



CORONER'S COURT OF BRITISH COLUMBIA

held at Kimberley, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 9 July, 2007 at Kimberley, British Columbia, and continued on the following dates July 10, 11, 12, 13 into the death of Douglas Lloyd Erickson find he came to his death at approximately early pm hours on the 15th day of May AD, 2006 at or near Kimberley, British Columbia

MEDICAL CAUSE OF DEATH

- (1) Immediate Cause of Death: a) Anoxia b) Low atmospheric oxygen c)
Antecedent Cause if any:
Giving rise to the Immediate cause (a) above, stating underlying cause last.
(2) Other Significant Conditions Contributing to Death:

PROPERTY OF SOLICITOR GENERAL OF BRITISH COLUMBIA

In accordance with the Freedom of information and Protection of Privacy Act and to the policies and procedures made pursuant to it, selected personal Identifiers have been blacked out on this document. If you have any questions, contact the office of the Chief Coroner at (604) 660-7745

CLASSIFICATION OF THE EVENT [X] ACCIDENTAL [] HOMICIDE [] NATURAL [] SUICIDE [] UNDETERMINED

The above verdict certified by the Jury on the 13th day of July AD, 2007.

JEFFREY M. DOLAN

Presiding Coroner's Printed Name

[Handwritten Signature]

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age: 48 years Gender: [X] Male [] Female
Date of Birth: [Redacted] Native: [] Yes [X] No
Coroner's Case No.: 2006:422: 0022 Post Mortem: [X] Full [] External [] None
Police File No.: 06-856 Toxicology: [X] Yes [] No
Police Department: Kimberley RCMP Identification Method: [X] Visual [] Other (specify below)
Court Reporter: Verbatim Words West Identified by: friend
Phone: (604) 591-6677 Premise of Injury: Sampling shed at #1 waste dump, Sullivan Mine
Premise of Death: As above





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VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 9 July, 2007 at Kimberley, British Columbia, and continued on the following dates July 10, 11, 12, 13 into the death of Shawn Michael Currier find he came to his death at approximately 1052 hours on the 17th day of May AD, 2006 at or near Cranbrook, British Columbia

MEDICAL CAUSE OF DEATH

(1) Immediate Cause of Death:

a) Anoxia

DUE TO OR AS A CONSEQUENCE OF

Antecedent Cause if any:

b) Low atmospheric oxygen

DUE TO OR AS A CONSEQUENCE OF

Giving rise to the immediate cause (a) above, stating underlying cause last.

c)

(2) Other Significant Conditions Contributing to Death:

PROPERTY OF SOLICITOR GENERAL OF BRITISH COLUMBIA

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CLASSIFICATION OF THE EVENT ACCIDENTAL HOMICIDE NATURAL SUICIDE UNDETERMINED

The above verdict certified by the Jury on the 13th day of July AD, 2007.

JEFFREY M. DOLAN

Presiding Coroner's Printed Name

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Age: 21 years Gender: Male Female
Date of Birth: January 17, 1985 Native: Yes No
Coroner's Case No.: 2006:422: 0023 Post Mortem: Full External None
Police File No.: 06-856 Toxicology: Yes No
Police Department: Kimberley RCMP Identification Method: Visual Other (specify below)
Court Reporter: Verbatim Words West Ltd Identified by: friend
Phone: (604) 591-6677 Premise of Injury: Sampling shed at #1 waste dump, Sullivan Mine
Premise of Death: East Kootenay Regional Hospital, Cranbrook, B.C.





CORONER'S COURT OF BRITISH COLUMBIA

held at Kimberley, British Columbia

VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 9 July, 2007 at Kimberley, British Columbia, and continued on the following dates July 10, 11, 12, 13 into the death of Kim Karlene Weitzel find she came to her death at approximately 1029 hours on the 17th day of May AD, 2006 at or near Cranbrook, British Columbia

MEDICAL CAUSE OF DEATH

- (1) Immediate Cause of Death: a) Anoxia DUE TO OR AS A CONSEQUENCE OF Antecedent Cause If any: b) Low atmospheric oxygen DUE TO OR AS A CONSEQUENCE OF Giving rise to the immediate cause (a) above, stating underlying cause last: c) (2) Other Significant Conditions Contributing to Death:

PROPERTY OF SOLICITOR GENERAL OF BRITISH COLUMBIA

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CLASSIFICATION OF THE EVENT ACCIDENTAL HOMICIDE NATURAL SUICIDE UNDETERMINED

The above verdict certified by the Jury on the 13th day of July AD, 2007

JEFFREY M. DOLAN

Presiding Coroner's Printed Name

Handwritten signature of Jeffrey M. Dolan

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Form with fields for Age (44 years), Date of Birth (November 14, 1961), Gender (Female), Post Mortem (Full), Police File No. (06-856), Police Department (Kimberley RCMP), Court Reporter (Verbatim Words West Ltd.), Phone ((604) 591-6677), Identification Method (Visual), Identified by (friend), Premise of Injury (Sampling shed at #1 waste dump, Sullivan Mine), Premise of Death (East Kootenay Regional Hospital, Cranbrook).





