

**REPORT
OF
THE MINING HEALTH AND SAFETY PROGRAM
FOR
*2006 and 2007***



MINISTRY OF LABOUR
Operations Division – Provincial Mining Co-ordinator's Office
Occupational Health & Safety Branch
933 Ramsey Lake Road
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This report is prepared for the purpose of publicizing the types of incidents that are occurring within the mining industry and their causes.

It would serve this purpose best if the Report, or appropriate components, were made available to front line supervisors, workers, and health and safety committees.

This Report contains all of the Initial Reports on fatalities since the last report of 2005.

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2006 FATALITY – INITIAL REPORT

Name: Robert E. Nesbitt

Employer: Inco Ltd.

Location: Sudbury, Ontario

Incident: On March 6, 2006, Robert Nesbitt was fatally injured when he became pinned. Vital signs were confirmed absent by Sudbury Regional Police on scene.

Name: Ray Campeau

Employer: Dynatec

Location: Podolsky Mine, Capreol, Ontario

Incident: On May 25, 2006, Ray Campeau, age 47, was injured while removing an electrical winch. He suffered loss of consciousness, significant blood loss and two broken legs. He was taken by air ambulance to St. Joseph's Health Centre in Sudbury where he died of his injuries.

Name: Phil McAuley

Employer: Unimin Canada Ltd.

Location: Nephton Mining Plant, Havelock, Ontario

Incident: On February 27, 2006, Phil McAulay was fatally injured when he was checking the discharge chute of the ore storage bin. The reported cause of death was compression asphyxia.

2007 FATALITY – INITIAL REPORT

Name: Dennis Clouthier

Employer: Hoyle Pond Mine Underground

Location: South Porcupine, Ontario

Incident: On October 12, 2007, a fall of ground occurred in Alimak on 1200 level. Worker had to be extracted. Worker succumbed to his injuries.

Name: Lyle Dufoe

Employer: Falconbridge Kidd Mine Site

Location: Cochrane, Ontario

Incident: On July 23, 2007, it was discovered that a male worker had not come to surface at the end of his shift. A search was made in the area where the worker had been working, operating a scooptram. The scooptram was found to have fallen approximately 150 feet into an open stope. Upon further investigation, the body of the worker was found in the stope.

2007 FATALITY – INITIAL REPORT – cont'd

Name: Willis Howden

Employer: Keystone Granite Management

Location: Minden Hills, Ontario

Incident: On August 16, 2007, worker operating a drill in a quarry near Minden Hills Township was fatally injured when the pins on the boom became loose and fell on the worker.

Name: Calvin Parkinson

Employer: Liberty Mines

Location: Timmins, Ontario

Incident: On November 17, 2007, worker was struck by a six yard scoop and suffered extreme trauma to his mid section. Worker succumbed to his injuries at the scene.

JURY RECOMMENDATIONS FOR 2006

- Jonathan Davis
- Terry Fairservice
- Gord Heffern
- Stephane Joannis
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**SUMMARY OF CIRCUMSTANCES
CONTRIBUTING TO THE DEATH OF**

Jonathan Davis

Deceased: June 15, 2002

**Quantec GeoScience Inc
Date of Inquest: November 3 & 4, 2004**

SUMMARY OF CIRCUMSTANCES – (Quoted from Coroner’s report)

“On the afternoon of June 15 2002, Jonathan Davis, age 28, an employee of Quantec Geoscience Ltd was conducting geophysical work on INCO Ltd. property along Coleman Mine Road, north of Levack Ontario. He was retrieving a LAN cable that went up through a wooded area and uphill over a large rock outcrop.

After the deceased had not been heard from for some time, a search was done and Davis was found, not responsive, not breathing and laying on a rock ledge of a cliff, near an outcrop of trees. It was evident that Mr. Davis had suffered life-ending injury. The Greater Sudbury Police Service was notified, as was the Ministry of Labour”.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Jonathan Davis

Deceased: June 15, 2002

**Quantec GeoScience Inc.
Coleman Mine**

Date of Inquest: November 3 & 4, 2004

There was one recommendation made by the jury, to which the Ministry of Labour (MOL) is responding as follows:

Re: Recommendation No. 1

“Adopt the use of a climbing helmet the same or similar to the one presented which was a Petzl Ecrn Roc A01, when the work environment involves being out in the field and is potentially hazardous to falls.

Rationale:

Climbing helmets are designed with a chin strap that ensures the helmet would remain in proper position, therefore provide better protection”.

The MOL agrees that personal protective equipment, clothing and devices as are necessary to protect the worker from the particular hazard to which the worker may be exposed are important and must be both provided by the employer and worn by the worker. *The Occupational Health and Safety Act (OHSA)* and the *Regulations for Mines and Mining Plants* require this at present.

There are many unique hazards in various workplaces. It is the responsibility of the employer, with the help of the Joint Health and Safety Committees or Health and Safety Representatives, to determine the hazards to which the worker may be exposed and the appropriate type of head protection required for the specific needs of their workers while complying with the general requirements of the *OHSA* and *Regulations*.

Currently, mine workers are required to wear hardhats that are manufactured and tested in conformity with CSA and ANSI standards. In situations where there may be a potential risk of falling, it is recommended that a hardhat with certain types

of chinstraps be worn. A chinstrap attached to the hardhat helps keep the hardhat in place in the event of a fall and may be required as determined by the employer based on the hazards in the workplace.

The climbing helmet mentioned, Petzl Ecrn Roc A01, does not meet current CSA **and or ANSI** standards for head protection and should not be used where CSA/ANSI approved head protection is required

The recommendations of the Jury and this response will be forwarded to the Provincial Coordinators of the Construction Health and Safety Program and the Industrial Health and Safety Program of the Ministry of Labour for their consideration.

SUMMARY OF CIRCUMSTANCES CONTRIBUTING TO THE DEATH OF

Terry Fairservice

**Deceased April 17, 1997
Winston Lake Mine**

Date of Inquest: April 4-6, 2005

Quoted from Coroner's Summary

"Mr. Fairservice and a co-worker were employed by Aurora Quarrying Ltd as subcontractor to Inmet Mining Corp at the Winston Lake Division underground zinc mine in April of 1997. They had been assigned the task of cleaning out an old spill of muck on the 335 (meter) level, which was blocking access to a backfill raise (a vertical waste ore pass from surface to deep in the mine intersection at various levels with horizontal drifts such as the 335 drift here). This backfill raise had become blocked (hung up) since November 1996, and of significance had a history dating back years of intermittent hang ups requiring a variety of remedial measures (principally blasting procedures) to clear. Original development of the raise was in 1984-85. The current job was required by the Mine, as the raise was a necessary conduit for transportation of backfill to lower levels at that phase of the mining plan.

Mr. Fairservice and partner had commenced the 12-8 midnight shift, April 13, 1997. They had learned from the two workers on the previous shift that a (concussion) blast had been set around 220h, as the muck (dry in consistency) that had previously been flowing had stopped. Mr. Fairservice and partner were standing back (from the intersection of the mucked out drift and raise), at the intersection of the center and left drifts, listening for any signs of muck falling down the raise. Suddenly (approximately 0150h) and without warning, there was a trickle of muck flow, then within seconds the hang up had let go from above, the only egress for this material being the horizontal drift the two men were standing in. A massive liquefied run of muck calculated at about 2400 tons swept up the two men carrying them in different directions. Mr. Fairservice's body could not be located by rescue crews till April 17th, he was recovered down the main left drift his partner had been swept in the opposite direction and luckily survived."

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Terry Fairservice

**Deceased April 17, 1997
Winston Lake Mine**

Date of Inquest: April 4-6, 2005

The Ministry of Labour (MOL) has responded to all the recommendations whether or not they were specifically directed at the MOL. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

The following responses are grouped together due to the similarity of the recommendations:

3 and 4
5, 6, and 7

Re: Recommendation No. 1

"All backfill, waste and ore raises must have appropriate protection to control the entry of water, including both ground and surface water. Protective devices that must be considered include, but are not limited to, covers, shelters, grouting, berms, and diversion structures".

Rationale: Water was one of the main contributing factors to this accident. Efforts must be made to ensure water does not enter the raise.

The *Occupational Health and Safety Act* (OHSA) requires an employer to take every precaution reasonable in the circumstances for the protection of a worker. This could include consideration of protective devices at the raise design stage. In addition the Regulation for Mines and Mining Plants (the Regulations) requires precautions be taken to guard against an accumulation of water in a chute or raise where the material in it may block drainage.

Re: Recommendation No. 2

“A “grizzly” must be placed over all raises used for the transport of muck/material, with the exception of maintenance and service of the grizzly.

Rationale: A second major contributing factor was the various sizes of material send down the raise. A grizzly ensures foreign material is kept to a minimum and proper sizes are maintained.”

While water impoundment certainly constitutes a safety hazard in a raise, there are many times when dry material of different sizes can be safely sent down the raise. However, the addition of scrap timber, pipe and steel may contribute to blockages of muck in the system, which in turn may cause hang-up removal hazards and the potential for water build-up. Although the use of a grizzly is not a requirement under the Mining Regulations, there are circumstances, such as to prevent the dumping of oversized material, where using a grizzly would be considered a reasonable precaution.

Re: Recommendation No. 3

“Mines must develop a written procedure to identify hang-ups and immediately stop the addition of muck/material in the event a hangup is suspected. A system of communication to all appropriate workplace parties must be a part of this written procedure.

Rationale: A lack of communication was a third contributing factor. Written and communicated procedures ensures all involved are aware.”

Re: Recommendation No. 4

“A written procedure must be developed requiring the tracking of loads added to any backfill raise and loads removed, together with a balance of material calculation to determine the amount of material present in the raise. These records must be available for personnel employed to remove a hangup in the raise.

Rationale: Communication”

Hangups are not uncommon phenomena in underground mining, most of which are dealt with safely by various devices and techniques. Mine procedures include routine monitoring to detect these promptly. In addition it is normal mine practice to monitor material going into a raise and material removed from a raise. Not only is this critical to production scheduling but it is also the basis for paying piece-work bonus to the workers doing this work. The comparison of material put into the raise with material removed is normal practice for scheduling production from various areas of the mine. A problem will be highlighted if the comparison indicates an imbalance of material in the raise. The MOL supports these recommendations and considers them an essential part of industry practice.

Re: Recommendation No. 5

“In the event of a hangup in any such raise, immediate, defined and documented steps must be taken to determine the amount of material likely present in the raise, and to detect any accumulation of water, before any operations to bring down the hangup are implemented.

Rationale: Accountability”

Re: Recommendation No. 6

“In the event of a hang-up in any raise, an evaluation of the current status of the raise, including the presence of material and water, and the procedures to safely bring the hang-up down should be planned, recorded, communicated and followed.

Rationale: Communication”

Re: Recommendation No. 7

“All mines must ensure that no attempt to blast, drill, or otherwise clear a hangup unless the raise below the hangup is clear, so that there is no danger of muck rushing into areas occupied by workers.

Rationale: Safety”

The Mining Regulations were amended (in 2002) to include dealing with non-routine hazardous tasks. The procedures on how to deal with non-routine hazardous tasks include:

- written procedures,
- communication to workers,
- identification of unsafe areas,
- preventing workers from accessing these unsafe areas, and
- providing safe exits.

Re: Recommendation No. 8

“All mines adding waste to a backfill raise must develop a written procedure that ensures foreign material is prevented from entering the raise.

Rationale: Safety”

The Mining Regulations were amended in 2002 to require that: Precautions be taken to guard against an accumulation of water in a chute or raise where the material in a chute or raise may block drainage. The addition of backfill to the raise could lead to the development of hang-ups and as such this practice should be avoided. A written procedure communicated to workers and supervisors at the mine is desirable.

Re: Recommendation No. 9

“All mines must develop written procedures for communication of information regarding hazards such as raise hang-ups to contractor personnel working on site. Such communication must include all documentation on the history of hazards, and internal procedures regarding the scope of work.

Rationale: Communication”

Communication of hazard information specific to a site needs to be shared and given to all workers that may be affected by the hazard in that site, regardless of the identity of the employer. The OHSa already requires that the employer give the worker information, instruction and supervision necessary to protect him/her. The supervisor is also required to advise the worker of potential or actual dangers, provide written instructions, and take every precaution reasonable to protect the worker. This would also include an inspection of the workplace to determine if any unusual conditions exist.

The mine owner is responsible under OHSA to ensure the workplace complies with the regulations and this would include the communication of hazards as prescribed in the regulations.

Re: Recommendation No. 10

“Mining regulations pertaining to mine design need to be amended to include records of unique and significant site hazards other than ground instability, such as raise hang-ups locations and wet raises.

Rationale: Compliance through legislation”

The mine design and working drawings should include information on hazards unique to the site. This recommendation to develop a regulatory amendment is presently under review by the MOL.

Re: Recommendation No. 11

“Common Core Training in modules for mucking and chute pulling must incorporate details on wet muck and hangup blasting hazards. Completion of specialty modules relevant to worker activities need to be done in a defined time frame.

Rationale: Safety and Training”

Existing common core modules contain requirements for inspection to identify and correct unsafe conditions. Wet muck and impounded water would be considered indicators of a potential unsafe condition.

The Mining Tripartite Committee (MTC) has been approached with this recommendation. The MTC is a tripartite committee, which develops and recommends training programs for the mining industry. The MOL and the Ministry of Training Colleges and Universities are members of this committee.

The MTC has decided not to develop such a module because such occurrences are site specific to each raise and as such are better addressed as non-routine hazardous tasks. The regulation presently addresses non-routine hazardous tasks. The MTC is currently discussing how to implement a defined time-frame for specialty modules.

Re: Recommendation No. 12

“Supervisors, miners, and mining contractors in all mines must receive training in a communication plan of any and all potential hazards. A regular review process of this topic must be incorporated into the plan”.

Rationale: Safety and Training

Communication of hazard information specific to a site needs to be shared and given to all workers who may be affected by the hazard in that site, regardless of the identity of the employer. This is included in the general duty clause of the OHSA. Inclusion in the site orientation requirements of the Mining Regulations is presently under review by the MOL.

**SYNOPSIS OF SIGNIFICANT FACTORS
CONTRIBUTING TO THE DEATH OF**

Gordon Heffern

Deceased July 29, 2001

**Copper Cliff, Nickel Refinery - INCO
Sudbury**

Date of Inquest: November 15-19, 2004

**Summary of the circumstances of the death (quoted from
coroner's report)**

"On July 27, 2001 Mr. Gordon Heffern was injured in an accident at the INCO nickel refinery complex in the City of Greater Sudbury. He had over 27 years' seniority with the company and was regarded by his co-workers as one of the most knowledgeable people at work in dealing with the high pressure oxygen lines at the worksite.

The injury occurred while he was operating a 6-inch manual valve on a 600 psi oxygen line located some 20 feet above the ground. The valve was being tested to see if it would successfully isolate a section for the line so that it could be depressurized to permit the removal of some heavy equipment located above the oxygen line. Mr. Heffern closed the valve, climbed down the ladder that he used to reach it and then viewed the line pressure at a set of gauges located about 80 feet away from the valve. Once a differential was observed across the valve he went back up the ladder. As he opened the valve an explosion occurred resulting in him receiving burns to about 80% of his body. He was assessed and treated at the Sudbury hospital and then transferred to a burn unit in Buffalo, New York. He underwent surgery there and died late on the evening of July 28.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Gordon Heffern

**Deceased July 29, 2001
Copper Cliff, Nickel Refinery – INCO
Sudbury
Date of Inquest: November 15-19, 2004**

MOL supports the recommendations of the coroner's jury, but notes that none of them is directed at the Ministry. In order to provide additional information, MOL's comments are confined to Recommendation #3.

Recommendation No. 3:

"INCO shall ensure that through its training program, employees are instructed on established procedures related to all non-routine hazardous tasks associated with the oxygen system."

In subsection 62.1(2) of the Regulation for Mines and Mining Plants under the Occupational Health and Safety Act, the employer and the joint health and safety committee or the health and safety representative are required to jointly establish safe procedures for performing non-routine hazardous tasks. Subsection 62.1(4) requires the employer to ensure that workers are informed before work begins that a task is of a non-routine, hazardous nature and how to perform it. {NOTE from LSB: sections of regulation should be cited}

Currently, MOL is developing a guideline on non-routine hazardous tasks. This guideline, which will be distributed to the mining industry, is intended to help clarify and make more consistent the mining industry practices and help ensure safety in these situations.

