

April 9th, 2025

Kyle Amsel
Resource Management Officer
Kivalliq Region, Field Operations Unit
Crown-Indigenous Relations and Northern Affairs Canada
Rankin Inlet, NU
XOC 0G0

Sent via email: kyle.amsel@rcaanc-cirnac.qc.ca

Re: Follow-up Report Spill #2025-143- Release of 50 L of Sewage at the Meliadine Gold Mine

On March 30th, 2025, the Nunavut Spill Line was notified by Agnico Eagle personnel via email (spills@gov.nt.ca) of a spill of approximately 50 L of sewage at the Meliadine Gold Project site (spill location coordinates: 63°2'25.73"N, 92°13'38.34"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 2AM-MEL1631 Water Licence (the Licence), Part H, Item 8c.

Description of Incident

On March 30th, 2025, at approximately 06:30, approximately 50 L of sewage spilled onto the industrial pad outside the Wing 16 lift station. Upon inspection, it was discovered the lift station pump impeller was obstructed by non-compliant material, which led to the pump's failure and the lift station to overflow.

The spill occurred within the site's water management infrastructure, and as such, no waterbodies were impacted. The closest water body (Lake G2) is approximately 260 meters northwest, shown in Figure 1.



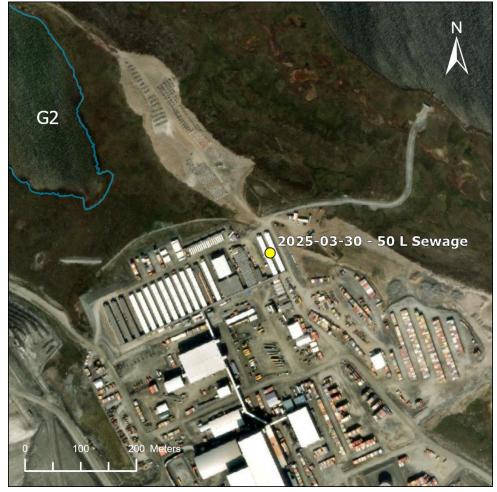


Figure 1: Location of the spill and proximity to waterbodies.

Response and Remediation

Upon discovering the spill, a vacuum truck and a plumber were displaced to respond to the spill. The vacuum truck was utilized to empty the contents within the secondary containment. The contaminated material was excavated and transported to Landfarm A in accordance with the Spill Contingency Plan.

Root Cause and Corrective Measures

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



• Non-compliant material had been flushed in a toilet at Wing 16, resulting in the pump impeller being obstructed, which led to the pump's failure and the lift station overflow.

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

- A site wide communication was distributed to remind staff of permissible and prohibited items that can be flushed. The topic was also included in all departments' safety meetings.
- Instructional signs were printed and posted on every room in the affected wing, informing occupants of permissible and prohibited items that can be flushed.
- Supervisors met with the occupants of Wing 16 to emphasize the importance of properly disposing of items that could affect the lift stations.

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





Appendix A - Photos





Photo 1: Spill location



Photo 2: Spill remediation