Follow Up Report: #20-364
September 27th, 2020 – 500 L Hydrex 6240 Spill

The following information refers to a spill reported by Agnico Eagle Mines Ltd. September 27th 2020, and is being provided in accordance with:

- the Nunavut Water Board License 2AM-MEL1631 Water License, part H, item 8c
- the Government of Nunavut's, Environmental Protection Act subsection 5.1(a)

Description of Incident:

On September 27, 2020, shortly after 17:00, the Environment Department received a call requesting assistance in spill response at the SWTP. Upon arrival, the supervisor of the employee involved informed us that the equipment operating was attempting to transport a ¾ full tote of coagulant, did not use a spotter, and accidentally punctured the tote (Figure 1). The spill occurred directly outside of the SWTP loading doors (Figure 2) at the following coordinates:

63°1'35"N, 92°12'37"W

Figure 1: Punctured tote with remaining liquid inside.

Figure 2: Location of the spill on the exterior loading ramp area of the SWTP.

Spill Response & Cleanup

Upon puncturing the tote, the operator acted quickly by using the loader to tip the tote onto its side, preventing it from emptying completely (Figure 3). Spill pads and absorbent booms were deployed in an initial attempt to prevent the spill from spreading (Figure 4). The material itself was a sludge-like consistency and did not absorb deep into the compacted pad. However, the spill occurred on a sloped area, so the material spread out over a large surface area.

Workers manually began to shovel material into an empty tote, until a back-hoe arrived (Figure 4). The back-hoe was then used to scrape up a few inches of gravel/sand which helped to soak into the coagulant. The pile of contaminated gravel was then transferred into approximately 25 quatrex bags which will be shipped south as hazardous waste.

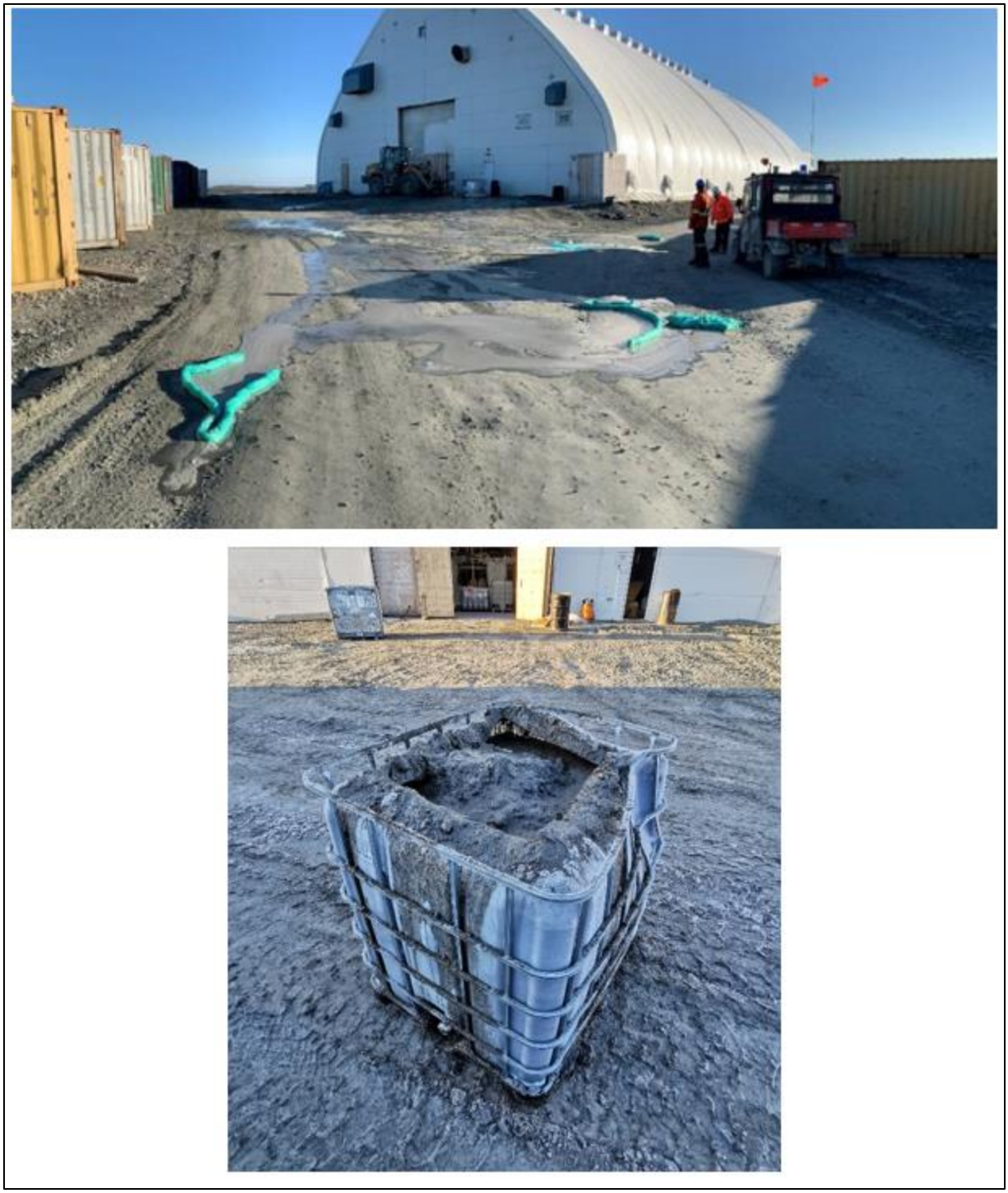

Figure 3: Initial effort to contain the spilled material from flowing away from the source.