SUMMARY OF CIRCUMSTANCES CONTRIBUTING TO THE DEATH OF

**Stephane Joanisse
Deceased: October 15, 2003**

Cementation Skanska Canada Inc.
Falconbridge Kidd Creek Mine

Date of Inquest: October 26 and 27, 2005

On October 15, 2003, at approximately 16:35 hours, Stephane Joanisse, a Cementation Skanska Canada Inc. employee, was fatally injured while traveling in a shaft-sinking bucket. This fatal injury occurred in the #4 shaft, at the 6800 level shaft station of the "Deep Mine Project" operated by Falconbridge Ltd. The shaft-sinking bucket is a conveyance approximately 6.5 feet in diameter by 11 feet high used to hoist men, materials and broken rock from a mine shaft as it is being deepened. The shaft at the Deep Mine Project was being deepened to mine ore at lower levels of the mine. The deceased was in the shaft-sinking bucket leaving a work platform near the bottom of the shaft going upwards to another level in the mine. It is believed that Mr. Joanisse had his head over top of and outside the rim of the bucket as it was coming up under the crosshead which guides the bucket as it is hoisted to surface. The crosshead is suspended some distance above the shaft bottom so as to not interfere with activity at the shaft bottom. His head was squeezed between the rim of the bucket and the bottom of the crosshead and his hardhat fell to the work platform alerting the workers below. The crew on the platform noticed a miners cap lamp hanging over the edge of the bucket. The bucket was then lowered down to the platform and Mr. Joanisse was found lying unconscious in the bucket with a very serious head injury. He was taken to surface and pronounced dead at the Timmins District Hospital.

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

**Stephane Joannis
Deceased: October 15, 2003**

**Cementation Skanska Canada Inc.
Falconbridge Kidd Creek Mine**

Date of Inquest: October 26 and 27, 2005

As requested, the following is the Ministry of Labour's (MOL's) response to recommendations number 1-7:

Re: Recommendation No. 1

"We the jury recommend that all recommendations from the joint investigation Committee of Cementation and Falconbridge be reviewed by the Ministry of Labour, the M.L.R.C. committee, with the results being implemented in similar workplaces throughout the province."

Note: *The attached acrobat document contains recommendations from the joint Cementation Skanska Canada Inc. and Falconbridge Ltd investigation committee:*



The MOL has reviewed all recommendations from the joint investigation committee. The Mining Legislative Review Committee (MLRC) will **also** review all recommendations. The MLRC is a section 21 committee established by the MOL to advise the Minister on matters of health and safety and among other things reviews all mining fatalities and subsequent Coroner's Inquest Jury recommendations. Some of the regulations pertaining to mines are a direct result of such recommendations.

Code 2

Re: Recommendation No. 2

“The bucket be equipped with a remote wireless communication device to be operated by occupant as an additional safety signal. Recommendation to Cementation and the M.L.R.C. Committee.”

Re: Recommendation No. 3

“a camera to give the hoist man a visual of the interior of the bucket. this enables the hoist man to verify the safety of the occupant through a monitor in the hoist room. Recommendation for Cementation and M.L.R.C. Committee.”

Re: Recommendation No. 4

“The main (man) platform could be lowered a few inches more for optimal safety. Recommendation for Cementation and M..R.C. Committee.”

Re: Recommendation No. 5

“When the man platform is being utilized include a safety screen or guard at the lip of the bucket to prevent a worker from leaning over while still allowing clear access to the bell cord. Recommendation to Cementation and M.L.R.C. Committee.”

Re: Recommendation No. 6

“The use of streamers as a tactile safety feature is important as it warns the worker of impending dangers.”

Re: Recommendation No. 7

“The jury recommends all of the above to be reviewed by the M.L.R.C. Committee and possible implemented province wide.”

MOL and MLRC will also consider these recommendations.

MOL has also sent these recommendations to the Ontario Mine Contractors Safety Association (OMCSA) for their member's feedback. OMSCA members normally perform all shaft-sinking projects and are therefore very interested in the possible implementation of these recommendations.

1.0 CONCLUSIONS AND RECOMMENDATIONS

The Investigation Team provides the following four conclusions and associated recommendations:

Conclusion # 1:

The immediate cause of the fatal accident to Stephane Joannis was the fact that Stephane Joannis, while riding up in the bucket, had placed his head beyond the rim of the bucket prior to the bucket lip entering the crosshead fairlead. The information from the data and the interviews was not sufficient to enable the Investigation Team to determine why Stephane Joannis had done this. The Investigation Team believes that either Stephane Joannis did not know how close the bucket lip was to the crosshead fairlead, and/or he did not realize that the bucket was moving or about to move up.

No Recommendation:

The Investigation Team believes that Stephane was well aware of the hazards associated with riding in a bucket in the shaft. Recommendations have been provided to address system and process factors. The Investigation Team did not believe it possible to provide an effective recommendation that would deal with the human factors resulting in this accident.

Conclusion # 2:

There is a warning system in place that activates buzzers and flashing lights whenever the bucket is in motion below the crosshead. This system was in operation at the time of the accident. The Investigation Team believes that the audible signal was loud enough to be heard at the time of the accident, however, this warning system does not differentiate between upward or downward motion. It does not specifically identify the proximity of the bucket to the crosshead fairlead.

Recommendation:

That Cementation Skanska Canada Inc. investigates with other stakeholders, the possibility of installing an additional warning, which specifically indicates the proximity of the bucket to the crosshead fairlead on the upward motion of the bucket.

Conclusion # 3:

The design of the crosshead fairlead is such that it creates a pinch point as the bucket lip enters the fairlead to engage the crosshead.

Recommendation:

That Cementation Skanska Canada Inc. reviews the design of the crosshead fairlead to determine the possibility of its removal, redesign or relocation in an attempt to eliminate the pinch point.

Conclusion # 4:

The man-riding basket was in place at the time of the accident and was installed as per the site standard. There are varying opinions in the industry regarding the safest elevation of the man-riding basket. The Investigation Team believes that the elevation of the “man riding basket” in the bucket may have affected Stephane’s Joannis’s exposure and/or reaction time to the pinch point.

Recommendation:

That Cementation Skanska Canada Inc. review the design and placement of the man riding basket, and also consult with other industry stakeholders to determine the safest elevation and design.

1.1 OBSERVATIONS AND RECOMMENDATIONS

During the course of the investigation several issues were identified that should be addressed. There was not sufficient evidence to conclude that these issues had a direct contribution to the accident. They are as follows:

Observation # 1:

The Investigation Team believes that the task procedures for the work being done were in place and were understood by the workers. Because there was no history of accidents involving the pinch point between the bucket lip and the crosshead fairlead, this had not been identified specifically in the "Process Hazard Analysis for Full Face Sinking". There are references in the PHA to other similar pinch points within the Galloway and the equipping deck.

Recommendation:

That Cementation Skanska Canada Inc. add this hazard to the # 4 Shaft PHA and to all existing and future Cementation Skanska Canada Inc. shaft sinking PHAs. This hazard should be reviewed throughout the industry.

Observation # 2:

The Investigation Team believes that standards for the work being done were in place and were understood by the workers. Information gathered from interviews indicates that there may be some confusion or inconsistency with the use of shaft sinking signals.

Recommendation:

That Cementation Skanska Canada Inc. and the their JHSC review the current use and effectiveness of the shaft sinking signals in the # 4 shaft, to ensure consistency, understanding, and compliance.

Observation # 3:

The installation and steadying of slings to the bucket requires the control of the bucket to be with a man on the deck. There was a man instructed to ride in the south bucket to go to 6400 to run the tugger. The length of the slings was of a standard length and commonly used to sling gear. In this case, however, the final stop to stabilize the slings, as they cleared the equipping deck, left the bucket in close proximity to the crosshead fairlead (0.4 m below). A 5-bell release signal was given to the hoistman to allow the hoistman to sling pipe in the north compartment while Stephane Joanisse was in the south bucket.

Recommendation:

That Cementation Skanska Canada Inc. reviews the practice of a worker outside of the bucket giving signals to the hoistman when another worker in the bucket may be unaware of the resulting bucket movement.

Recommendation:

That Cementation Skanska Canada Inc. reviews the practice of releasing the bucket to the hoistman to perform other tasks while a worker is in that bucket.

1.2 SUMMARY OF RECOMMENDATIONS

1. That Cementation Skanska Canada Inc. investigates with other stakeholders, the possibility of installing an additional warning, which specifically indicates the proximity of the bucket to the crosshead fairlead on the upward motion of the bucket.
2. That Cementation Skanska Canada Inc. reviews the design of the crosshead fairlead to determine the possibility of its removal, redesign or relocation in an attempt to eliminate the pinch point.
3. That Cementation Skanska Canada Inc. review the design and placement of the man riding basket, and also consult with other industry stakeholders to determine the safest elevation and design.

During the course of the investigation several issues were identified that should be addressed. There was not sufficient evidence to conclude that these issues had a direct contribution to the accident. They are as follows:

4. That Cementation Skanska Cementation Inc. add this hazard to the # 4 Shaft PHA and to all existing and future Cementation Skanska Canada Inc. shaft sinking PHAs. This hazard should be reviewed throughout the industry.
5. That Cementation Skanska Canada Inc. and the their JHSC review the current use and effectiveness of the shaft sinking signals in the # 4 shaft, to ensure consistency, understanding, and compliance.
6. That Cementation Skanska Canada Inc. reviews the practice of a worker outside of the bucket giving signals to the hoistman when another worker in the bucket may be unaware of the resulting bucket movement.
7. That Cementation Skanska Canada Inc. reviews the practice of releasing the bucket to the hoistman to perform other tasks while a worker is in that bucket.

BRIEF SUMMARY OF THE CIRCUMSTANCES OF THE DEATHS AND INQUEST

Scott Mason and Christopher Priestman

**Deceased August 8, 2001
J.G. Stewart Construction Ltd.
and St. Mary's Cement Inc. (Canada)**

Date of Inquest: June 7-11, 2004

Quoted from Coroner's Report

"J.G. Stewart Construction Ltd. was subcontracted by St. Mary's Cement Inc. to complete production of aggregate products for concrete and other construction from sand and gravel deposit known as the David Pit, located at 2209 Cedar Creek Road, North Dumfries Township in the Regional Municipality of Waterloo. Mr. Scott Mason had been the foreman at the David Pit since April 2000.

Mr. Chris Priestman had worked as a quality control technician for St. Mary's Cement Inc. since April 2001. One of his responsibilities was obtaining, evaluating and undertaking laboratory tests on materials produced at the David Pit.

On August 8, 2001, the St. Mary's Cement plant manager attended the David Pit after receiving a customer report about oversized material in a shipment of concrete sand. He initially met with Mr. Priestman at the concrete sand stockpile observing oversized material. Mr. Mason subsequently attended with Mr. Priestman and the plant manager at the shipping face of the concrete sand stockpile where sampling of the material was undertaken. Sampling was completed by industry-accepted procedure which involved removal of 3-4 buckets of material with a front-end loader from the stockpile with movement to a sampling pile located a safe distance from the stockpile. Oversized material was confirmed to be present. At the time of the plant manager's departure, plan was made for Mr. Mason and Priestman to determine the extent of the contamination in the stockpile, which may require re-processing.

A loader driver who typically worked removing raw material from the mining face, was removing material from the concrete sand stockpile with his loader as instructed by Mr. Mason. He had removed between 25-35 loader buckets of material when he was instructed to stop. He described the area that he had been removing material as indented into the stockpile with a horseshoe shape extending about 15-20 feet in from the toe of the pile with face height of about 24 feet. He turned back toward the location of material removal and observed that Mr. Mason and Priestman walked up to the face and scratched at the surface. Shortly after, as they had turned and began to walk from the sampling

location material slid from above partially burying Mr. Mason and completely burying Mr. Priestman. The loader driver ran to the area and uncovered Mr. Priestman although sand was sliding around him. He was instructed by Mr. Mason to attempt to remove sand with his loader but did not as he was not able to see the men. He called for assistance on his two-way radio. The loader driver dug with his hands uncovering Mr. Priestman who was having difficulty breathing.

After the location was discovered a number of men attended the collapse location with attempts made to free Mr. Mason and Priestman by digging in the sand. Others tried to locate shovels to assist with sand removal. During their attempts further collapse of a large amount of sand occurred completely burying the men. Those attempting to rescue the men managed to escape contact with the sliding material. Volunteer firefighters from North Dumfries Township attended and took over rescue attempts. Sand continued to slide downwards into the area of attempted rescue despite firefighters holding spinal boards up in attempt to block further sliding. About 30-45 minutes after the two men were completely buried they were found by the firefighters and determined to be deceased by the paramedics.”

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATHS OF**

Scott Mason and Christopher Priestman

**Deceased August 8, 2001
J.G. Stewart Construction Ltd.
and St. Mary's Cement Inc. (Canada)**

Date of Inquest: June 7-11, 2004

The Ministry of Labour (MOL) has responded to all the recommendations whether or not they were specifically directed at the MOL. The MOL response is meant to guide the chief coroner and provide context for the recommendations.

Due to their similarities, some of the recommendations and responses are grouped together as follows:

Recs 1-4

Recs 5, 15 and 16

Recs 8-11 and 17, 20 and 21

Recs 18 and 19

Re: Recommendation No. 1

"All employers in the mining industry have written procedures for working safely around and taking samples from stockpiles. Each employee must have their own copy of the document.

Rationale: There needs to be clear documented information from which employees can understand the hazards and learn safe procedures around working with stockpiles."

Re: Recommendation No. 2

"All workers employed at mines and mining plants are trained on safe work procedures for working around and taking samples from stockpiles.

Rationale: Employees need to clearly understand the proper procedures and hazards of taking samples from stockpiles. Apparent from the evidence, individuals have varying levels of knowledge in the proper safe methods of taking samples. ”

Re: Recommendation No. 3

“Training on safe work procedures for working around and taking samples from stockpiles be provided by a qualified and competent person and be carried out as part of a mine safety orientation program prior to a worker being assigned work. Refresher training and testing should be provided on an annual basis.

Rationale: The evidence suggested that the reliance of on the job training and the value of experience are not sufficient given that these can vary from individual to individual and given the overall risks which can be encountered when working around stockpiles. ”

Re: Recommendation No. 4

“All workers who have received training on safe work procedures for working around and taking samples from stockpiles be required to sign an acknowledgement of this training and provide this acknowledgement to the employer.

Rationale: This provides confirmation for both the employee and employer that the employee has received the training. ”

The *Occupational Health and Safety Act* (OHSA) requires an employer to protect the health and safety of workers by providing:

- information and instruction to them, including the development of procedures to perform the work; in this case, working around and taking samples from stockpiles;
- information concerning any hazard in the workplace to which they may be exposed; and
- adequate supervision.

The MOL agrees that after initial training, follow-up by refresher training at regular intervals and review of safe job performance is essential to any effective training program. Section 11. 2 (1) of the Regulations requires an employer to establish and maintain Program # 770210, Modular training standards – Surface Miner. This training does address safety issues for front-end loader operators associated with stockpiles. The Mining Tripartite Committee is in the process of developing more detailed training with respect to stockpile safety issues.

Although specific mention of “retraining” is not in the Regulation, there is an ongoing requirement for employers to ensure that workers and persons with authority over them, are aware of hazards in the work, and as a reasonable precaution, to ensure that procedures and programs are in place to protect the health and safety of workers.

Currently the training required by the Mining Regulations is tracked by the MCTU in conjunction with the employer. Where accreditation is required or desired the worker and trainer must be registered with the MCTU. A qualification record book is issued to the candidate and records are kept which indicate when the candidate has achieved the required standard of performance.

The MOL agrees that it is critical for all workplace parties to be knowledgeable about policies and procedures pertaining to the workplace. The recommendation for an acknowledgement system that workers have received and reviewed all policies and procedures would help ensure that at a minimum, workers and supervisors are reminded of current practices.

Re: Recommendation No. 5

“The requirement under section 17(6) of O. Reg. 854 be extended to apply to employers.”

Re: Recommendation No. 15

“Determine the appropriate means by which funding can be obtained to establish, equip, operate and maintain a surface mine rescue program.

Rationale: The evidence has shown that funding is not available to surface mines and the aggregate industry as it is for the underground mining industry even though significant hazards exist. ”

Re: Recommendation No. 16

“Mine rescue training be extended to surface mines. That surface mine rescue team members receive proper and adequate training from a qualified and competent person on rescue procedures applicable to operations being carried out at surface mines and that these procedures are reviewed periodically.

Rationale: From the evidence, it was clear that rescue techniques were not well defined. ”

The regulation currently requires that mine rescue training and facilities be provided to workers at the expense of the owner. This section is presently being reviewed by the Ministry.

The MOL understands that the provision of mine rescue to surface mines is presently under consideration by the Mines and Aggregates Safety and Health Association (MASHA). The Mine Rescue Program for underground mines in Ontario is recognized around the world as being outstanding in quality and consistency of training. The funding of mine rescue at surface mines is an issue that MASHA will address when responding to these recommendations.

Re: Recommendation No. 6

“The plans, specifications and drawings referred to in section 5 of O. Reg. 854 be extended to apply to employers. These plans should be reviewed on a periodic basis to ensure that any changes are in compliance with O. Reg. 854.

Rationale: For both points 5 and 6 the owner of the mine may not necessarily be the operator of the mine. ”

Before building a mine or mining plant, or making major alterations, among other things, section 5 requires the owner to have drawings, specifications and plans either provided or checked by a professional engineer to ensure compliance with OHSA and the regulations. The MOL believes that it is appropriate that the owner be responsible for ensuring that the mine and plant are in accordance with good engineering practice and in compliance with OHSA and the regulations. The employer has the responsibility under OHSA to ensure there are procedures and instructions for the work to be done, as well as training and supervision for the workers.

