FREEPORT- McMoRan

SAFETY ALERT NOTIFICATION

Sierrita Accidental Addition of Flush Water to NaHS

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|------------------------------------|----------------|---------------|
| | Safety Alert # | SA – 2016 - 8 |
| | IMS # | 72245 |
| | OPERATION: | Sierrita |
| | INCIDENT DATE: | 10/6/2016 |
| | TIME: | |
| | TYPE: | Near Miss |
| | | |
| s. Khyrstyne Chung or Kelsey Plank | | |

Issued By: **Kelsey Plank**Contact For Additional Details: **Khyrstyne Chung or Kelsey Plan**

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.

INCIDENT DESCRIPTION

Moly Plant Operator noticed that the NaHS flow was lost during plant operation. After further troubleshooting, it was found that water was actually discharging from the NaHS line into the Moly Flotation circuit. Once identified, the Moly Plant Supervisor contacted the Mill for further investigation. Upon investigation, it was found that the process raw water that is used to back flush the NaHS flow-raters/discharge lines to the Ceramic Filters was left running with the main isolation valve in the "open" position. This valve being left open allowed the process raw water to over pressurize the NaHS line, which is gravity fed from the Reagent tank farm. Subsequently, the water made its way upstream into the Moly Flotation circuit. If the flush water wasn't identified in a timely manner, a pH change could have occured in the when NaHS flow was restored to the flotation circuit. The drop in pH could have generated H₂S Gas.

GLOBAL SIGNIFICANT RISKS(if applicable)

| Bulk Material Handling | Choose an item. |
|------------------------|-----------------|
| Choose an item. | Choose an item. |

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

Hazardous Gas exposure

PROBABLE DIRECT CAUSES

- Human Error
- No 'safety' interlocks on equipment

IMMEDIATE CORRECTIVE ACTION(S)

- Water was shut off
- · Area audit was conducted
- Maintenance shifters installed check valve on NaHS line
- Incident was communicated to work force
- Incident was captured and a near miss was submitted
- Metallurgist conducted pH testing of raw water line to ensure compliance with Hazardous Gas Policy

Rev: 1 January 2016

REQUIRED ACTIONS(S)

- Automate flush water sytem (pneumatic valves) to be investigated
- Audit entire NaHS line
- Post warning signage in area
- Better area labeling
- Continuous operator training

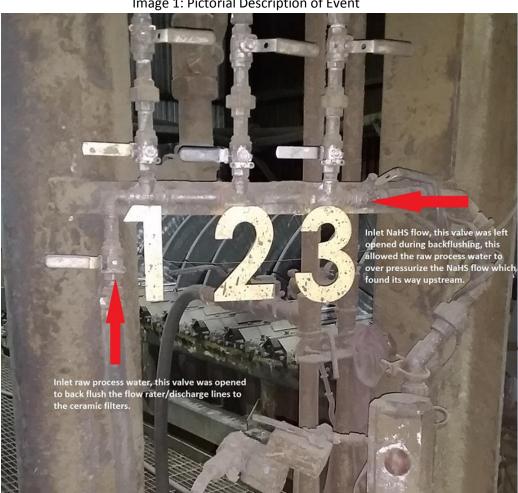


Image 1: Pictorial Description of Event

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.