

October 30th, 2023

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## Re: Follow-up Report Spill #2023-436 – Release of 10 L of Sewage at the Meliadine Gold Mine

On October 16<sup>th</sup>, 2023, the Nunavut Spill Line was notified by Agnico Eagle personnel via email (spills@gov.nt.ca) of a spill of approximately 10 L of sewage at the Meliadine Gold Mine site (spill location coordinates: 63° 2′ 22′N, 92° 13′ 53″W). This follow-up report provides supplemental information based on the results of the incident assessment and is being provided in accordance with:

Nunavut Water Board License 2AM-MEL1631 Water License, part H, item 8c.

## **Description of Incident**

On October 16<sup>th</sup>, 2023, at approximately 17:00, an estimated 10 L of sewage was spilled onto the industrial pad by wing 14 lift station. A transfer pump failed due to blockage at the intake of the pumps, resulting in the sewage spill. No water bodies were impacted by this spill. The closest water body (Lake G2) is approximately 195 m northwest, as seen in Figure 1.





Figure 1: Location of the sewage spill and proximity to water bodies.

## **Response and Remediation**

During a routine inspection of the site sewage system, an employee form the Energy and Infrastructure (E&I) maintenance department noticed that the high-water level strobe had been activated at wing 14 at 16:50. Upon inspection, the employee observed the presence of sewage effluent outside the lift station enclosure. In response, a vacuum truck was promptly dispatched to pump out the water accumulated in the lift station basin. The ground surface was hand excavated, and the recovered material was brought to Landfarm A as per the Spill Contingency Plan. The employee inspected the transfer pump and discovered a personal hygienic product obstructing the intake and had caused the pump to burn out. The personal hygienic product was then removed from the pump system, the pump was replaced, and the system was back on full functionality the same day.



## **Root Cause and Corrective Measures**

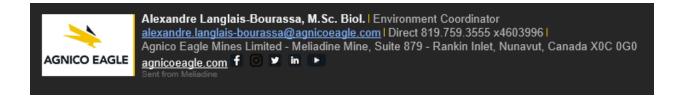
An incident assessment was conducted soon after the incident occurred to determine the root cause and contributing factors. The assessment concluded with the following:

• Investigation determined that personal hygienic products obstructed the intake of the float pump, causing the pump to fail.

The following corrective and preventative actions have been implemented to address the root cause and to reduce the likelihood of reoccurrence:

- All employees in wing 14 were met individually by their supervisor, and they were briefed on the importance of not flushing personal hygienic products in the bathroom.
- Site-wide notification was also sent in the Meliadine minute for supervisors to talk with their team about the importance of putting personal hygienic products in the garbage.

Should you have any questions or require further information, please do not hesitate to contact the undersigned.





Appendix – Photos





**Photos 1**: Sewage spill location.



Photos 2: Spill location post remediation.