Small employers such as contractors may not be involved in the design of the mine or mining plant and it would not be reasonable to expect them to provide a professional engineer to review the drawing and specifications for the owner's mine or mining plant. It is the owner's responsibility to ensure that the design and construction of the mine or mining plant is in compliance with the legislation.

Re: Recommendation No. 7

“The Ministry of Labour in consultation with the Mines and Aggregates Safety and Health Association (MASHA) and the Aggregate Producers Association of Ontario (APAO) consider reducing the vertical height of a working face referred to in section 88 (2)(b) of O. Reg. 854 from 3 meters and that this section be clarified to specify if this section applies to stockpiles.

Rationale: Evidence has indicated that the height of 3 meters is too high for unprotected workers. ”

The MOL will review this recommendation in consultation with the Mining Legislative Review Committee (MLRC) to determine if the Regulation should be changed.

Re: Recommendation No. 8

“O. Reg. 854 be amended to add a requirement that all mines and mining plants have an Emergency Preparedness Plan, which includes training with respect to the location and other information to be provided to the local emergency dispatcher. This plan will also include information on the roles and responsibilities of each employee in an emergency.”

Re: Recommendation No. 9

“Mines and mining plant operators be required to submit a copy of their emergency preparedness plans to the local fire department.

Rationale: For points 8 and 9, given that mines tend to be in rural versus urban areas and that emergency response times can be lengthy by definition, the more self sufficient the on-site employees can be, including their ability to direct further rescue workers to the site, the greater the chance of saving lives. ”

Re: Recommendation No. 10

“Employers at mines and mining plants invite their local emergency service providers (i.e.: police, fire and EMS) to observe their emergency preparedness training.

Rationale: That the local emergency response service providers can anticipate and be better prepared for the types of emergencies that might arise from a location. ”

Re: Recommendation No. 11

“A collection of properly maintained rescue equipment that is appropriate to the activities carried out at a mine or mining plant be stored in a well-marked, protected from the elements and designated location known to all workers. This rescue equipment should also remain portable and immediately accessible. A qualified and competent person shall properly train all workers on the use of such rescue equipment.

Rationale: Given that in a rescue situation time is of the essence, and the fact that most locations will be of some distance from local emergency response providers, safety equipment to be used by the on-site emergency response team must be readily available. ”

Re: Recommendation No. 17

“All telephone locations at a mine be equipped with a comprehensive emergency poster or sticker setting out, at a minimum:

- i. The municipal address or the emergency location number of the mine**
- ii. Directions on how to reach the mine**
- iii. The names and numbers of all services and agencies that may need to be contacted in the event of any type of emergency.**

Rationale: From the evidence, it was clear that there was some confusion in the communication of the location of the mine. ”

Re: Recommendation No. 20

Operating and effective communication devices should be immediately accessible to all workers at all mines and mining plants. ”

Re: Recommendation No. 21

“The industry should investigate other technologies to assist in determining the location of individuals within a site quickly.

Rationale: For points 20 and 21, the key to responding to an emergency situation is the ability to have the means to communicate and coordinate the efforts of the emergency response team along with identifying and locating the individuals within the site. ”

OHSA requires the employer to take every precaution reasonable in the circumstances. The MOL takes the view that an Emergency Preparedness Plan would be a reasonable precaution for all workplaces.

The plan should include the roles and responsibilities of the employees, ensure that training is appropriate and accessible, and that portable rescue equipment is maintained and periodically tested. Equipment such as infra red cameras that can locate workers is available and would be a valuable part of the rescue equipment. The MOL agrees the industry should investigate other devices for locating and rescuing workers. The plan must include a reliable communication system that workers can use to summon assistance. Employees must be trained in the communication system but it is a good idea to post in various locations the communication procedure along with the numbers to call.

Where an outside resource is included in the plan, familiarizing the local fire department or other rescue services with workplaces would be very good practice and fully supported by the MOL. Not all workplaces are close enough to include a rescue group such as a fire department in the plan, but those that do should involve their service in the plan's preparation and its periodic review.

MASHA operates the mine rescue training service for underground mines and is now committed to providing a surface response guideline and a self-audit tool. This is intended to allow firms to assess their capability in comparison to generally accepted emergency response standards. MASHA is also considering instituting an emergency response training service for surface mines.

Re: Recommendation No. 12

“The recommendations made for the mining industry with respect to stockpile safety should be examined for relevance for all industries where workers may be near or work with stockpiles.

Rationale: The circumstances of this incident could easily occur again in another industry and situation not covered by regulations concerning surface or underground mines. ”

The Provincial Coordinator Mining (A) will forward a copy of these recommendations on to the Provincial Coordinators for the Construction and Industrial Programs for their review and dissemination to appropriate parties.

Re: Recommendation No. 13

“At the working face of a mine or stockpile, the qualified and competent loader operator has ultimate authority on directing the movement of unprotected workers within their work area.

Rationale: Given the evidence, a single individual in a protected environment is in the best position to assess the situation. ”

This recommendation appears to have merit however the employer is responsible for delegation of authority and responsibility in the workplace and the direction of workers is normally the responsibility of the supervisor. The Internal Responsibility System requires all workers to do their part to improve safety in the workplace but the employer could delegate the loader operator to be responsible for the equipment in his area of work at the stockpile.

Re: Recommendation No. 14

“Amend the Modular Training Standards of the Surface Miner Common Core Program to include training regarding stockpiles in the Common Core Module as well as a Specialty Module devoted specifically to stockpile training.

Rationale: Individuals training to be surface miners must be given ample opportunity to learn the procedures and hazards of working with stockpiles. ”

This recommendation will be reviewed by MOL in consultation with the Mining Tripartite Committee (MTC). The MTC is responsible for the development of training programs for the mining industry and developed the Surface Miner

Common Core (SMCC) program. The committee is made up of management and labour representatives from the mining industry including surface and underground mines, the MOL and MTCU.

The Regulations for Mining and Mining Plants require the employer who operates a surface mine to establish and maintain training programs for workers at a surface mine.

Re: Recommendation No. 18

“Develop specific guidelines detailing when professional engineering reports or guidance are required regarding stockpiles after having given due consideration to the following suggestions:

- **Delineation of areas from the toe and top of the stockpile within which unprotected workers should not enter.**
- **Carrying out geotechnical investigations to ensure that areas underlying the stockpiles do not contain soft materials that would generate deep-seated failure of the stockpiles.**
- **Requiring a qualified professional engineer to provide written procedures where the stockpiles are excavated:**
 - a) From the top and are more than 1.5m in height;**
 - b) From the bottom in non-free sliding soil and are more than 6m in height;**
 - c) From the bottom in free sliding soil and are more than 10m in height.**
- **For excavation from the bottom of non-free sliding soil stockpiles that are less than 6m high, limiting the vertical excavation face to the eye level of the operator of the excavation equipment and keeping unprotected workers away from the toe of the stockpile slope for a distance of more than the height of the stockpile;**

- **Excavating the face of stockpiles in such a way that the face is straight or convex; and**
- **Taking samples of stockpile material by excavating the stockpile material with the excavation equipment and building a pile of less than 1.5 m height for sampling by unprotected workers.**
- **Unprotected workers should never take samples from stockpiles greater than 1.5 meters in height.**

Rationale: From the evidence, stockpiles can be composed of many different types of material, can take many shapes and forms and can be of varying sizes. At the same time they are inherently dangerous. As such proper professional planning needs to take place in determining the acceptable working conditions and safety considerations of a stockpile. ”

Re: Recommendation No. 19

“The MASHA guidelines on stockpiles should be reviewed by MASHA in consultation with the Ministry of Labour and the APAO in light of Recommendation 7 set out above regarding O. Reg. 854 s. 88.

Rationale: The recommendations include suggested changes to the regulations governing the use of stockpiles. The Guidelines should reflect these recommendations. ”

The MOL worked with MASHA and the APAO to review the existing MASHA guideline and include as appropriate the items mentioned in Recommendation No. 18. Several of these issues are addressed in the existing guideline. A revised guideline has been developed and is being distributed to the industry.

The issues of when a Professional Engineer is to be involved in the design and working of a stockpile will be considered.

Upon completion of the review, the guideline will be distributed to the industry.

Re: Recommendation No. 22

“That industry representatives undertake a survey of best practices in the industry across North America.

Rationale: From the evidence, other jurisdictions have documented guidelines, procedures and plans for similar situations.”

The MOL supports this and would add that any best practices be compiled and distributed in either a guideline or similar document to the industry. The MOL will discuss this with MASHA and the APAO.

SUMMARY OF CIRCUMSTANCES
CONTRIBUTING TO THE DEATH OF:

David Roesler

Deceased June 24, 1996

Employer: Timminco Met Pit

Date of Inquest: September 22, 23 and 28, 2005

Quoted from Coroner's Summary

Mr. Roesler was a crown press operator at the Timminco plant at Haley in Renfrew County. At the time of his death he had worked for 3-4 months on the crown press machine. This machine received, via a conveyor belt, tubular condensers containing magnesium that had been cooled and condensed into solid form from a vapour. It then pushed the solid magnesium, called a crown, out of the surrounding cylindrical tube before moving the empty condensers to the side of the machine. This machine can be either manually or automatically operated. The operating panel for the crown press machine is positioned at the front of the machine.

No part of a press operator's job required that the operator be behind the machine. Behind the machine there is a moving part, the index beam carriage that is used to push the magnesium out of the condenser. The area behind the machine was partially fenced and partially obstructed by a chain to prevent unauthorized persons from coming behind the crown press machine. The only authorised persons were maintenance personnel and supervisors. Nevertheless operators occasionally went behind the crown press machine.

On June 24, 1996 Mr. Roesler was discovered by a co-worker to be pinned behind the machine by the index beam. The machine was switched from automatic to manual to release Mr. Roesler. He was then taken to the Renfrew Victoria Hospital where he died shortly after admission to the emergency department.

REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF:

David Roesler

Deceased June 24, 1996

Employer: Timminco Met Pit

Date of Inquest: September 22, 23 and 28, 2005

As requested, the following is the Ministry of Labour's (MOL's) response to recommendations 1 to 7 and 9:

Re: Recommendation No. 1

"That the Ministry of Labour ensure standard minimum levels of Occupational Health and Safety Act training and institute rigorous testing and certification of all supervisors (any person that is responsible for the supervision of other persons). Certification of current supervisors should be completed by 2011, throughout the Province of Ontario in all workplaces. Following 2011, required certification levels must be achieved by individuals prior to commencing supervisory duties in any workplace in the province.

In recognition of the Internal Responsibility System, all levels of supervisors –CEOs to front-line supervisory staff – should be required to complete and pass certification levels appropriate to and designated by their sector. No grandfathering of current supervisory staff or exemptions based on seniority, education, training, etc. should be permitted.

In addition, given the frequency and significance of amendments to the Occupational Health and Safety Act and Regulations, on-going upgrading and re-certification requirements should be strongly considered when developing this new certification program/system."

Under the "*Occupational Health and Safety Act*" (OHSA), employers are responsible for providing proper supervision. Employers must ensure supervisors are "competent"

persons. A “competent person” is defined in the *OHSA* as, a person who is qualified because of knowledge, training and experience to organize the work and its performance; is familiar with the *OHSA* and the regulations that apply to the work; and has knowledge of any potential or actual danger to health or safety in the workplace.

In addition, the “Regulations for Mines and Mining Plants “ (the Regulation) requires that employers provide workers, which would include supervisors, with common core training for the type of mining operation in which they will be working. In mines, employers are required to provide supervisors with common core training specifically directed to supervisors. Programs are available for underground hard rock mine supervisors, and a generic supervisor program for all other supervisors in mines and mining plants. These supervisor-training programs were developed by the Mining Tripartite Committee. This Committee consists of representatives from industry, labour, the Ministry of Labour, and the Ministry of Training Colleges and Universities.

Employers may ensure competency in several ways, including certification, regular refresher training, and annual performance reviews.

Re: Recommendation No. 2

“The definition of “competent persons” found in Section 1 of the occupational health and Safety Act should be amended to read:

- “competent person” means a person who,**
- a) is qualified because of knowledge, training and experience to organize the work and its performance,**
 - b) is familiar with the Act and its regulations and is trained and certified in areas designated by the sector that apply to the work, and**
 - c) has knowledge of any potential or actual danger to health and safety in the workplace; (“personne competente”).”**

Under the current provision employers are required to ensure that supervisors have adequate training. Further, the *OHSA* requires an employer to acquaint a worker or a person in authority over a worker with any hazard in the work. The *OHSA* also requires a supervisor to advise a worker of the existence of any potential or actual dangers, and, where required under the Regulations, provide the worker with written instructions as to the measures and procedures to be taken for the worker’s protection.

Re: Recommendation No. 3

“Part VII of the Act should be revised or amended to place further expectations around the preservations of wreckage as found in Section 51(2). It is recommended that these revisions will clearly state that no workplace where a person has been injured be interfered with, disturbed, destroyed, altered, etc. until there is a clear indication as to the level of severity of the injury of the worker and it is confirmed by senior or medical staff that the worker has not been critically or fatally injured.”

Section 51(2) of the *OHS*A requires, that where a person is killed or critically injured in a workplace, no one shall interfere with, disturb, destroy, alter or carry away any wreckage, article or thing at the scene of or connected with the occurrence until permission to do so has been given by an inspector.

In the Ministry’s view, the regulation is sufficiently clear about preservation of the wreckage, and we are not considering amendments at this time.

Re: Recommendation No. 4

“That Mining Regulation 185 of the Occupational Health and Safety Act be amended to include a subsection that speaks directly to the requirement that all safety equipment associated with any machine be in place and secured during the operation of that machine.

In cases where any modifications or requirements to remove fencing or guarding for maintenance or other similar purposes are necessary, equivalent safety provisions that protect exposed moving parts that may endanger the safety of any person must be put in place and verified prior to operation of that machine.”

Section 185 of the Regulation was amended in 2004. It requires that a machine with an exposed moving part that may endanger the safety of any person must be fenced or guarded unless its position, construction or attachment provides equivalent protection. The section also requires that before any work is done on the machine, all moving parts shall be stopped and a worker shall verify that energy sources have been dissipated or contained and that energy isolating devices are installed, properly engaged, locked and tagged. Section 185 also requires that, where it is necessary for the machine to operate while adjustments are being made, there must be barriers, shields or other effective precautions in place to protect the worker.

No further amendments to this section are being considered at this time.

Re: Recommendation No. 5

"That the Workplace Safety and Insurance Board (WSIB) and the Safe Workplace Associations (SWAs) as a part of their stated mandate of "overseeing Ontario's workplace safety education and training systems" be required to, within current funding levels, implement strategies, mechanisms and supports that more fully and adequately assist employers to develop internal health and safety documentation, materials and systems. These supports should ensure and accommodate all levels of literacy, education, cultural differences etc., and confirm that all reasonable steps have been taken to ensure comprehension by individuals within the workplace."

The MOL suggests that the Workplace Safety and Insurance Board and the Safe Workplace Associations respond to this recommendation. A copy of the jury's recommendations and our response will be forwarded to these organizations for their review and consideration.

Re: Recommendation No. 6

"That the Ministry of Labour further to its role of "checks and balances" should,

- Ensure that employers have in place and adhere to rigorous policies and procedures to address Occupational Health and Safety infractions within their workplaces;**
- Ensure adequate and responsible support is given to employers by the Workplace Safety and Insurance Board and safe Workplace Associations in the employers effort to meet legislative and regulatory requirements placed on them by the Occupational Health and Safety Act; and**
- Ensure that employers have in place and adhere to rigorous training practices beyond WHMIS and specific to their sector to ensure knowledge and appreciation of the hazards present in the workplace."**

Employers are required by the *OHS*A to prepare, and review at least annually, a written occupational health and safety policy. Employers are also required to develop and maintain a program to implement the policy and to post a copy of the policy in a conspicuous location in the workplace.

The *OHS*A also requires employers to provide information and instruction to workers to protect the health and safety of workers and, ultimately, to take every precaution reasonable in the circumstances for the protection of a worker.

Ministry of Labour Inspectors have a number of options for ensuring compliance with the *OHS*A. An Inspector may issue an order. An order may require immediate action, a plan to rectify the contravention or may stop work on specific equipment or in the workplace. An Inspector can also issue tickets and summonses to workplace parties, which could result in fines of up to \$500. An Inspector can also swear an information against a corporation or individual charging them with violations of the *OHS*A. The potential penalties for this type of charge is a fine of up to \$25,000 and/or imprisonment for up to 12 months for individuals and a fine of up to \$500,000 for corporations. Inspectors are trained and instructed to use the enforcement necessary for the circumstances.

Employers are able to utilize the services of Safe Workplace Associations when training; auditing or consulting services are required. These associations are all knowledgeable in sector specific workplace hazards.

Re: Recommendation No. 7

“That the Ministry of Labour and its Minister institute an Internal Responsibility System which encompasses all stakeholders within the field of health and safety that legislate, oversee and support the actions of employers – to include the Ministry of Labour, the WSIB, and SWAs. As part of this Internal Responsibility System, employers should be provided a formal mechanism to raise concerns/issues when they believe their pursuit of safe workplace practices legislated under the Occupational Health and Safety Act is not adequately supported by those bodies responsible to do so.”