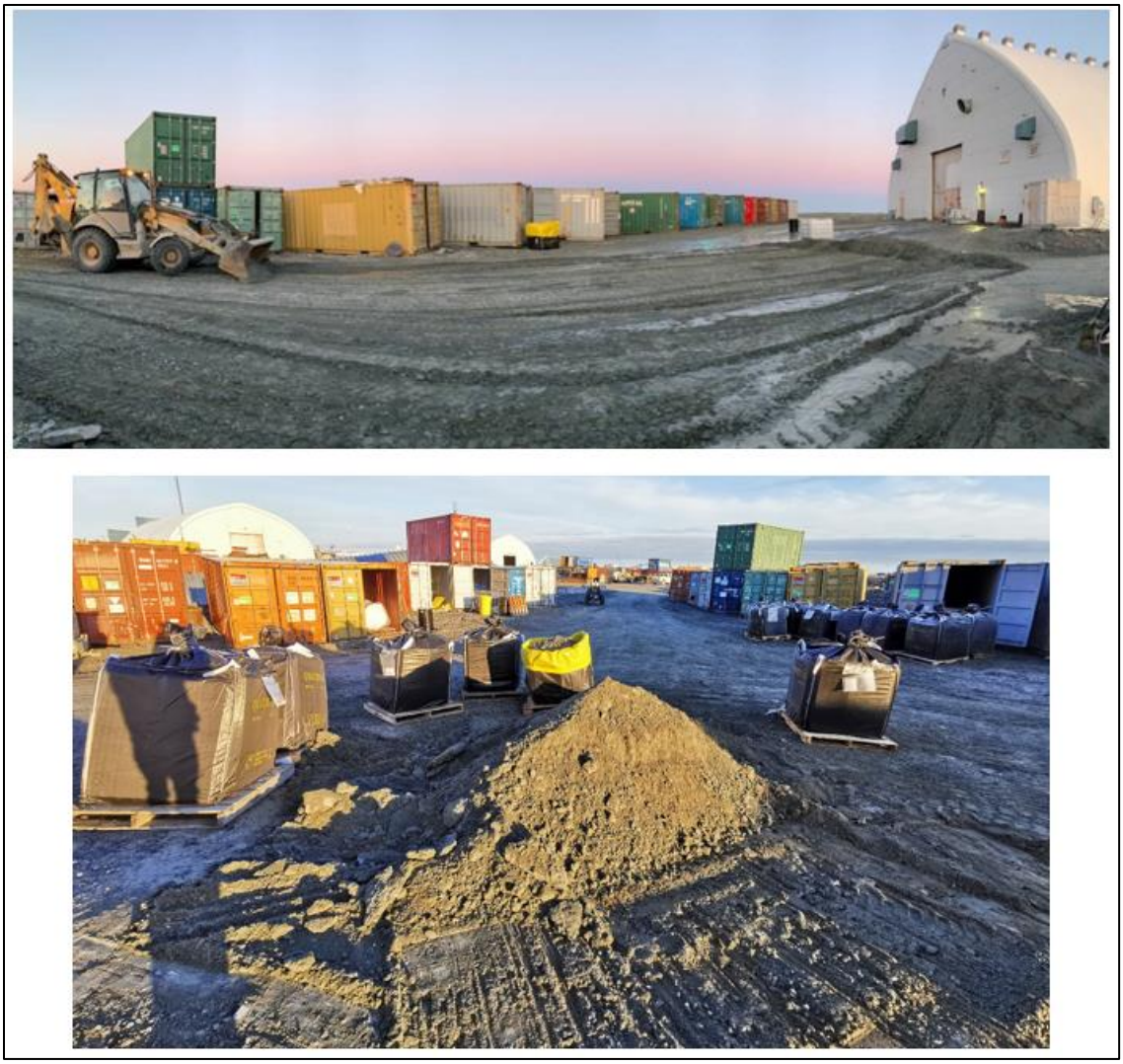

Figure 4: Spilled material and contaminated gravel removed.

Cause of Incident and Corrective Measures

The root cause of the incident was the failure of the operator to follow the procedure of using a spotter to ensure the proper alignment of the forks. In the last year Meliadine has been pushing for the all departments to ensure that a spotter is used whenever forked equipment is required to transport hazardous materials (liquids, powders, etc.). Training material has been created and communicated to workers through toolbox meetings, and a site-wide reminder has been sent out following this most recent incident. Another round of toolbox meetings will be held as an additional reminder of the importance of the use of a spotter.

AGNICO EAGLE

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