CORONER'S COURT OF BRITISH COLUMBIA

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VERDICT AT CORONER'S INQUEST

We, the Jury, having been duly sworn and serving at the inquest, commencing on 9 July, 2007 at Kimberley, British Columbia, and continued on the following dates July 10, 11, 12, 13 into the death of Charles Robert Murray Newcombe find he came to his death at approximately 1039 hours on the 17th day of May AD, 2006 at or near Cranbrook, British Columbia

MEDICAL CAUSE OF DEATH

- (1) Immediate Cause of Death: a) Anoxia b) Low atmospheric oxygen c)
Antecedent Cause if any:
Giving rise to the immediate cause (a) above, stating underlying cause last.
(2) Other Significant Conditions Contributing to Death:

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CLASSIFICATION OF THE EVENT [X] ACCIDENTAL [] HOMICIDE [] NATURAL [] SUICIDE [] UNDETERMINED

The above verdict certified by the Jury on the 13th day of July AD, 2007.

JEFFREY M. DOLAN

Presiding Coroner's Printed Name

Handwritten signature of Jeffrey M. Dolan

Presiding Coroner's Signature

TO BE COMPLETED BY PRESIDING CORONER

Form with fields for Age (50 years), Gender (Male), Date of Birth, Native (No), Coroner's Case No., Post Mortem (Full), Police File No., Toxicology (Yes), Police Department (Kimberley RCMP), Identification Method (Visual), Court Reporter (Verbatim Words West Ltd.), Identified by (friend), Phone ((604) 591-6677), Premise of Injury (Sampling shed at #1 waste dump, Sullivan Mine), Premise of Death (East Kootenay Regional Hospital, Cranbrook)





VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST INTO THE DEATH OF

File No.: 2006:422:0022
2006:422:0023
2006:422:0024
2006:422:0025

Erickson
Newcombe
Weitzel
Currier

Douglas Lloyd
Charles Robert Murray
Kim Karlene
Shawn Michael

SURNAME

GIVEN NAMES

PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner: Mr. Jeff Dolan

Coroner Counsel: Mr. Rodrick MacKenzie

Court Reporting/Recording Agency: Verbatim Words West

Participants/Counsel:

Mr. Richard Meyer and Ms. Mailyne Ouellette representing Ministry of Energy

Ms. Carmela Allevalo representing the Currier and Weitzel families

Norm Trerise representing Teck Cominco

Mr. Andy King representing United Steelworkers and Newcombe family

Mr. Hugh Gwillim and Ms. Anne Maloney representing the BC Ambulance Service

Mr. Mark Powers representing WorkSafeBC

Donald Howieson representing the City of Kimberley Fire Department

The Sheriff took charge of the jury and recorded 23 exhibits. 23 witnesses were duly sworn in and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. The following summary of the evidence as presented at the inquest is to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.

During the course of the five day inquest, the jury heard from a number of witnesses on the specific features that identify a confined space:

- The space is enclosed or partially enclosed
- The space must be of size and shape to allow a person to bodily enter and perform assigned work
- The space must have restricted openings that make it difficult to enter and leave
- The space must not be designed for continuous human occupancy



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A confined space expert who gave evidence stated that, quite often, the first sign that there is a hazard is the death or critical injury of a worker and those attempting to render assistance. It was evident from witness testimony that not all of the individuals associated to the incident at the Sullivan Mine in Kimberley recognized the sampling shed at the #1 waste site as a confined space. Since the incident all are in agreement that it was in fact a confined space.

The expert witness on geochemical behaviour in the mining industry explained the chemical and geological factors that contributed to the incident that led to the deaths of Mr. Erickson, Mr. Newcombe, Ms. Weitzel and Mr. Currier. It was the evidence of the witness that the air inside the waste rock pile was very near 0% on May 15-17, 2006. Due to the fact the temperature in the rock dump was approximately 10° Celsius and lower than the external air temperature, the air fell off the rock to the bottom of the dump. The dump was capped which prevented the flow of air out of the site, reducing it to diffusive movement. The drainage pipe leading from the toe into the sampling shed allowed for the deoxygenated air to leave the site and enter the shed; thereby creating an atmosphere that would not sustain human life.

Witnesses testified that Pryzm Environmental employee Douglas Lloyd Erickson was under contract with Teck Cominco to perform water quality monitoring at the closed Sullivan Mine in Kimberley, BC. Mr. Erickson would have attended the sampling shed at the #1 waste dump at some point during the early PM hours of May 15, 2006. Mr. Erickson was not seen or heard from again until he was located collapsed and unresponsive in the shallow water of the sump at approximately 0745 hours on May 17, 2006. The jury found that Mr. Erickson died shortly after entering the shed during the early afternoon hours of May 15, 2006.

The Acting Charge Dispatcher at the BC Ambulance Service (BCAS) Kamloops Communication Centre on May 17, 2006 testified that a report of a possible drowning was received at 0745 AM MST. The caller identified himself as Bob Newcombe of Teck Cominco and reported that there was a man down in shallow water at the #1 shaft waste dump at the Sullivan Mine. Evidence given at the inquest revealed that Mr. Newcombe subsequently entered the shed and collapsed.