The MOL is responsible for the regulation of health and safety in Ontario workplaces. Inspectors attend workplaces to ensure compliance with the *OHS*A enforce the regulation.

The Internal Responsibility System (the “IRS”) is a doctrine, which serves as the foundation for the *OHS*A. The IRS, places responsibility for workplace safety on all workplace parties (e.g. workers, supervisors, employers). Each has specified obligations under the *OHS*A designed to ensure the health and safety of workers.

Under the *OHS*A, employers have a broad responsibility to ensure the safety of workers employed in their workplaces. Where an employer requires assistance in meeting its

statutory obligations, it may choose to contact the safe workplace association specific to the sector in which the employer operates. In addition, employers may choose to seek assistance from health and safety consultants or engineers.

The SWAs are funded and administered by the WSIB. Employers should forward concerns about the nature and type of training provided by the SWAs to the WSIB for its follow up and response.

Re: Recommendation No. 9

“That all stakeholders impacted by the aforementioned recommendations, including but not limited to the Ministry of Labour, Workplace Safety and Insurance Board, Safe Workplace Associations and employers, follow the example set by Timminco Ltd after the tragic death of David Roesler. We recommend that, just as employers must react swiftly in situations such as David’s death, all parties likewise act with expediency to take all steps necessary to implement these recommendations and not permit dismissal or deferral based on arguments such as limited funding or human resources.”

The Coroner’s Act requires mandatory inquests for fatalities occurring in mining workplaces. These fatalities and resulting inquest jury recommendations are then reviewed by the Mining Legislative Review Committee (MLRC) to determine if guidance material should be provided to the mining industry or if legislative changes are necessary. The MLRC is a committee of labour, industry and MOL representatives that advises the Minister on matters of health and safety related to the mining industry. Many sections in the Regulation are a direct result of mining fatalities and inquest jury recommendation.

JURY RECOMMENDATIONS FOR 2007

- Chad Lamond
- Igor Lobko
- Kevin Payette
- Christopher James White

**BRIEF SUMMARY OF THE CIRCUMSTANCES
OF THE DEATH AND INQUEST:**

Chad Lamond

Deceased: March 7, 2002

Employer: Moran Mining & Tunnelling Ltd.

Date of Inquest: November 5 & 6, 2007

Quoted from Coroner's Report

“Chad Lamond, an employee of Morin Mining and Tunnelling, was working underground at #9 Shaft of Creighton Mine belonging to CVRD INCO, Sudbury on March 7, 2002. He was using a jumbo drill at the 6400 level on a platform in the shaft, when he was noted to have disappeared from the platform. His tether from his body harness was not tied off to the sala block attached to the Galloway platform (a safety line mechanism). Mr. Lamond was later found dead 600 metres below in the shaft.”

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Chad Lamond

Deceased: March 7, 2002

Employer: Moran Mining & Tunnelling Ltd.

Date of Inquest: November 5 & 6, 2007

As requested, the following is the Ministry of Labour's (MOL's) response to Recommendations 1 to 7:

Recommendations 1, 5 & 6 and Recommendations 3 & 7 are being responded to together due to their similarities.

Recommendation No. 1

"In the event that a worker working in the vicinity of a hole, has chosen not to or forgotten to tie off, that steps be taken to develop and implement a warning system that would be applicable in the mining industry, the construction industry and other industries where falling is a hazard. Such a warning system would include audio and/or light warning systems to alert workers, and their co-workers that they are not tied off."

Recommendation No. 5

"To implement and enforce a minimum disciplinary policy for safety infractions regarding not tying off. For example, this may include a first incident verbal warning, second incident written warning, and third incident time off without pay."

Recommendation No. 6

"Implementation of a camera system located only in areas where supervisors are not able to arrive to the job site unannounced. This will allow supervisors to see if any workers are not tied off and address the issue immediately."

Recommendations 1, 5 and 6 suggest that certain measures and procedures should be developed and implemented if a worker has chosen not to or forgotten to tie off. Several provisions under the Regulation for Mines and Mining Plants (the

Regulation) address fall hazards (section 14 – general fall arrest requirements; section 60 – working in bins; section 84 – movement of bulk materials; section 190 – scaffolds and stages). To prevent a worker from falling off a sinking stage or platform, subsection 14(5) of the Regulation permits the adoption of measures and procedures that will provide equal or greater protection to a worker if a fall arrest system is not used.

The existing health and safety guideline issues by the Ministry of Labour in 2002 on “Guideline for the Design and Operation of Work Stages and Platforms” states that:

- anchor points for fall arrest equipment must be properly designed and located; and,
- a fall arrest system must be used when there is irregular wall surface due to an over break, or if there is a possibility that a worker may fall more than three meters (ten feet) unless equal or greater protection for the worker is provided.

It should be noted that the legislation provides minimum requirements and employers may adopt measures and procedures that exceed the requirements.

The Occupational Health and Safety Act (OHSA) is based on the principles of the Internal Responsibility System (IRS). The IRS is a system within an organization that encourages workplace parties (employers and workers) to take responsibility for workplace health and safety. The Joint Health and Safety Committee (JHSC) plays a very important role in the functioning of the IRS. For example, one of the principal functions of the JHSC is to recommend corrective action and to follow up on implementing jury recommendations.

The Ministry will discuss the intent of the above recommendations with the Mining Legislative Review Committee (MLRC) to ensure that the Regulation adequately addresses them. This is a committee established under Section 21 of the *OHSA* to advise the Minister on matters of health and safety in the mining industry. It includes representatives of both labour and management in the mining sector.

The Ministry will send copies of this report along with all the jury recommendations to the mining industry, construction industry and the organizations that represent the industries where falling from heights is a hazard for their information.

Recommendation No. 2

“All mining galloways should have lighting installed to increase visibility of the surface and perimeter of the platform, in addition to lighting below that would enhance depth perception of the environment. This would allow workers to have

better visibility of their own work environment as well as that of their co-workers.”

The MOL agrees that proper illumination is important for the health and safety of workers. Subsection 262(1) of the Regulation requires the provision of effective illumination appropriate for work performed in an underground mine where the nature of the equipment or the operation may create a hazard due to insufficient illumination.

The Ministry will discuss the intent of this recommendation with the MLRC to ensure that the Regulation adequately addresses it.

Recommendation No. 3

“Implementation of real life height awareness in existing training programs which would expose workers to vertical heights realistic to their actual work environment in a fully lit condition. This would allow workers to understand the critical importance of tying off to a safety line.”

Recommendation No. 7

“To develop and implement educational programs that seek to change current mining culture to one where safety is paramount above all else, including pride, work experience and the right to refuse and unsafe work environment. This could be in addition to current on the job training and may include courses, workshops and certification.”

Under the *OHSA*, employers are responsible for providing information, instruction and supervision to a worker to protect the health or safety of the worker. This would include acquainting the worker with the hazards associated with working from heights. In addition, *OHSA* requires employers to ensure that all required protective devices are provided, maintained and used as prescribed by the legislation or its regulations. The legislation also requires, where prescribed, that safe work measures and procedures be written and communicated to workers, and that workers comply with these instructions.

A copy of this report will be forwarded to the Mines and Aggregates Safety and Health Association (MASHA) for their consideration. MASHA is a safe workplace association responsible for providing programs and information to the mining industry. MASHA may wish to develop some training programs to address recommendations 3 & 7.

The recommendations will also be shared with the Mining Tripartite Committee (MTC). The MTC is a tripartite committee consisting of representatives from the mining industry, labour, the Ministry of Training Colleges and Universities (MTCU) and the MOL. This committee develops and recommends training programs for workers in the mining industry to MTCU. A copy of this report will be forwarded to MTCU

Recommendation No. 4

“Develop and implement an adjustable plug that would allow for more coverage of the open hole. In addition, reinforce with all employees that the plug is not a substitute for tying off.”

The MOL believes that existing requirements in the *OHS*A meet the intent of this recommendation. Under the *OHS*A, the employer must take every precaution reasonable for the protection of the worker. This could include requiring the JHSC, safety personnel or other knowledgeable people to complete a risk assessment at the site, and develop a specific checklist for each piece of equipment to ensure all safety items are considered.

As stated in responses to recommendations 1, 5 and 6, the MOL will discuss the intent of this recommendation with the MLRC.

**BRIEF SUMMARY OF THE CIRCUMSTANCES
OF THE DEATH AND INQUEST:**

Igor Lobko

Deceased: December 14, 2005
Employer: Kirkland Lake Gold Inc.

Date of Inquest: June 5 & 7, 2007

Synopsis - quoted from Coroner's report

"Igor Lobko, 47, met with co-workers for the day shift at the Kirkland Lake Gold Mine (Macassa Division) at 0700h December 14, 2005.

The assigned task discussed at the planned meeting (at surface) was to hoist a long hole drill up the Alimak Egress Raise (4247) from the bottom (4250 ft level) to the 4247 long hole complex (called sublevel #4).

This egress raise is a 7 ft by 8 ft service raise, driven in 2003 from the 4250 ft level to the 3800 ft level. It is equipped with engineered steel grated landings at regular 25 ft intervals, within which are "manway" openings that allow workers to climb up or down the ladder (countersunk in the shaft and providing access to the landings).

Mr. Lobko was tasked to descend to the Sublevel 1 to monitor the slinging action of the drill up the raise (once the landings had all been raised to permit this activity). As he reached sub-level 3, he met with 3 co-workers who were about to raise the landing (it would be pulled up and tied off to the wall).

Events happened quickly at this point. Mr. Lobko was halfway through the manway on the ladder when he stopped to assist the other 3 (who were standing beside the landing and behind it). He apparently turned his body 180 degrees on the ladder so that he was then facing away from the ladder, and reached up with both hands to assist in lifting the landing. One of the others started lifting from his side. This situation then negated the 3-point contact established by Mr. Lobko; he lost his balance and fell down to the next landing (about 25 feet). Because the remainder of the egress was in essence 'open-hole' with the manway doors still open, he continued on down to his death approximately 230 feet below. This was thought to have occurred at about 0805 h."

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Igor Lobko

Deceased: December 14, 2005

Employer: Kirkland Lake Gold Inc.

Date of Inquest: June 5 & 7, 2007

As requested, the following is the Ministry of Labour's (MOL's) response to Recommendations 8 and 9:

"Re: Recommendation No. 8

"We the jury recommend that the supervisor be required to do a job observation of each of his workers, on a regular basis, actually performing their duties in order to ensure they are being done safely and according to proper procedure and regulation. We are recommending this so the worker will be corrected from unsafe or improper habits."

The MOL believes that existing requirements in the *Occupational Health and Safety Act (OHSA)* meet the intent of this recommendation. Under the *OHSA*, a supervisor shall ensure that a worker works in accordance with the Act and regulations. This could include job observation to ensure safe work practices are adhered to. There is nothing to prevent an employer from incorporating job observation as part of the supervisor's training and duties.

Re: Recommendation No. 9

"We the Jury recommend that the Fall Protection provisions of the Mining Regulations be updated with regards to fall restraint (which is different from fall arrest), tie off anchors, (as to marking them, locating them conveniently and specifying what is adequate), providing for shock absorbers in harnesses and protection from suspension trauma (as to devices and having another worker present for rescue). We are recommending this so the worker will be kept safe if he does fall with the fall arrest equipment on. Also, a convenient

**location will encourage use of tie-off anchors
when required.”**

The mining industry encourages the use of fall arrest systems, tie off anchors and special detachable shock absorbers as good practice; however, these are not explicitly required by regulation.

The MOL will discuss this recommendation with the Mining Legislative Review Committee (MLRC). The MLRC is a labour-management advisory committee for the mining sector. It was established under section 21 of the OHSA, to address occupational health and safety issues in the mining sector and to make recommendations to the Minister to update and modernize the mining regulations.

VERDICT OF CORONER'S JURY

Name of deceased: Kevin Payette

Date and time of death: July 29, 2001 10:35 pm

Place of death: St. Joseph's Medical Centre - 700 Paris Street - Sudbury, Ontario

Cause of death: Severe crushing injury to abdomen, associated with massive blood loss.

By what means: Accident

JURY RECOMMENDATIONS

1. The Ministry of Labour should consider organizing itself with separate investigation and inspection divisions similar to the Ministry of Environment.

Rationale:

To facilitate the flow of ideas and recommendations to improve safety from the Ministry of Labour to the company.

Directed to:

Ministry of Labour

Coroner's comment: Testimony was heard that the Ministry of Labour inspector was advised not to send his recommendations to improve safety to the company until all legal proceedings (including the inquest) were complete. It was felt that, if there were separate inspection and investigation branches, potentially important communication might not be withheld.

2. Review and develop procedures for all blasting aids. If new blasting devices are introduced to the workplace, evaluation and training should take place.

Rationale:

Ensure that workers are aware of the safe operation of the devices.

Directed to:

Xstrata Nickel and other mining companies

Coroner's comment: Neither Mr Payette nor his co-worker had been trained specifically on the blasting buggy although they had taken general blasting courses. The jury heard that there are an ever increasing variety of blasting aids available to miners, most introduced without written protocols and specific training.

3. The baffle gate control valve handle should be fully enclosed.

Rationale:

To prevent any inadvertent contact.

Directed to:

Xstrata Nickel and other mining companies

Coroner's comment:

The valve handle that controlled the gate which fatally injured the deceased was not enclosed in any way at the time of the accident. Several witnesses recalled bumping or catching it inadvertently. The company put covers over the handles shortly after the accident but the front and underside of the handle remained exposed at the time of the inquest.

4. Common core modular training guidelines should be reviewed with the trainee at the beginning of each modular training session as set out by the Mining Tripartite Committee and Ministry of Training, Colleges and Universities. A successful demonstration of skills by a trainee is required for each task in the module before the trainee can be accredited in the module. Accreditation for each task should be signed off and dated when the successful demonstration for the task is completed.

Rationale:

To ensure competency in the task and consistency in accreditation.

Directed to:

Xstrata Nickel and other mining companies

Coroner's comment: Some witnesses testified that workers had been signed off after having a task described to them but without actually being observed to perform it themselves.

5. That the company identify tasks that are hazardous and/or dangerous, and create written procedures for each. If the procedures cannot be followed as written, the Non Routine Hazardous Task protocol should be followed.

Rationale:

To maximize the safety of the worker performing the task and to ensure consistency in the way the task is completed.

Directed to:

Xstrata Nickel and other mining companies

Coroner's comment: The Non Routine Hazardous Task protocol includes notifying one's supervisor and working out a new procedure for the job.

6. Investigate the feasibility of "pulling chute" more often to reduce "hang-ups".

Rationale:

To minimize the frequency of blasting.

Directed to:

Xstrata Nickel and other mining companies

Coroner's comment: "Pulling chute" is a term used for emptying the mine shaft of rock debris/ore. The jury heard that the longer rock stays in the chute, the more likely it is to oxidise and solidify, becoming jammed.

In closing, I would stress once again that this document has been prepared solely for the purpose of assisting the reader in understanding the inquest jury's verdict and recommendations. It does not replace the verdict and recommendations, but rather consists of my comments and recollections of the evidence presented, upon which I believe the jury based its conclusions. If any party feels that I have made a gross error in my recollection of the evidence or a conclusion of the jury please bring it to my attention. If any further information or clarification is required please contact the Inquest unit at the Office of the Chief Coroner.

Respectfully submitted,



Shelagh McRae MD CCFP FCFP
Gore Bay

March 22, 2007

**BRIEF SUMMARY OF THE CIRCUMSTANCES
OF THE DEATH AND INQUEST:**

Christopher James White

Deceased: June 28, 2004

Employer: Musselwhite Mine, Placer Dome

Date of Inquest: January 10 to 12, 2007

Quoted from Coroner's Report

“At 0645 hr on June 28, 2004, at the Musselwhite (Placer Dome) gold mine north of Pickle Lake, Christopher White and his partner (pre-selected as the “Mine Clearance Team”), went underground to the 475 meter level in the “Toyota” to commence post production blast gas checks. This important procedure involves taking readings of toxic gases following blasts of carbon monoxide and nitrogen dioxide (there are other gases and contaminants as well), to ensure that the ventilation system is functioning and clearing gas build-up in working areas, prior to the miners entering the area to proceed with mucking out the blasted rock.

On this occasion, the 475m level was deemed clear and the two men proceeded up to the next drift at 450m. The critical area of concern would be adjacent to the open stope at that level where the blast had occurred. On entering the ramp, they encountered gas and a reading taken proximal (on the safe side) of a rope and sign (indicating explosives; open hole) barricade was higher than acceptable for CO and NO₂. In addition the adjacent ventilation fan was not operating for reasons unknown at the time. The two repaired briefly to a safe area and returned with a smaller caliber air hose to assist in pushing out the gases.

Inexplicably, Mr. White crossed the barrier and within moments, the partner witnessed Mr. White step off the brow and disappear into the open stope. He fell approximately 12-15 meters to his death.”

**REPORT OF THE MINISTRY OF LABOUR
ON THE RECOMMENDATIONS OF THE CORONER'S JURY
REGARDING THE INQUEST INTO THE DEATH OF**

Christopher James White

Deceased: June 28, 2004

Employer: Musselwhite Mine, Placer Dome

Date of Inquest: January 10 to 12, 2007

Although the Chief Coroner's letter states that Recommendations 1 to 8 be responded to by the Ministry of Labour (MOL), the coroner's jury directs Recommendations 3 to 7 to the mining industry. Accordingly, below is the MOL's response to Recommendations 1, 2 and 8.

