SULLIVAN MINE REPORT CONFIRMS UNPRECEDENTED INCIDENT

CRANBROOK – The tragic circumstances that led to four fatalities at a water sampling shed at the decommissioned Sullivan mine on May 15 - 17, 2006 was an unprecedented incident caused by an oxygen-deficient atmosphere, the Province’s chief inspector of mines Fred Hermann has concluded.

“The incident was caused by an oxygen-deficient atmosphere. However, previous to this incident, there was no indication of a problem at the sampling shed or anywhere on the mine site,” said Hermann. “We have clearly established the cause of death of the four victims, but this accident is unprecedented in the history of mining and the process that led to the oxygen-depleted atmosphere has not, to our knowledge, occurred anywhere else in the world.”

The incident claimed the lives of Doug Erickson, a Pryzm Environmental consultant working for Teck Cominco, Bob Newcombe, an employee of Teck Cominco, and BC Ambulance Service Paramedics Kim Weitzel and Shawn Currier.

The chief inspector of mines presented his conclusions as well as recommendations to further ensure the safety of workers and rescue personnel at all mines in British Columbia.

“I accept the chief inspector of mines’ report and its findings and support his recommendations to ensure the safety of workers and first responders at mine sites,” said Minister of State for Mining Bill Bennett, who expressed condolences to the families and friends of the victims. “At this time our thoughts and prayers are with them as well as the residents of the Kimberley and Cranbrook area who have been touched by this loss.”

The chief inspector of mines’ report includes the following conclusions:

- The accident was caused by the accumulation of oxygen-depleted air within the shed. This atmosphere was unexpectedly mobilized from within the dump, entering the shed through the drainage pipe installed to direct water from the collection ditch to a treatment facility.
- The lack of any prior indication of a hazard at this sampling shed contributed to Doug Erickson and Bob Newcombe entering the shed without concern for a potentially hazardous environment.
- Kim Weitzel entered the shed with the understanding that she was responding to a drowning. On her way down the ladder she uttered an exclamation and questioned the presence of gas. By the time she asked that question it was too late for her to extricate herself.
- Lack of basic hazard recognition training and experience contributed to the loss of Shawn Currier. Currier entered the shed to render assistance to his partner immediately after Kim Weitzel was overcome.
“We are doing additional research and tests to determine what caused the oxygen-depleted air to be in the shed,” Hermann said.

The chief inspector of mines has determined that the accident was caused by the accumulation of oxygen-deprived atmosphere in the sampling shed. This air mixture was transported through a drainage pipe feeding into the shed from the covered ditch surrounding the toe of the dump. The ditch was designed to direct water flowing through the dump into a collection system for treatment.

Research and modelling as to why the shed had an oxygen-depleted atmosphere will be conducted, including simulating the conditions (including temperature and atmospheric conditions) present during the incident in the sampling shed in May 2006. Results will be released in fall 2007.

Following the incident, the chief inspector of mines ordered interim measures in May to ensure that a similar event could not happen at any other mine site in the province. Directives issued by the chief inspector of mines following the accident will remain in place, and the chief inspector is recommending additional amendments.

The chief inspector of mines, a statutory officer, carried out this investigation under the authority of the Mines Act and Mines Regulation. Now complete, this report will be provided to the provincial coroner and concludes the investigation into the events of May 15 – 17, 2006 by the Ministry of Energy, Mines and Petroleum Resources.

The chief inspector of mines’ report is available on the Ministry of Energy, Mines and Petroleum Resources website at www.gov.bc.ca/empr.

1 backgrounder(s) attached.

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Included in the chief inspector of mines’ final report into the May 15 - 17, 2006 incident at the decommissioned Sullivan mine are the following recommendations to improve safety for workers and first responders at all mine sites in British Columbia.

**Sullivan Mine Site**

1. Implement the directives issued by the chief inspector of mines on May 25, 2006 related to identification of hazards downstream of dump sites. In addition, ensure that workers entering confined space environments downstream of waste dump sites are qualified in air sampling or accompanied by someone qualified in air sampling and that proper samples are taken and a safe atmosphere determined prior to entering these environments.

2. Sullivan mine operations shall develop and implement a tallying procedure to include all workers on site which will meet the requirements of Section 3.2.2(1) of the Health, Safety, and Reclamation Code (HSRC).

3. Sullivan mine operations shall develop and implement a procedure to ensure that a check is made to ensure the wellbeing of workers who may be working alone and that this check is made in accordance with Section 3.2.3 of the HSRC.

4. Develop and implement a monitoring program to determine the mechanism of mobilization of the atmosphere from within the dump out to the shed.

**Other Mine Sites in B.C.**

1. All mines in B.C. shall implement the directives issued by the chief inspector of mines on May 25, 2006 related to identification of hazards downstream of dump sites.

2. All mine sites in B.C., including non-producing mine sites, shall review the access procedures developed for that site and ensure that a tallying procedure is implemented in accordance with Section 3.2.2(1).

3. Workers on all mine sites shall be subject to a check made in accordance with Section 3.2.3 of the HSRC.

4. Entrances to mine sites in B.C. shall be signed to include contact information to ensure that all persons entering a mine site are under the supervision of a qualified person.

5. When entering into agreements with emergency responders from off the mine site, the manager shall provide information that identifies hazards that may be encountered on the mine site and where the likelihood of encountering these hazards might occur.

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Emergency Responders (non-mine site) i.e. BC Ambulance Service, Fire and Rescue, RCMP, Coroner’s Service

1. All responders to mine sites shall be accompanied by a qualified representative of the mine appointed by the mine manager.

2. Emergency responders who may be called upon to assist in an emergency at a mine site shall be:
   - Familiarized with the hazards that may be encountered on the mine site and where these hazards might be encountered.
   - Trained to recognize and safeguard against the hazards identified above.

Ministry of Energy, Mines, and Petroleum Resources (the Ministry)

1. Incorporate the requirements of the chief inspector’s directive of May 25, 2006 as regulations within the Health, Safety, and Reclamation Code (HSRC).

2. Modify the chief inspector’s directive of May 25, 2006 to include the following:
   - Any opening (culvert or large pipe) with the potential to act as a conduit for transport of a hazardous atmosphere from within a mine waste dump shall be tested to ensure the atmosphere at the mouth of the opening is safe.

3. Modify the requirement of Section 1.3.1 of the HSRC to include site access contact information.

4. Include in the HSRC the requirement to advise emergency responders of the hazards which may be encountered on a mine site and the possible locations of these hazards.

5. Modify the requirement for notification of fatality to the Ministry (Section 1.7.1(1)) to Immediate.

6. Modify Section 37 (3.1(b)) of the Mines Act to increase the time limit for laying an information for an offence from six months to one year after completion of the Chief Inspectors’ report or three years from date of occurrence.

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