During his 2.5 minute conversation with Mr. Newcombe, the charge dispatcher made the initial determination that the call was that of a possible drowning and cardiac arrest. Prompted by certain key words, the charge dispatcher referred to the Emergency Medical



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Once the suspicion of H₂S was raised, all attending emergency personnel were instructed to stay out of the shed without proper breathing apparatus and harnesses.

The Kimberley Fire Chief testified that the firefighters were of the initial understanding that they were attending a drowning in a pond. As a result the engine was returned to the fire hall and only the KFD command vehicle attended the scene. Once it was identified that the four individuals were inside what appeared to be a confined space, the engine carrying the breathing apparatus and harnesses was recalled from the Kimberley fire hall.

The on site first aid attendant testified that he had been employed at the Sullivan Mine since its closure. On May 17, 2006 the attendant assisted other emergency personnel at the sampling shed. He did not enter the shed due to the fact that he had neither the equipment nor the training to do so safely.

All four individuals were removed from the sump area of the shed by KFD personnel. Mr. Newcombe, Ms. Weitzel and Mr. Currier were transported to EKRH by ambulance where, despite the aggressive efforts of emergency medical personnel, they were pronounced deceased. Upon extracting Mr. Erickson it was determined that he was deceased. The jury heard from the pathologist who conducted the autopsies that all four died of anoxia due to low atmospheric oxygen.

As of June 10, 2006, procedures were developed to control entry into the incident site. The three levels of entry control consisted of a fenced enclosure with a single key locking gate and a 30' x 30' area surrounding the shed is designated as a hazard area marked by signage and ropes and requiring continuous monitoring of oxygen levels. The third level of entry is the shed itself with a single key lock. Access can only be gained via a confined space entry permit.

As of November 23, 2006 Teck Cominco has a confined space entry procedure in place.

Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:



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in from the region as well as work-related discussions amongst staff. Telephone communication is often further compromised by data bursts, described as simultaneous voice and data and the fact that the caller may be on a mobile phone in a remote area.

4. Enforce that communication centre dispatchers take entitled breaks away from their work stations.

Coroner's comments: The jury heard that staff members at the Kamloops BCAS dispatch centre may work in excess of twelve hours without taking a scheduled break; thereby increasing the potential for fatigue. When breaks are taken, it is common for the employee to remain at their work station.

5. Issue one oxygen sensor per ambulance mandatory to be worn by the senior person at all times while on shift. Appropriate training along with the issue of the sensor be provided.

Coroner's comments: The jury heard that gas sensors are worn by some emergency responders, but not by ambulance attendants in the Kimberley area. This type of sensor would have alerted the attendants of the low oxygen levels in and around the sampling shed at the dump site.

6. Make it mandatory for all BCAS staff to review the BC Worksafe website and take the confined space course annually and have the supervisor record and track their progress.
7. The Kimberley station assign a full time unit chief to ensure training and compliance are maintained to a high standard.
8. BCAS designate a contact for the families of the deceased to provide periodic updates on the progress and state of implementation

Coroner's comments: The jury heard that there were inconsistencies amongst emergency responders and mine employees with respect to knowledge, training and experience in the areas of:

- Confined space training; identification and entry
- Hazard recognition and identification on mine property



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To: Honourable Richard Neufeld
Ministry of Mines, Energy and Petroleum Resources
PO Box 9060 Stn Prov Govt
Victoria, BC V8W 9E2

11. Amend the Mines Act regulations to meet or exceed the WCB standards with regards to confined space provisions in the OH&S regulations.

Coroner's comments: The jury heard that the WCB standards with respect to confined spaces exceeded those in the Ministry's OH&S regulations in May 2006. In B.C. OH&S guidelines at mines fall under the Mines Act and not WorkSafe BC, or the Workers' Compensation Board. Contractors are responsible for adapting the H&S regulations under the Mines Act when working for Teck Comino.

12. Review the effectiveness of Ministry's enforcement strategy to establish a minimum number of site visits per mine per year and increase the penalty provisions with enforcement of the Mines Act to reflect the seriousness of non-compliance.
13. All B.C. mines must identify with signage all of the confined spaces on their respective mine sites within the next six months.

Coroner's comments: The Sullivan Mine Reclamation site, including the monitoring shed, had been the subject of inspections by the Ministry of Mines, Energy and Petroleum Resources on a regular basis. One or two inspections had been conducted between January 1 and May 15, 2006. During the reclamation period there was no indication of atmospheric hazards in or around this shed.

Prior to the 15th of May, 2006, no human hazards associated to the sampling shed had been identified. During previous health and safety tours, the shed had not been identified as a confined space. On May 15 and 17, 2006 the only signage on the sampling shed read "Danger Open Hole Behind Door".

14. Have all decommissioned mines in B.C. contact local fire/rescue and notify of hazards.



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A representative of Teck Cominco Limited testified that the mining company had complied with all of the directives.

JEFFREY M. DOLAN

Presiding Coroner's Printed Name



Presiding Coroner's Signature