The MOL discusses all mining fatalities with the Mining Legislative Review Committee (MLRC). The MLRC was established under section 21 of the Occupational Health and Safety Act (OHSA) to advise the Minister of Labour on health and safety issues in the mining industry. It is comprised of representatives of employers and labour in the mining industry. Recommendations 1, 2 and 8 will be discussed at a future meeting of the MLRC.

Re: Recommendation No. 1

"The Ministry of Labour and the Mining Industry at large investigate standards for signage on barricades to ensure adequate warning of the nature of the danger or hazards present in a mine.

This is to reduce confusion regarding dangers and hazards in the mining industry."

The Regulation for Mines and Mining Plants (O. Reg. 854, the Mining Regulation) sets out requirements for effective signage that address the intent of this recommendation. Specifically, section 68 requires:

"Where a workplace, travelway, manway or other area of an underground mine is under repair or where there is a danger or hazard to a worker, (a) the workplace, travelway, manway or other area shall be closed by barricades, fencing or other suitable means; and (b) warning signs shall be posted indicating that it is under repair or indicating the nature of the danger or hazard."

These are performance-based requirements that allow compliance to be achieved based on the specific circumstances at a particular workplace.

Additional guidance for the industry regarding signage and barricades can be found in CSA Z321-96 standard “Signs and Symbols for the Workplace”. This standard contains some simple and practical information useful in preparing signs, such as:

- a. Prohibition signs shall have a black image on a white disc surrounded by a red ring with a red diagonal slash;
 - b. Danger signs shall have a white image on a red triangle, with the colour red covering at least 50% of sign [Psychologically, red has a long-standing association with danger. The triangle is a well-known symbol for traffic warnings];
 - c. Each sign should be used only for the purpose for which it was intended, particularly in the case of workplace signs that have a clearly defined function;
 - d. Signs are generally more effective when placed alone. If signs are grouped together they should be placed in order of importance;
 - e. Too many symbols in one area may be confusing. The number of symbols in one location should be kept to a maximum of three.
- d. It is very important for a sign to be conspicuous and legible.

The Mines and Aggregates Health and Safety Association (MASHA), which is receiving copies of this report, may wish to make further comment about this recommendation.

Re: Recommendation No. 2

“The Ministry of Labour and the Mining Industry at large develop standards for barricades that are visible, practical and which impede inadvertent access to open holes or stopes.

This is to clarify and define acceptable barricades and establish uniformity across the mining industry.”

As per Section 68(a) of the Regulation for Mines and Mining Plants, fences and barricades must achieve their function whether it is a warning or restriction of access. MOL inspectors would assess the adequacy of a particular fence or barrier based on the circumstances of any given situation. In some situations, barricades need to be movable and are intended to be in place short periods of time. In other situations, where the hazardous condition is more permanent, more robust fencing and barricades are required. Ultimately, the barricade should protect workers from the hazard present.

The MASHA can provide information about current industry examples of barricade use and design.

Re: Recommendation No. 8

“The Ministry of Labour investigate the feasibility of implementing a regulation that defines minimum [training] requirements for mine workers involved in post-blast clearance gas checks.

This is to ensure a minimum uniform standard across the mining industry.”

“In conjunction with Recommendation 3 above, the jury is asking for legislation to be considered to ensure this skill-specific task be in essence specialized.”

The *OHS*A and Mining Regulation set out instruction and training requirements that meet the intent of this recommendation. Sections 25 and 27 of the *OHS*A require the employer and supervisor to provide information, instruction and supervision to workers; take every precaution reasonable to protect the worker; and advise workers of dangers. Also, the Regulation for Mines and Mining Plants requires workers to complete a common core training program about the hazards of underground mining.

Guidance for gas-checkers is well-laid out in an MOL Health and Safety Guideline based on Section 121 (protecting workers from explosive fumes) and Section 260 (protecting workers from blasting gas) of the Regulation for Mines and Mining Plants. The guideline provides a detailed description of the hazards associated with blasting contaminants and it outlines precautions that should be taken to safeguard workers, including workers conducting post-blast examinations.

NOTICE:

- Changes to Regulation
854/90 for Mines and Mining
Plants

ONTARIO REGULATION 84/07
made under the
OCCUPATIONAL HEALTH AND SAFETY ACT
Made: March 7, 2007
Filed: March 9, 2007
Published on e-Laws: March 12, 2007
Printed in *The Ontario Gazette*: March 24, 2007

Amending Reg. 854 of R.R.O. 1990
(Mines and Mining Plants)

Note: Regulation 854 has previously been amended. Those amendments are listed in the Table of Regulations – Legislative History Overview which can be found at www.e-Laws.gov.on.ca.

1. Subsection 5 (3) of Regulation 854 of the Revised Regulations of Ontario, 1990 is revoked and the following substituted:

5. (3) The employer shall notify an inspector,
- (a) when portable crushing, screening or associated washing equipment is installed in or about a surface mine; and
 - (b) before a test drill is operated at the surface to prove mineral bearing substances, rock, earth, clay, sand or gravel.

2. Section 11 of the Regulation is revoked and the following substituted:

11. (1) Employers in the types of mines and mining plants described in Column 1 of the Table to subsection (2) shall establish and maintain the training programs identified in the corresponding lines of Columns 2 and 3.

(2) The training programs identified in the Table to this subsection shall be developed jointly by labour and management in the mining industry and the Ministry of Training, Colleges and Universities and approved by the Director:

Column 1	Column 2	Column 3
Type of mine or mining plant	Name of training program	Number of training program
A. Hard rock underground mine	A1. Common Core for Basic Underground Hard Rock Miner	P770010
	A2. Speciality Modules for Underground Hard Rock Miner	P770010
	A3. Common Core for First Line Underground Mine Supervisor — Underground Hard Rock Mining	P770121
B. Soft rock underground mine	B1. Common Core for Basic Underground Soft Rock Miner	P770130
	B2. Speciality Modules Program — Underground Soft Rock Miner	P770130
	B3. Common Core for First Line Underground Mine Supervisor — Underground Soft Rock Mining	P770131
C. Mill process operations	C1. Common Core for Basic Mill Process Operations — Mineral Ore	P810050
	C2. Speciality Modules Program for Mill Process Operator — Mineral Ore	P810050
D. Other mines and mining plants (not including smelters, mills and refineries)	D1. Common Core for Generic First Line Supervisor — Surface Mining, Surface and Underground Diamond Drilling Operations, and Underground and Surface Mining Trades	P770141

(3) An employer shall train each full-time worker who commences employment on or after April 1, 2007 in the program identified in Columns 2 and 3 of the Table to subsection (2) that is appropriate for that worker, within the first year of the worker's employment.

(4) Subject to subsection (5), an employer shall train each full-time worker who commences employment after June 1, 1987 and before April 1, 2007 in the program identified in Columns 2 and 3 of the Table to subsection (2) that is appropriate for that worker, within the first year of the worker's employment.

(5) The requirement in subsection (4) does not apply to items A3, B3 or D1 of Column 2 and the corresponding lines of Column 3.

(6) Subsection (3) or (4), as the case may be, does not apply if the worker,

- (a) successfully completed the appropriate program for that worker before being employed by the employer, and gives the employer proof of successful completion; or
- (b) was accredited under the predecessor of this section and gives the employer proof of accreditation.

(7) A worker who would otherwise be required to be trained in the program listed in item A3 of Column 2 of the Table to subsection (2) is not required to do so if he or she completed Program #P770120 (Common Core for First Line Production Supervisors, Underground Hard Rock Mining) on or before April 1, 2007.

(8) A document issued by the Ministry of Training, Colleges and Universities showing that a worker has successfully completed a program listed in the Table to subsection (2) or referred to in subsection (7) is conclusive proof of the worker's successful completion of the program, for the purposes of this section.

3. Section 11.3 of the Regulation is amended by striking out "subsection 11 (4)" and substituting "subsection 11 (8)".

4. Section 71 of the Regulation is revoked and the following substituted:

71. (1) An overhead protective device to protect the operator from falling objects shall be installed on every motor vehicle that is used,

- (a) in an underground mine that is developed after June 1, 1988; or
- (b) in an area in an underground mine with respect to which the Director has given the owner a written opinion that local ground stability presents a hazard to the operators.

(2) Clause (1) (a) does not apply to a motor vehicle while it is being used in an area in an underground mine that is made safe,

- (a) by scaling, timbering or rockbolting; or
- (b) by measures that provide safety equal to or better than scaling, timbering or rockbolting.

(3) An overhead protective device required by subsection (1) shall comply with the falling-object protective structures requirements of International Standard ISO 3449;1992 (E) "Earth-Moving Machinery — Falling-Object Protective Structures — Laboratory Tests and Performance Requirements".

(4) An overhead protective device shall be maintained in good condition.

5. Clause 105 (1) (b) of the Regulation is amended by striking out "all operating grades" and substituting "all operating grades, slopes and ramps".

6. Sections 119 and 119.1 of the Regulation are revoked and the following substituted:

119. (1) In this section and in sections 119.1 and 119.2, "emergency brake system" means a secondary brake system that is used for stopping a motor vehicle in the event of any single failure in the service brake system.

(2) The brake system on a motor vehicle that is operated on a grade, slope or ramp shall be able to perform the individual system function requirements of,

- (a) a service brake system;
- (b) an emergency brake system; and
- (c) a parking brake system.

(3) The capacity of retarders shall not be considered in determining the capacity of the brake systems described in clauses (2) (a), (b) and (c).

(4) Any combination of the system function requirements described in clauses (2) (a), (b) and (c) may be performed by a single brake system.

(5) Each brake system shall be capable of being,

- (a) tested independently; and
- (b) readily applied by a worker seated in the driver's seat.

(6) A service brake system may consist of a hydraulic pump motor drive system.

(7) The service brake system and the emergency brake system shall be capable of safely stopping the motor vehicle while it is being operated,

- (a) on the maximum grade, slope or ramp in its area of operation;
- (b) at its maximum authorized speed; and
- (c) with its maximum authorized load.

applied automatically or manually, a deliberate act is required to release it.

(10) Before a motor vehicle is first put into service, the following systems shall be tested by a competent person for proper operation:

1. Service brake.
2. Emergency brake.
3. Parking brake.
4. Steering.
5. Warning devices.
6. Lighting.

(11) A record of the tests described in subsection (10),

- (a) shall be signed by the competent person who performed the tests;
- (b) shall be kept as long as the motor vehicle is in service; and
- (c) shall be made available to the joint health and safety committee or the health and safety representative, if any.

119.1 (1) The brake system of a rubber-tired motor vehicle that was first used in an underground mine after September 1, 1992 shall meet the requirements of CAN/CSA-M424.3-M90, "Braking Performance — Rubber-Tired, Self-Propelled Underground Mining Machines".

(2) The brake system of a rubber-tired motor vehicle that was first used in a surface mine on or after October 1, 2007 shall meet the requirements of CSA-M3450-03, "Braking systems of rubber-tired machines — Performance requirements and test procedures".

(3) The brake system of a tracked motor vehicle that was first used in an underground mine or in a surface mine on or after October 1, 2007 shall meet the requirements of ISO 10265: 1998 "Earth-moving machinery — Crawler Machines — Performance requirements and test procedures for braking systems".

119.2 (1) This section applies with respect to motor vehicles, other than vehicles operating on rails, that are,

- (a) first put into service by the employer on or after August 16, 1997;
and
- (b) equipped with a stored energy brake system that uses a pneumatic system or a full hydraulic system to apply the service brakes.

(2) For the purposes of this section, the critical level of pressure is the level of pressure in a motor vehicle's stored energy brake system, torque converter or transmission below which the manufacturer has determined that the vehicle is unsafe to operate.

(3) A motor vehicle that is operated on the surface must be equipped with a device that warns the operator that the vehicle's stored energy brake system is approaching the critical level of pressure, so that the vehicle can be safely stopped.

(4) A motor vehicle that is operated underground must be equipped with,

- (a) a device that automatically applies the emergency brake system and stops the vehicle before the vehicle's stored energy brake system, torque converter or transmission pressure reaches the critical level of pressure; and
- (b) a device that warns the operator that the emergency brake system is about to be applied.

7. Clause 123 (2) (a) of the Regulation is revoked and the following substituted:

- (a) constructed in conformity with "Storage Standards for Industrial Explosives, May 2001" published by the Explosives Regulatory Division of the Department of Natural Resources (Canada);

8. (1) Subsection 125 (3) of the Regulation is revoked and the following substituted:

(2) Subsection 125 (5) of the Regulation is amended by striking out "suitable storage place that is not a magazine" and substituting "suitable storage area that is not a magazine".

(3) The employer shall ensure that suitable plans and specifications showing the following are prepared, kept up to date and kept readily available at the mine site:

- 1. The design and location of magazines.
- 2. The design and location of explosive storage areas other than magazines.
- 3. The maximum explosive storage capacity at each magazine and at each explosive storage area that is not a magazine.

(4) The employer shall, in consultation with the joint health and safety committee or the health and safety representative, if any, establish a procedure for,

- (a) identifying the location of explosives that are being kept in explosive storage areas other than magazines; and
- (b) ensuring that they are recorded under subsection (3).

9. Subsection 126 (1) of the Regulation is amended by striking out "subsection 125 (5)" in the portion before clause (a) and substituting "section 125".

10. Section 129 of the Regulation is revoked and the following substituted:

129. (1) All electrical equipment and wiring installed or used in a magazine or in an explosives storage area that is not a magazine,

- (a) shall comply with,
 - (i) the requirements of the Ontario Electrical Safety Code with respect to Class II, Division 2 hazardous locations, and
 - (ii) "Storage Standards for Industrial Explosives, May 2001", published by the Explosives Regulatory Division of the Department of Natural Resources (Canada); and
- (b) shall be protected against lightning strikes and electrical surges.

(2) The reference to the Ontario Electrical Safety Code in subclause (1) (a) (i) is to the 23rd edition (2002), published by the Electrical Safety Authority.

11. Subsection 135 (1) of the Regulation is amended by striking out "and" at the end of clause (c), by adding "and" at the end of clause (d) and by adding the following clause:

- (e) the motor vehicle or train shall display and operate a flashing red light whenever explosives are being transported.

12. The Regulation is amended by adding the following section:

135.0.1 (1) In this section,

"bulk explosives vehicle" means a motor vehicle that is used to transport bulk explosives underground.

(2) A bulk explosives vehicle shall be provided with a fire suppression system that uses sprinklers, foam or some other suitable means of suppressing fire.

(3) Whenever a bulk explosives vehicle is not in use, it shall be parked in a place designated as a safe parking place by the employer.

(4) A place may be designated as a safe parking place for the purpose of subsection (3) only if it is located at least 60 metres away from,

- (a) the main access into or from a mine;
- (b) key mechanical and electrical installations that remain in service during a mine emergency;

(6) Subsections (3), (4) and (5) do not apply during the initial stages of development and exploration in a mine.

(7) A bulk explosives vehicle shall not be parked in a magazine.

(8) The employer shall, in consultation with the joint health and safety committee or health and safety representative, if any, develop a procedure for the regular power washing of bulk explosives vehicles.

(9) Without limiting the generality of subsection (8), the procedure shall specify how often washing is to take place.

(10) Before a bulk explosives vehicle enters a garage for maintenance,

- (a) all explosives, detonators and explosive residue shall be removed from the vehicle; and
- (b) the vehicle shall undergo power washing in accordance with the procedure mentioned in subsection (8).

13. Subsection 186 (5) of the Regulation is revoked and the following substituted:

186. (5) An elevator installation shall meet the following standard:

- 1. If it was installed before October 15, 1991, CSA Standard B44-1975, "Safety Code for Elevators, Dumbwaiters, Escalators and Moving Walks".
- 2. If it was installed on or after October 15, 1991 and before April 23, 1999, National Standard CAN/CSA-B44-M90, "Safety Code for Elevators".
- 3. If it was installed on or after April 23, 1999 and before October 1, 2007, National Standard CAN/CSA-B44-94, "Safety Code for Elevators".
- 4. If it was installed on or after October 1, 2007, CSA Standard B44-00, "Safety Code for Elevators".

14. Section 187 of the Regulation is revoked and the following substituted:

187. A dumbwaiter, escalator or moving walk shall meet the following standard:

- 1. If it was installed before April 1, 1994, CSA Standard No. B44-1975, "Safety Code for Elevators, Dumbwaiters, Escalators and Moving Walks".

2. If it was installed on or after April 1, 1994 and before April 23, 1999, National Standard CAN/CSA-B44-M90, "Safety Code for Elevators".
3. If it was installed on or after April 23, 1999 and before October 1, 2007, National Standard CAN/CSA-B44-94, "Safety Code for Elevators".
4. If it was installed on or after October 1, 2007, CSA Standard B44-00, "Safety Code for Elevators".

