayshift on February 10, 2015 a caustic transfer was completed. Flush water was left on and the caustic storage tank valve was not completely closed. This caused the caustic storage tank to overflow and flood both the Caustic and Nokes sides of the Nokes building with caustic solution. At 01:05 a.m. on Feb 11, MCC P1 tripped, caused by the Nokes building flooding. A 480V portable heater was plugged in, using an extension cord, to the temporary power outside the Nokes building (set up during building construction activities). The connection between the heater and the extension cord was lying on the floor of the Caustic building. When this was submerged it caused electricity to go to ground, tripping the MCC. The emergency generator power turned on at this point, re-energizing the Nokes building and the 480V extension cord. This hazard remained in place until the building power was isolated as part of incident response (5:20 a.m., Feb 11) When the nightshift leach operator reported to the Nokes building to transfer caustic at 01:40 a.m. on Feb 11, the building was filled with 3-4" of caustic solution that had overflowed from the storage tank. The operator did not enter the building and contacted the relief supervisor. The relief supervisor, boiler operator (both MERT trained) and leach operator entered the building from the east side dock door to view the flooding from above. They identified several items bubbling below the surface of the solution, including the 480V cord. Also identified during the area inspection was the open flush water valve. The group exited the building and the relief supervisor proceeded to call out additional emergency response personnel to respond to the incident.				
DETAILS OF INJURY TYPE:	N/A				
POTENTIAL FOR INJURY:	Fatality	Lost Time	Permanent Disability	Other Potent	ial
				Х	

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PROBABLE DIRECT CAUSES:	Failure to follow rule or procedure- The SOP for caustic transfer was not followed properly. Flush water was left on and caustic storage tank valve not closed completely. Inadequate Warning System - The High alarm was set to 100% so the alarm did not engage in the Mill Control room since the tank overflows before reaching alarm point.
IMMEDIATE CORRECTIVE ACTION:	<ul> <li>The building power was isolated following LOTOTO procedures.</li> <li>The material was pumped out of the building back into concentrator.</li> <li>The emergency response team cleaned the building.</li> <li>The Maintenance and electrical personnel inspected the building for any hazards or damage.</li> </ul>
REQUIRED ACTIONS:	<ul> <li>The team will perform a detailed review and improvement of the Caustic Transfer SOP</li> <li>An Electrical review of the current Nokes Building Power supply will be completed to determine if any protection/safety upgrades are warranted.</li> <li>A Root Cause Analysis will be completed.</li> <li>FCX sites should verify there aren't non-rated power cords in locations vulnerable to being submerged.</li> <li>FCX sites should verify that secondary containment is adequate for their designed application.</li> <li>FCX sites should verify that alarm systems are set appropriately.</li> </ul>



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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.