15. Clause 197 (1) (f) of the Regulation is revoked and the following substituted:

- (f) have an overspeed safety device that,
 - (i) will stop the climber and hold it in place if it begins to travel faster than its design speed,
 - (ii) is approved by the manufacturer of the climber,
 - (iii) is overhauled at least once every three years by the manufacturer or by another competent person, and
 - (iv) bears a suitable mark identifying the device's serial number, the most recent date on which the device was overhauled and the name of the person who performed the overhaul.

16. Clause 229 (6) (c) of the Regulation is amended by striking out "embedded length of wire in the socket" and substituting "embedded length of rope in the socket".

17. Section 265 of the Regulation is revoked and the following substituted:

265. An air supplied respirator that provides compressed air for breathing purposes shall comply with CSA Standard Z180.1-00, "Compressed Breathing Air and Systems".

18. (1) Subject to subsection (2), this Regulation comes into force on April 1, 2007.

(2) Sections 1 and 3 to 17 come into force on October 1, 2007.



SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

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NOTE: For occurrences resulting in a fire, (F) is added to the subscript.

SUMMARY OF MINING REPORTABLE INCIDENTS

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EF – EQUIPMENT FAILURE OR DAMAGE

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1109925 EF (F) 14-Dec-06 Goldcorp Inc. - Red Lake Complex: Mill

Incident:

Sparks/slag from cutting structural steel around the feed hopper dropped down to the gravity floor and onto plastic sheets covering floor jacks. As a result, plastic melted causing smoke.

Cause:

Workers were using oxy/ace torches.

Preventative Action:

Fire watch to be assigned to all areas where oxy/ace torches are used. Area to be watered down prior to job starting. Workers to use fire retardant covering if needed when hot work is being carried out.

Event ID: 1104254 EF 27-Dec-06 Xstrata - Kidd Metallurgical Division

Incident:

A failure occurred in the mechanical drive components of the 200 PH #2. Recycle water pump, entity 43-704, causing the motor and shaft to be detached from the motor base. There were no injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

EL – ELECTRICAL

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090635 **EL** **(F)** **17-May-06** **Xstrata - Kidd Creek: Metsite Copper**

Incident:

Contract employee cutting and welding overhead S furnace. A spark from this task caused a piece of cardboard that was lying on the floor of S furnace to ignite resulting in small fire which was extinguished immediately. No injuries or equipment damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1073600 **EL** **14-Nov-06** **Iron Mountain**

Incident:

While installing an alarm system, worker brushed his hand against a live wire (1600 volts) and received a shock. Worker was not seriously injured and missed no time from work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102976 **EL** **(F)** **11-Dec-06** **FNX Mining Inc. - Podolsky Mine**

Incident:

A scheduled shut-down for maintenance purposes was being done on the property. After the maintenance was completed and power was re-energized, the end section of heat trace located in the sub collar area ignited into flames. All heat trace inspected and ends properly isolated. The power feeding this section of heat trace was immediately shut down and then the piece of damaged heat trace was removed. The end section of heat trace was then properly isolated so that power could be restored. All known heat trace on property is being inspected and the contractor who did the initial installation.

Cause:

Heat trace improperly installed.

Preventative Action:

Will be seeking information the proper installation of heat trace.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1103431 **EL** **(F)** **10-Dec-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

There was a full fire alarm in ES2 switch room D floor. Found the switch room to be full of smoke but no fire visible. The DCS was informed of the smoke and the fire department was called. The switch room below (ES1) was also inspected thinking the smoke could have risen up from below since no flames were visible in ES2. There was no smoke at all in ES1, so ES2 was re-inspected, while waiting for the fire department to arrive, a level one was in process of being called, by the DCS, once the source of the smoke was identified with no indication of fire the level one was cancelled before it was initiated by contact to first aid. The fire department arrived on site and inspected ES2 switch room and the disconnect and the area was released

Cause:

The source of the smoke was from a 30 amp disconnect unit which feeds door 151 stair / ramp heat trace. Arcing inside of breaker self extinguished when power kicked off.

Preventative Action:

None given.

Event ID: 1109925 **EL** **14-Dec-06** **Goldcorp Inc. - Red Lake Complex: Mill**

Incident:

Sparks/slag from cutting structural steel around the feed hopper dropped down to the gravity floor and onto plastic sheets covering floor jacks. As a result, plastic melted causing smoke.

Cause:

Workers were using oxy/ace torches.

Preventative Action:

Fire watch to be assigned to all areas where oxy/ace torches are used. Area to be watered down prior to job starting. Workers to use fire retardant covering if needed when hot work is being carried out.

Event ID: 1101902 **EL** **19-Oct-06** **Drain Bros Excavating**

Incident:

The driver of a dump truck was driving away with the dump box up in the air and knocked down a hydro pole. 4800 volts. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096311 **EL** **30-Jul-06** **Xstrata - Smelter**

Incident:

Workers were operating two cranes when both lost power at 01:30 hours. Power was restore at approx. 01:35. Apparently the seal had checked the #2 powerhouse at approx. that time and found #2 rectifier off (this was reported to the shift electrician while he was troubleshooting). The rectifier power re-set on its own. Workers had also lost power to both cranes at 06:10 hours. The electrician attended the powerhouse and found #2 rectifier off. At that time, the power came back on the cranes without any intervention and after approx. a minute duration. Injuries/damages: loss of power on #3 and #4 cranes. Steps taken to prevent reoccurrence: appears to be a problem with #2 rectifier resetting itself.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104252 **EL** **(F)** **23-Dec-06** **Xstrata - Kidd Creek - Copper Refinery**

Incident:

A fire occurred involving a 12-ton crane at the copper refinery tank house. Two workers were taken to hospital as a precaution due to smoke inhalation.

Cause:

An electrical arc occurred on a bus bar.

Preventative Action:

None given.

Event ID: 1093751 **EL** **07-Nov-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Electrical construction contractor inadvertently cut a power cable feeding the South Mine skip hoist controls. The worker was in the process of cutting an isolated cage hoist control power cable into sections which was to be replaced and had mistakenly cut a section of a skip hoist control cable which was not isolated of power. Both cable were located in an electrical cable tray. 600V electrical power cable was being cut into section using a saws-all. No injuries. Corrective measures taken: lighting was increased in the area. Section lengths for cutting were reduced in order to ensure the dead end of the cable is near the cutting action.

Cause:

None given.

Preventative Action:

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

None given.

Event ID: 1089208 **EL** **25-Mar-06** **Xstrata - Craig Mine**

Incident:

50 ton haulage truck struck 4160V power cable. Power and communication was lost. Initial findings place probable cause on a 4160V power cable having been struck by a 50 ton haulage truck. No injuries. Damage to power cable and power outage. Stench was injected, crews went to underground refuge stations and were accounted for. Investigation underway concerning height of truck.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091959 **EL** **17-May-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

A tandem dump truck contacted overhead telephone cables and pulled down the power lines, shutting off power to some surface buildings. The drive had raised the box so a mechanic could inspect the rear of the truck for the source of a 'noise'. After the inspection, the drive pulled ahead approx. 60 feet with the vox inadvertently left in the raised position.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089395 **EL** **05-Mar-06** **Xstrata - Kidd Metallurgical Division**

Incident:

Worker from service crew as hoisting 1" steel balls from a storage bin area and shuttling them to the ball mills. The equipment being used was a 5 ton P&H overhead rail crane, in which a magnet attached to the crane hook is used for picking up steel balls and dropping them into the grinding mills. It appears that the local single phase disconnect generated heat and melted or burned off one of the 60 amp fuses. The load was over top the storage bin when the fuse melted. Once the fuse burned, the electrical energy de-energized the magnet that was being used to hoist the steel balls and the load of steel balls on the magnet fell back into the storage bin.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092118 **EL** **(F)** **03-May-06**

Incident:

Electrical fire on a Maclean rock bolter underground. This incident occurred while the unit was briefly unattended. The mechanic smelled burning plastic/rubber. He investigated and extinguished the possible flame (there was definitely smoke present).

Cause:

A fire was caused by possible faulty remote drive system solenoid.

Preventative Action:

None given.

Event ID: 1101416 **EL** **10-Mar-06** **Inco Ltd. – C.C. Transportation & Traffic**

Incident:

Employee removed redundant pole with guide when the pole shifted and made contact with a 4160v electrical wire. Equipment consisted of a high-rail logging truck with grappler. No injuries. No damage to overhead power

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089144 **EL** **(F)** **09-Sep-06** **Goldcorp Inc. - Musselwhite Mine**

Incident:

An underground haulage truck (Tamrock 40D) was travelling up the underground ramp system fully loaded when the high speed drive line U-joint failed causing drive line to spin out of control hitting a number of hoses and electrical components on the transmission compartment. The oil from the hydraulic lines sprayed on the electrical components and ignited. The operator saw the flames and shut down the truck and activated the fire suppression system inside the cab and turned off the master switch. This action extinguished the fire.

Cause:

The drive line hit the hoses causing oil to spray at the same time as some electrical components of the shift tower were hit. The sparks from these components ignited the oil spray.

Preventative Action:

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

None given.

Event ID: 1092175 EL (F) 04-Feb-06 Inco Ltd. - Coleman Mine

Incident:

The 24 volt wires from the pump block distribution box shorted and caught on fire.

Cause:

Plastic cause of incident.

Preventative Action:

None given.

Event ID: 1094659 EL (F) 20-Jul-06 Xstrata - Smelter

Incident:

Lightning strike hit smelter shutting down the furnace fans. Hot gas contacted shuttle floor conveyor from dilution valve. Extinguisher used to extinguish flames at shuttle conveyor.

Cause:

Lightning.

Preventative Action:

Engineering investigation new location for valve.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

EX – EXPLOSIVES

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093198 **EX** **05-Jun-06** **Inco Ltd. - Coleman Mine**

Incident:

They have found an old roll of tape fuse while cleaning out a refuge station. The caller reports that he is unsure how it got there as tape fuse has been banned since the 80's and this is a new level. The material was taken to the powder mag and will be detonated during shift change.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103486 **EX** **01-Dec-06** **St. Andrew - Taylor Mine Project**

Incident:

Worker was testing cap with tester and cap went off causing safety bay to go off.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093708 **EX** **15-Jun-06** **Inco Ltd. - Coleman Mine**

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: **1094121** **EX** **29-May-06** **Inco Ltd. - Creighton Mine**

Incident:

Found explosives 3 shaft ramp area. Four electric blasting caps (very old - may over 5 yrs. Old). Caps have been properly disposed of.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1090803** **EX** **29-Apr-06** **Inco Ltd. - Coleman Mine**

Incident:

Employee noticed a cap lying along the right hand side of the cap mag under the floor boards of a decommissioned fuse magazine. Removal of the wall and some floor boards and inspected the area further, finding 12 caps and a booster. The explosives were returned to proper magazines.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1091681** **EX** **20-Apr-06** **Inco Ltd. - Garson Mine**

Incident:

The nonel fuses were forgotten on surface. The nonel were still in their original package and crate. No injury or damage. The fuse couldn't be sent underground due to an extended maintenance to the shaft and forgotten on surface. The crew were all given a personal contact as to deliver the nonel underground without delay.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1093752	EX	13-Jul-06	Inco Ltd. - Coleman Mine

Incident:

Perils of amex were discovered when a valve was removed from the tank of a bulk loader. No injuries or damage. Bulk loader was parked in the wash bay when a mechanic removed the valve of the bulk loader and discovered a small amount of amex that had not been washed out of the valve. The amex was returned to the proper magazine and the tank and valve were properly washed.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093066	EX	18-Apr-06	Inco Ltd. - Coleman Mine

Incident:

Mishandling of explosives.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093472	EX	13-Jul-06	Inco Ltd. - Coleman Mine

Incident:

Bulk loader being sent for servicing. While it was in wash bay, the valve at bottom of tank was removed and some explosive poured out. Explosives taken to powder storage and tank finished being washed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090806 EX 05-Apr-06 Inco Ltd. - Copper Cliff North Mine

Incident:

An electric explosive blasting cap was discovered with a bag of domestic garbage in the surface headframe. The cap and garbage were brought up from 1400L station. No injuries or damage. The electric cap was brought to the 2400L fuse magazine and properly stored. The garbage was inspected and no additional explosive materials were found.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090632 EX 30-Apr-06 Inco Ltd. - Coleman Mine

Incident:

11 old nonel caps were found in what used to be a fuse magazine/electrical storage shed. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093063 EX 04-Dec-06 Inco Ltd. - Copper Cliff North Mine

Incident:

Exterior building cladding containing asbestos was exposed during renovation of the surface mobile garage parts room. The area under renovations was sealed off and access restricted. A company equipped in asbestos clean-up was brought in to clean the area which was suspect to contamination.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088532 **EX** **22-Mar-06** **Xstrata - Craig Mine**

Incident:

The detonator had what appeared to be indications of heating and a small hole on one side but failed to detonate. No injuries, no damage. The defective detonator will be given to Orica for failure analysis.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088197 **EX** **18-Mar-06** **Inco Ltd. - Stobie Mine**

Incident:

Seven cases of nonel fuses on a pallet were stored into a development explosive magazine. No injury or damage. The pallet was moved away from the fuse magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1092528 **EX** **03-Oct-06**

Incident:

Mishandling of explosives. Worker was in the refuge station near the end of his shift when he noticed a 12" to 16" piece of B-line on a shelf where they store their tea and coffee. Worker returned the piece of B-line to the magazine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090613 **EX** **19-Apr-06** **Inco Ltd. - Garson Mine**

Incident:

Electric detonators left unattended in surface yard.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101154 **EX** **13-Oct-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

Kidd Mine gas check team reported a sulphide blast (low to moderate sulphide area). A secondary sulphide dust explosion occurred which caused melting of the front of the vent ducting.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103437 **EX** **27-Dec-06** **Inco Ltd. - Coleman Mine**

Incident:

Two electrical blasting caps were found improperly stored.

Cause:

None given.

Preventative Action:

The blasting caps were returned to proper storage.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1103379 EX 18-Dec-06 FNX Mining Inc. - Podolsky Mine

Incident:

A worker discovered five explosive cartridges in the ditch along the whistle pit ring road between the Podolsky rear gate and the explosive magazine. He returned to the scene the next morning with a 6-man crew and they found one more.

Cause:

A worker failed to secure the cartridges in the proper magazine.

Preventative Action:

All workers have been instructed again on the procedures for transportation and storage of explosives. The worker was verbally warned and the mine manager held meetings with all crews regarding the seriousness of this incident.

Event ID: 1108769 EX 16-Dec-06

Incident:

A gas checker who was travelling in the ramp after a long hole blast came upon a near full case of 75mm stick powder.

Cause:

None given.

Preventative Action:

The powder was picked up and returned to the nearest powder magazine for proper storage.

Event ID: 11005809 EX 29-Dec-06 Inco Ltd. - Creighton Mine

Incident:

During a blast, approx. 300 tons of backfill material failed from the back drift, which is located next to the stope. It was found that the failed backfill was supported with procedure 3. In addition, the backfill appears in layers indicating that quality of this backfill is poor. It should also be noted that a fog occurred previously in this area but was double guard-railed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1105808 **EX** **27-Dec-06** **Inco Ltd. - Coleman Mine**

Incident:

When maintenance mechanics were doing inspection of a chute, they found 2 electric blasting caps.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093741 **EX** **07-Apr-06** **Inco Ltd. - Coleman Mine**

Incident:

Several electric caps were found abandoned in a powder bag. No injuries or damage. Several electric caps were found by SCR in a red powder bag wedged behind a beam at the 3220 loading pocket. Electric caps were returned to proper magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1100189 **EX** **17-Oct-06** **Inco Ltd. - Frood Mine**

Incident:

A scissor lift with explosive on it was left unattended in the garage on 1200 level. The operator drove the scissor lift to the garage with some explosives on it then went to do other chores. When an electrician discovered the scissor lift, arrangements were made to return the powder. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089477 **EX** **22-Feb-06** **Inco Ltd. - Coleman Mine**

Incident:

Doing tour - found nonel electrical cap on side of drift. Tube was damaged, only part of tube left.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094371 **EX** **10-Dec-06** **Lac des Iles Mine American**

Incident:

A stope blast of approximately 30,000 tonnes was initiated. The underground supervisor identified the pillar had some failure.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099627 **EX** **10-Nov-06**

Incident:

Worker at the Onaping landfill site had emptied a refuse container from the mine and noticed 6, 4 meter Nonel detonators. No injuries or damage. Incident will be reviewed at all sites along with review of procedure for the handling of refuse at cap magazines.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101133 **EX** **22-Sep-06** **Agrium - Agrium Inc. Pit**

Incident:

A cut off occurred in a blast pattern. 6 rows of blast holes (approx. 60 holes) did not fire as planned. All unnecessary personnel and equipment are being kept from the area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101402 **EX** **21-Sep-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Careless act of placing an explosive. 6 tapeviews were placed in a power magazine on the 690 levels. The explosives have been removed and put in proper storage. Instructed the employees to not touch the explosives.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095136 **EX** **08-Jan-06** **Inco Ltd. - Stobie Mine**

Incident:

Found remnants of stick powder explosives and b-line in the surface load out stockpile and it was just remnants and no actual pieces and no detonators were found at the time.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096275 EX 27-Jul-06 Inco Ltd. - Coleman Mine

Incident:

Mishandling of explosives - found bailer bag with approx. 1/2 cup remnants on ground. Employees discovered a small bailer bag at the 3370 shaft station with a residual amount of anfo explosive left inside, approx. 1/4 cup. Explosive bailer bag containing a small amount of anfo explosive. No injuries or damage. The anfo explosive was properly disposed in the

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099910 EX 18-Oct-06 Inco Ltd. - Frood Mine

Incident:

Careless handling of explosives. A scissor truck with explosives was parked in a garage - somebody possibly moved it from location.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099082 EX 09-Sep-06 Xstrata - Kidd Creek: Metside Copper

Incident:

Furnace slag explosion at the outlet of CL slag furnace. No major injuries - one worker complaining of headache.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086814 EX 01-Feb-06 Inco Ltd. - Coleman Mine

Incident:

A single 4' stick powder (32MM x 1200MM) was found on the bed of 814 scissor truck. No injuries or damage. The supervisor was notified and powder was immediately returned to 4810 level powder mag.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086527 EX 01-Jan-06 Xstrata - Smelter

Incident:

Worker had just opened the south tap hole with a lance into a new launder. The matte started flowing down the launder and came in contact with some wet releasing agent and caused an explosion which blew molten metal out of the chute towards worker and blew the fibre board onto the platform. Worker was wearing all the proper aluminized protective equipment which helped prevent any major burns due to the flying matte. Worker got two small burns to his right ear. Review this accident with all crews and reinforce the importance of inspecting the launder for any signs of moisture before

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098451 EX 30-Sep-06 Inco Ltd. - Stobie Mine

Incident:

3 short pieces of b line (blasting line) were found on muck pile underground. Pieces were from 6 inches to foot long and were placed in proper powder

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1098453	EX	30-Sep-06	Inco Ltd. - Stobie Mine

Incident:

Mishandling of explosives. It was found that 3 balongne apex packs fell down below in the scoop onto the VR muck pile. One of the water gel packs was retrieved. There are still 2 on the left side of the pile. Caller figures that they will disintegrate.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1102366	EX	26-Sep-06	Hemlo - David Bell Mine

Incident:

A bundle containing 18 3 meter long blasting caps were discovered at loading pocket.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1087200	EX	03-Jun-06	Inco Ltd. - Copper Cliff South Mine

Incident:

Found old powder at 1750 L. Magazine was abandoned and not properly cleared out. Explosive have been removed to a normal powder magazine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101397 EX 13-Sep-06 Inco Ltd. - Copper Cliff Smelter

Incident:

A crane operator was in the process of picking up a pot of slag. His bails just touched the ladle 478 when there was an explosion, causing first layer of the front bottom window to shatter on #5 crane, also kicking off the power. The ladle #478 was used to haul damp quench cleaning material to there west end at the start of the shift - 7:30 p.m. The explosion incident happened at 9:30 p.m. No injuries.

Cause:

None given.

Preventative Action:

The quench cleaning material will no longer be routed through the converter main aisle until there is a safe means of doing so without a reoccurrence.

Event ID: 1086797 EX 01-May-06 Xstrata - Kidd Creek; Deep 7000

Incident:

Five boosters (explosives) were found in ramp. Properly stored by area lateral development contractor. Investigated and properly stored boosters in power mag.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098882 EX 09-Jul-06 Inco Ltd. - Creighton Mine

Incident:

The 4494 slot-slash panel crown blast was fired. This blast was larger than recent crowns. Blasted early due to abnormal peeling of the ore alongside a previously filled apnel. Approx. 1350 tons of ore fell into the stope included shotcrete from the pillar between this double-sill blasting horizon.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089575 **EX** 29-Mar-06 Inco Ltd. - Creighton Mine

Incident:

Powder bag returned to surface. 4 sticks of Epex super 3000 found in empty bag. Explosives returned to underground storage. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088886 **EX** 27-Mar-06 Inco Ltd. - Frood Mine

Incident:

One stick of powder fell off the vehicle transporting the powder. No injury or damage. The explosives were returned to the powder magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089534 **EX** 26-Mar-06 Inco Ltd. - Stobie Mine

Incident:

During top sill inspection, a box of nonels was found 10 feet away from the powder. No injury or damage. The nonels were left into the stope from the previous shift who were loading the panel. The box of nonel was returned to the cap magazine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086793 EX 02-Oct-06 Pele Mountain Resources

Incident:

Police Constable notified MOL of unattended explosives found near Debeers Victor Mine Project (Attawapiskat).

Cause:

None given.

Preventative Action:

None given.

Event ID: 1052116 EX 02-Jul-06 Lac des Iles Mine American

Incident:

Supervisor was checking scaling face - hit un-detonated cap with scaling bar. It exploded and sprayed rock into his face. 1st aid injury - no injury to eyes - worker was wearing safety glasses. Has several pock marks on face. Worker still at work. Investigation underway.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098449 EX 25-Sep-06 Inco Ltd. - Garson Mine

Incident:

A nonel blasting cap hanging from hook inside the latrine was discovered. The chock cord appeared to have been cut making the cap inappropriate for use.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088080 EX 19-Jan-06 Inco Ltd. - Creighton Mine

Incident:

1 x 10' tape fuse was found on the top of a vent door on 1040 level in Creighton's #3 shaft area. No injuries or damage. Tape fuse was immediately returned to the nearest magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086990 EX 02-Jul-06 Agrium - Agrium Inc.: Pit

Incident:

Misfire was discovered. All personnel and equipment were immediately removed from area. Location of hole was marked and roped off to restrict access. Exact location of hole was surveyed and recorded. Misfire was destroyed today following all procedures and regulations.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087193 EX 17-Feb-06 Inco Ltd. - Copper Cliff South Mine

Incident:

1 electric cap was found resting on a rock bolt at the 1500 level shaft station. No injuries or damage. The procedure for mishandling of explosives was followed and the electric cap was returned to the fuse.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087189 EX 02-Jan-06

Incident:

Mishole on lower left wall in drift going into 1300 panel. Powder has been removed and returned to powder mag.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088712 EX 02-Jan-06 Inco Ltd. - Creighton Mine

Incident:

Several sticks of powder were found mixed in with the sandfill along the wall in 1300 bottom sill drift. No injuries or damage. A section of shotcrete had peeled off exposing the stick powder. The procedure for mishandling of explosives was followed and the sticks were returned to the powder mag.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1085180 EX 30-Jan-06 Williams - Williams Mine

Incident:

While two employees were completing an inspection on a Cobra tractor, they noticed a cone pack (explosives) in behind a muck berm that was being used along with a fenced control access to an unused ore pass. The explosive pack was immediately returned to underground storage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087188 **EX** **24-Jan-06** **Inco Ltd. - Creighton Mine**

Incident:

1 electric cap was found in an abandoned fuse mag. No injuries or damage. Proper mishandling of explosives protocol was followed and electric cap was returned to proper storage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086693 **EX** **01-Mar-06** **Inco Ltd. - Frood Mine**

Incident:

While travelling up the ramp with his jeep, an employee found a 25 kg. case of minerite2 on the side of the road. No injury or damage. The case of Minerite2 fell off the load in the delivery process. The supervisor was notified right away and instructed to return the powder to magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088079 **EX** **20-Jan-06** **Inco Ltd. - Creighton Mine**

Incident:

Found 1 electric cap tucked in behind screen. No injuries or damage. Proper notification was followed and electric cap was immediately removed and placed into proper storage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087185 EX 01-Apr-06 Inco Ltd. - Copper Cliff South Mine

Incident:

A Toro scooptram was damaged after the initial blasting of 7410 VRM block. The scoop was parked in the 7410 VRM bottom sill access on 3700 level due to mechanical failure earlier in the shift. The scoop remained parked there for the remainder of the shift. A VRM was blasted at shift end, burying the front section of the scoop. The front half of the scoop is buried with muck. No injuries. Damage to scoop to be assessed upon retrieval. Access restricted to area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086981 EX 19-Jan-06

Incident:

Supervisor instructed his drift leader to drill and blast a drift round in 6500 level 806-DD (high sulphide area). Leader completed drilling the round and crew loaded and got ready to blast. Crew made their last checks. They used only one atomizer, did not wash the draft for 150 ft back and used 150 ft of B-line to connect to their blasting cap.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087022 EX 17-Jan-06 Xstrata - Smelter

Incident:

While adding Fesi to #8 slag cleaner, they had a small explosion. #8 taken off-line to investigate.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087187 EX (F) 16-Jan-06 Inco Ltd. - Creighton Mine

Incident:

During cleanup / housekeeping in the lunchroom area and repositioning a large steel cabinet that had been displaced by a recent blast, a box containing two electric detonators was found by the crew. No injuries or damage. Those detonators were immediately returned to the correct magazine and the protocol for mishandled explosives was followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086954 EX 01-May-06 Inco Ltd. - Creighton Mine

Incident:

Two industrial mechanics discovered three electric detonators within a box (original package) at the 7400L chute. No injuries or damage. The detonators were left there from prior blasting at the chute. The electric detonators were immediately transported to a proper storage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087183 EX 01-May-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Damage to the windshield of 9965 jeep occurred from concussion of a blast. Concussion originated from a shot placed in 6860 stope bottom sill on 3540 level. Concussion from the secondary blasting shot in the VRM panel lifted the hood of jeep and broke the windshield. No injuries. Hood dented and front windshield broken on equipment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088707	EX	03-Feb-06	Inco Ltd. - Frood Mine

Incident:

While performing initial check of workplace, employee found a powder bag containing 42 electric blasting caps. The electric blasting caps were in a blue powder bag underneath a chunk. They appeared to have been there for a considerable amount of time. No injury or damage to equipment. The electric caps were returned to a fuse magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1085178	EX	23-Jan-06	Lac des Iles Mine

Incident:

Workers were blasting a rock knob off the north end of the 425-08 pattern which is in the northeast end of the pit directly above the underground portal. This knob had an open face to the west in the direction of the portal infrastructure so they took all available precautions and moved the mobile equipment out of the area before the blast. With the blast being approx. 100M horizontally to the east of the portal and the fact that they were confident that other than some small rocks potentially landing in the area, everything else would be fine. When the blast was fired, there was an unexpected amount of rock that blew straight out from the open face of the blast to the west, which caused the 4160 cable and other equipment in the portal area to be damaged. The electrical cables will be moved into the raise as soon as it is ready. There will be no further need to have the equipment there once the incline is completed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

FG – FLAMMABLE GAS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101406 **FG** **21-Sep-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Methane gas encountered while diamond drilling. Standard methane procedure was followed, proper signs posted on barricade, and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090804 **FG** **29-Apr-06** **Inco Ltd. - Garson Mine**

Incident:

Methane was intersected at the face while drilling on 5050 level in the #11 remuck off the main ramp. Four tests were done in the atmosphere of the drill and no methane was detected at the collar of the hole. Every 4 hours a test was taken.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093317 **FG** **30-May-06** **Inco Ltd. - Garson Mine**

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093324 FG 06-Jul-06 Inco Ltd. - Garson Mine

Incident:

Flammable gas is present. The diamond drill intersected methane on 4950 level at #9 remuck. No injury or damage. Test was done in the atmosphere. The area was guarded with signs, drill was not operating, foreman notified.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093323 FG 06-Jul-06 Inco Ltd. - Garson Mine

Incident:

Methane gas was interested on 5000 level in the east side cut out. No injury or damage. The area was tested and the levels of methane were recorded as listed above. The area was guarded with signs, drill was not operating, foreman notified. The area was not cleared at the time of reporting and diamond drilling was not resumed. The area will be monitored during the shift while work is carried out on the level in other areas where the workers were made aware of methane.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093328 FG 06-Aug-06 Inco Ltd. - Garson Mine

Incident:

Diamond drill intersected methane. No injury or damage. The methane procedure was followed and notification was made. The area was guarded with signs, drill was not operating, foreman notified. The hole was still emitting methane at 4:00 p.m. and drilling did not start. Further monitoring will be carried out on the next shift.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093720 FG 19-Jun-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Water gushed out of drill hole while diamond driller was drilling on hole 118444 (-37 deg.) at a depth of 620 feet. Conditions normal with no cracks or fissures in the rock mass. No injuries or damage. Methane gas encountered while diamond drilling. Standard methane procedure was followed, proper signs posted on barricade, and compressed air blowing at

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093332 FG 20-Jun-06 Inco Ltd. - Garson Mine

Incident:

The diamond driller intersected methane. The methane was intersected by an Inco drill. No injury or damage. The area was guarded with signs. Drill was shut down. The area was not cleared during the shift reporting and further monitoring will continue.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093728 FG 21-Jun-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller encountered methane gas while drilling on hole 118457 (-45 deg.) at a depth of 207 feet. Water gushed out of the diamond drill hole. Conditions normal. No cracks or fissures in the rock mass. No injuries or damage. Standard methane procedure was followed, proper signs posted on barricade.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094653 **FG** **26-Jun-06** **Inco Ltd. - Garson Mine**

Incident:

The development driller intersected methane while drilling a lifter hole in #4 west on 5100 level. No injuries or damage. The area was guarded, the drill was shut down.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101174 **FG (F)** **12-Jun-06** **Agrium - Agrium Inc: Mill**

Incident:

Welder performing hot work on the ball mill classifier noticed small puncture on his oxygen line, likely caused by slag. A small fire had ignited which was immediately extinguished when a second worker assigned to that job shut the gauges on the oxygen & acetylene bottles.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101399 **FG** **19-Sep-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Methane gas encountered while diamond drilling. Diamond driller noticed an odour associated with flammable gas while drilling. No injuries or damage. Standard procedure was followed. Proper signs posted on barricade, and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091849 FG 30-Apr-06 Inco Ltd. - Garson Mine

Incident:

Methane was intersected at the face while drilling. The power of the drill was shut down and foreman was notified. The area was double barricaded c/w signs, work stopped at the diamond drill station and methane procedure was followed. The area will be monitored for the next working shift. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101921 FG (F) 29-Oct-06 Xstrata - Kidd Met Site

Incident:

A leaking gas coupling caught fire while casting jumbos in the zinc casting plant. The gas line was shut down and flames extinguished with a portable fire extinguisher. No injuries or equipment damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1100856 FG 11-Jan-06 Inco Ltd. - Garson Mine

Incident:

Methane was intersected. Diamond drill equipped with a XAM 3000 methane detector. Hite methane on hole. No methane concentration in the atmosphere. The reading at the collar of the hole was 1.20%. No injury or damage. The area was cleared and work resumed at that time. All procedures were followed and the area was deemed safe.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1100857 FG 11-Feb-06 Inco Ltd. - Garson Mine

Incident:

Diamond drill intersected methane while drilling. The drill was drilling a hole. No injuries or damage. The area was cleared and work resumed at that time. All procedures were followed and the area was deemed safe.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101327 FG 08-Nov-06 Inco Ltd. - Garson

Incident:

Jumbo drill intersected methane gas while drilling a test hole. Jumbo was drilling a test hole when they encountered some methane gas at depth of 30 feet. No injuries or damage. Area barricaded off and all procedures

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102462 FG 11-Aug-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Methane gas occurrence noticed during diamond drilling operations. No injuries or damage. Ventilation department was notified and the standards procedure for flammable gas was followed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101297 **FG** **(F)** **11-Aug-06** **Inco - Garson Mine**

Incident:

Diamond drill intersected methane gas while drilling on the east diamond drill station #4. No injuries or damage. All procedures were followed until the area was deemed safe for drilling.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102656 **FG** **08-Dec-06** **Vale Inco - Garson Mine**

Incident:

Flammable gas. Methane came out from a hold that had intersected methane at 350' and had been cleared. The drill was actually drilling in another hole in the same drill station when methane was noted be bubbling from the idle hole. No injury or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102978 **FG** **12-Dec-06** **Inco Ltd. - Garson Mine**

Incident:

A contract development driller using a jumbo drill intersected methane gas while drilling the first hole in #1 west on 5100 level. No injuries or damage. The hole was tested and the level of methane was recorded. The area was guarded, the drill was shut down and the foreman was notified. The area was cleared with no methane present in the atmosphere and at the hole.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101759 FG 13-Nov-06 Inco Ltd. - Garson Mine

Incident:

Diamond drill intersected some methane gas in a hole. No injuries or damage. The area was barricaded and monitoring will continue until cleared. All procedures were followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101761 FG 22-Nov-06 Inco Ltd. - Garson Mine

Incident:

Diamond drill intersected methane gas while drilling a hole. The diamond drill was equipped with a continuous monitoring detector. No injuries or damage. Proper procedures were followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094110 FG 08-Feb-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Water was noticed bubbling out of a drill hole in the face of 4680 downramp with a strong smell usually associated with methane gas. Methane gas occurrence while development drilling on the face of 4680 downramp. No injuries or damage. Corrective measures taken: the standard methane procedure was followed, proper signs were posted, the area barricaded off and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089480 FG 27-Feb-06 Inco Ltd. - Creighton Mine

Incident:

In the process of drilling a diamond drill hole, methane gas was intersected. The operator noticed an odour associated with methane and immediately shut down the drill. Contacted the supervisor and took the necessary action. No injuries or damage. Followed all required procedures / precautions in regards to dealing with flammable gas occurrence.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086971 FG 01-Jun-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole number 117438 (-51 deg.) at a depth of 320 feet. No injuries or damage. Hit methane while diamond drilling. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing on the collar of the hole.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087704 FG 01-Jul-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole number 117460 (+17 deg.) at a depth of 250 feet. No injuries or damage. Hit methane gas while diamond drilling. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing on the collar of the hole.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087408 FG 01-Jul-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole number 117438 (-51 deg.) at a depth of 371 feet. No injuries or damage. Hit methane gas while diamond drilling. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing on the collar of the hole.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088007 FG 15-Jan-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Development miner noticed an odour associated with flammable gas while working in the down ramp heading. No injuries or damage. Methane gas occurrence while drilling on face with jumbo. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing at the crack.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088371 FG 21-Jan-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole. No injuries or damage. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088370 FG 21-Jan-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Methane gas encountered in drilling diamond drill hole. Standard methane procedure was followed - proper signs posted on barricades and compressed air blowing at the collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088372 FG 25-Jan-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087243 FG 26-Jan-06 Inco Ltd. - Garson Mine

Incident:

Encountered methane in the face of a jumbo drift round. A hole on the left side of the face above the knee hole was spraying water as well as a knee hole on the right side. The jumbo was shut off as soon as the methane was discovered and the area was barricaded off. The fan was left running to ventilate the area. No injury or damage to equipment. As per the methane procedure, the drilling operation was stopped, the area barricaded and vented. Monitoring will continue until the area clears.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087135 FG 28-Jan-06 Inco Ltd. - Garson Mine

Incident:

The jumbo operator was drilling perimeter holes when he heard a hiss followed by a bang. The area was cleared and a reading of 1.15% methane was obtained at about 20 feet behind the jumbo. Cleared the area immediately, shut the power off to jumbo and increased the flow of ventilation at the face. No injury or damage. The methane procedure was followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087598 FG 30-Jan-06 Inco Ltd. - Garson Mine

Incident:

Encountered some methane while drilling a diamond drill hole. No injury or damage. Work was stopped at the diamond drill station. Area was double barricaded with the proper signs and methane procedure followed. The area will be monitored on the next working shift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091844 FG 23-Apr-06 Inco Ltd. - Garson Mine

Incident:

The diamond drill operator noticed that the buzzer on the methane detector was on when he arrived to the 4950 diamond drill station. No injuries. The area was guarded with sign, foreman notified and work suspended in the

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089476 FG 21-Feb-06 Inco Ltd. - Copper Cliff South Mine

Incident:

While diamond drilling, diamond driller noticed an odour associated with flammable gas while drilling on hole. No injuries or damage. Methane gas occurrence while diamond drilling underground. Standard methane procedure was followed, proper signs posted on barricade and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091841 FG 19-Apr-06 Inco Ltd. - Garson Mine

Incident:

Methane was intersected by a diamond drill. No injury or damage. The foreman was notified and the area guardrailed off. The area will be monitored until cleared.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087197 FG 03-Jan-06 Inco Ltd. - Copper Cliff North Mine

Incident:

ITH driller reported an unusual smell while drilling on top sill. No injuries, no damage to equipment. Possible methane gas occurrence while drilling stope with in-the-hole drill. The area was subsequently investigated by the vent dept. using a TMX gas detector (2). There was no methane gas found in the atmosphere, no methane gas found at the hole, no unusual smell. Tests for gases were conducted throughout the drilling operation. There were no unusual gas smells detected at any time. Driller was left with a gas monitor and instructions to leave the area, properly barricade and advise supervision if any further gas occurrences developed. The area is very well ventilated, with fresh air and the driller is confident that he would be able to safely follow proper procedures should another gas occurrence develop.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087196 FG 03-Jan-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on hole. No damage to equipment. Analysis of occurrence: methane gas occurrence during diamond drilling. Standard methane procedure was followed - proper signs posted on barricade and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087203 FG 03-Aug-06 Inco Ltd. - Copper Cliff South Mine

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087217 FG 16-Mar-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Worker noticed a smell usually associated with flammable gas. No injuries or damage. Standard methane procedure was followed - proper signs posted on barricade, and compressed air blowing at the hole collar. Work is stopped until the general atmosphere readings returned to zero and hole will be grouted upon completion.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087893 FG 16-Mar-06 #3 Shaft

Incident:

Crew noticed a rotten egg smell coming from hole. Tests were made of the work site environment and methane was detected in concentrations of +5%. Hydrogen sulphide levels were also measured and were undetectable. Measures were taken to eliminate the gas by allowing the drill water to flush to hole overnight. The crew ceased all work and entry to the area was appropriately barred. Further testing will follow.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088531 FG 21-Mar-06 Inco Ltd. - Garson Mine

Incident:

A diamond drill encountered some methane at a face in number 11 remuck. Drill kicked out / power shut down.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089915 FG 04-Oct-06 Inco Ltd. - Garson Mine

Incident:

Flammable gas is present in a workplace in an underground mine. Area was double barricaded with signs. Work stopped at diamond drill station and methane procedure was followed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090286 FG 13-Apr-06 Inco Ltd. - Garson Mine

Incident:

Flammable gas is present. Supervisor was notified a double barricade was installed with signs and work was stopped in the area until cleared.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090503 FG 17-Apr-06 Inco Ltd. - Copper Cliff North Mine

Incident:

While diamond drilling, operator encountered the presence of methane gas at the collar of the hole. The D.D. personnel notified the supervisor and implemented the standard practices for a methane gas occurrence. Proper procedures were followed when operator encountered gas. The area was guard railed off and the auxiliary ventilation system was activated. Area was tested for presence of methane gas.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1092176 FG 04-Mar-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed water gushing from hole collar while drilling. Caused by a small pocket of gas. Standard methane procedure was followed, proper signs posted on barricade and compressed air blowing at the hole collar. Hole will be grouted upon completion.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089475 FG 20-Feb-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Diamond driller noticed a smell usually associated with flammable gas while drilling on diamond drill hole. No injuries, no damage. Standard methane procedure was followed, proper signs posted on barricades and compressed air blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

HS – HOISTING

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1101758	HS	11-Dec-06	Xstrata - Nickel Rim South Mine

Incident:

Sinking bucket chain pin failure. During the mucking cycle, it was noted by the deckman and mechanic that as the bucket was returning down from the dump, it was not hanging plumb. They stopped the bucket at the collar for inspection. No injuries or damage resulted from this incident.

Cause:

It was found that one bucket chain attachment pin had failed. The incident is under investigation with mining and engineering personnel.

Preventative Action:

The bucket was removed from service. The pin was changed and a full inspection performed on the other two attachment points and chains

Event ID:	1095017	HS	16-Jul-06	Norman Mining Project

Incident:

When raising the cryderman clam wit the electric winch, the winch gearbox mounting brackets (base of gearbox) broke, causing the gearbox and electric motor to become free and allowing the cryderman clam to fall approx. 5 to 6 feet onto safety doors on #5 deck. No injuries.

Cause:

None given.

Preventative Action:

Cryderman secured onto galloway. Engineer to assist in investigation and implementing remedial actions.

Event ID:	1093767	HS	26-Jul-06	Inco Ltd. - Copper Cliff South Mine

Incident:

Contractors were in the process of installing a metal support plate (30" x 10" x 3/4") in the headframe skip compartment. While manually handling the plates, one of the plates fell down the shaft cage compartment and caused damage to a shaft guide. No injuries. 1 shaft guide was damaged.

Cause:

Contract employees were manually handling a metal support plate in the skip compartment of the shaft headframe. The plate slipped while being handled and fell down the shaft cage compartment side. The plate caused damage to 1 shaft guide and became wedged in the compartment timbering

Preventative Action:

A shaft inspection was performed and the damaged guide was replaced. Contractor has changed their procedure for handling the metal plates. They are now installing handles on all the plates and tying the plates off before installation or handling in the shaft headframe.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1094665	HS	08-Aug-06	Inco Ltd. - Creighton Mine

Incident:

The cage was travelling down the shaft to 5400L. The cage inadvertently stopped at 2100L elevation. The dogging mechanism engaged and the cage tender fell to the floor. The shaft compartment and rope were inspected and found to be in good order.

Cause:

The problem was identified to be the pilot pressure leak to "S" valve on the weight brake.

Preventative Action:

Hoisting specialists performed troubleshooting of problems and corrected the problem by re-fastening the pilot valve and tightening the air lines to the valve. Testing was completed at full speed and hoist returned to normal use. Repairs were made to the hoist controls through consultation with ABB.

Event ID:	109744	HS	09-Jan-06	Inco Ltd. - Creighton Mine

Incident:

#4 skip was travelling up the shaft with a full load and the hoist tripped. The skip rolled back down the shaft approx. 40 ft. before coming to a complete stop. No injuries or damages.

Cause:

The cause of the rollback was determined to be the programming of the regulated braking system which did not provide immediate and secure stopping of the hoist.

Preventative Action:

Changes were made by ABB in the programming of the regulated braking system that will greatly reduce the rollback during emergency braking in low speed and high load conditions.

Event ID:	1095987	HS	13-Sep-06	Xstrata - Kidd Creek: Deep 7000

Incident:

Hoist incident involving ABB hoist controller automatic feature. Hoist moved inadvertently.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 096500 **HS** **18-Sep-06** **Kirkland Lake Gold Inc.**

Incident:

Hoistman attempted to raise conveyor but noticed amp metre was over amping and stopped. When conveyance initially hit the chain, the skip tenders reported hearing a loud bang and loading pocket shook. Skip tenders climbed down to inspect damage and found chain beam twisted. A split guide (south) and cage was against the timber at the back of the shaft.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101428 **HS** **19-Oct-06** **Inco Ltd. - Coleman Mine**

Incident:

Knife (part of skip that slows the skip down should it go into the arresters. Similar to dogs on a conveyance) on skip made contact with old remnant section of crash beam. Conditions normal. No injuries. Knife broken off, hose for skip damaged, electrical connections broken. Corrective measures taken: Cut off piece of steel protruding into the shaft.

Cause:

One of the guide wheels was out of alignment causing the knife to make contact with a crash beam in the old loading pocket.

Preventative Action:

None given.

Event ID: 1094375 **HS** **24-Oct-06** **Goldcorp Inc. - Red Lake Complex Mine**

Incident:

While hoisting muck, the hoist kicked out due to a power surge. The UPS failed, causing the loss of the control E/stop which caused all the brakes to come on instantly. The rope strands separated slightly in the section between the dolly ball and bail. No damage occurred to the rope. The UPS was changed and work resumed. The UPS was changed. A two foot section of rope was cut.

Cause:

The UPS failed causing the loss of the control E/stop which caused all the brakes to come on instantly.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102479 HS 26-Oct-06

Incident:

During routing EM testing of the #3 hoist ropes, the conveyance inadvertently contacted the flap gates located in the shaft. No injuries and only minor damage to the skip canopy.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102106 HS 27-Nov-06 Xstrata - Nickel Rim South Mine

Incident:

Both hoist motors showed significant visual indications of electrical slash. Hoist kicking out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102447 HS 11-Jul-06 Inco Ltd. - Copper Cliff South Mine

Incident:

The skip hoist malfunctioned but did not stop automatically. The hoist room filled with smoked.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091846 **HS** **29-Apr-06** **Xstrata - Nickel Rim South Mine**

Incident:

The main shaft hoist #1 rope was pinched. Pinch resulted in a number of wire strands being broken. Inspected by maintenance and engineering staff at the site, less than 5% breakage. Returned to service for light duties only, not hoisting muck until EM test is completed. EM test is scheduled for this evening, rope will be replaced if needed - based upon EM test results.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102701 **HS** **(F)** **13-Nov-06** **Xstrata - Kidd Metallurgical Division**

Incident:

There was a fire reported in the cab of a dredger barge. Fire was extinguished. No injuries and no diesel spill and no oil spill to the tailings

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102458 **HS** **14-Nov-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

The cage dogs had engaged. No injuries. Dogging damage to the shaft compartment guides. During the weekly shaft inspection, inspectors noticed the cage dogs had engaged at approximately the 3800 level horizon of the cage shaft compartment at an undetermined time during the previous week. Occurrence under investigation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102463 HS 16-Nov-06

Incident:

Workers were hoisting a piece of equipment underground (crusher area) - hoisting down to a crusher area when the cable broke. It's a 3/4 wire cable. No injuries. Minimal damage to anything.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103225 HS 22-Nov-06 Williams - Williams Mine

Incident:

While changing ropes, a crosby clamp failed. No injuries. Cosmetic damage to the headframe.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102980 HS 13-Dec-06 Inco Ltd. - Stobie Mine

Incident:

The #7 shaft skip hoist over traveled through the track limit. The lower skip traveled down onto the arrestor beams at the loading pocket. The #5 skip lost current and rolled back onto the arrestors subsequently resulting in the upper #4 skip coming to rest 4 feet above the track limit position. No injuries. No damages either to the skip conveyances or the dump, however the track limit cable broke.

Cause:

None given.

Preventative Action:

Hoist specialists have added additional rollback logic protection to actively guard and react to any future rollback situations. Speed tracking fault protection has also been added. The additional rollback logic protection and speed tracking fault protection has been tested. All necessary tests, repairs and inspections have been completed.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1104239 **HS** **20-Dec-06**

Incident:

While performing routine electro-magnetic testing on the #2 south skip ropes, a 1.7 metre section of rope, located approximately 40 metres above the conveyance was noted to be cork screwed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103261 **HS** **20-Dec-06** **Inco Ltd. - Garson Mine**

Incident:

An inadvertent stop of the cage occurred during a routing man trip to the 3800 level. No injuries or damages were reported.

Cause:

A faulty fast brake valve was the cause of the stop.

Preventative Action:

The hoist was temporarily taken out of service and analyzed for deficiencies, the faulty valve was replaced and trial trips were performed. Once proper operation was assumed, the hoist was put back into normal operation. Personnel waiting to go underground were informed of the incident.

Event ID: 1103262 **HS** **22-Dec-06** **Xstrata - Lockerby Mine**

Incident:

An incident occurred in the #1 service shaft when the cage came up with the door down and bent the door in the process. No injuries resulted and the door is still operational.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102105 **HS** **25-Nov-06** **Xstrata - Craig Mine: Skip Hoist**

Incident:

A piece of rock entered a conveyance. They were skipping ore at the time. They stopped skipping, did a trial run and inspected the conveyance. A screen brattice had been pushed. On other damage or injuries resulted from the incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102467 **HS** **31-Oct-06** **Inco Ltd. - Levack Mine**

Incident:

Crew was checking for the problem with the shaft signals. The cage was descending at 30 ft/min. The cage entered into water. They used radio communication to call the hoistman. He pulled the cage up and brought them to surface. There were no injuries and the incident is being investigated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089471 **HS** **18-Feb-06** **Inco Ltd. - Copper Cliff Nickel Refinery: IPC**

Incident:

Employee entered the reactor area elevator on the 3rd floor in order to travel to the 1st floor. He pushed the button to go to the 1st floor and the elevator started. Immediately the elevator stopped and then dropped approx. 4 ft. The employee heard a loud noise which he suspected that "the dogs" engaged. Employee reported to 1st aid with a sore back. Called in Kone Elevator Maintenance to investigate. Tagged out and roped off the

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088880 HS 02-Sep-06 Inco Ltd. - Creighton Mine

Incident:

Master drive skip loop breaker failed causing slave loop breaker to trip on over current. Safety device to interrupt to hoist motor. Master loop breaker severely damaged from arcing. Damage to cell stacks resulting from high voltage ARC. Loop breaker replaced with spare loop breaker. Defective cell stack replaced with spare, changed drive interface card and fully tested system before putting back into service.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088980 HS 13-Feb-06 Inco Ltd. - Creighton Mine

Incident:

Position switch located approx. 245 feet below collar in 5 compartment failed intermittently causing the cage hoist to trip. No injuries or damage.

Cause:

The cage hoist tripped.

Preventative Action:

Switch was replaced and tested prior to the hoist being put back into operation.

Event ID: 1086458 HS 13-Feb-06 Xstrata - Fraser Mine

Incident:

Piece of tight lining dislodged from set and was struck by the skip going by. No damage and no injuries. Skip was inspected and shaft crew replaced the piece of tight lining and the remaining tight lining at the set was inspected and re-secured.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: **1089473** **HS** **15-Feb-06** **Inco Ltd. - Creighton Mine**

Incident:

Cage dogged between collar and sub collar. No injuries or damage.

Cause:

Timber truck caught station matte causing cage to dog.

Preventative Action:

None given.

Event ID: **1089573** **HS** **23-Mar-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Due to a communication error, the hoist operator inadvertently operated the hoist on long balance. The hoist was inadvertently run into the counterweight underwind and contacted the bulkhead at shaft bottom. The conveyance and the rope above the conveyance were inspected in detail. All damage has been repaired. The balance was set properly. Corrective actions were reviewed with all those involved.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1092451** **HS** **04-Mar-06** **Inco Ltd. - Creighton Mine**

Incident:

The hoistman was having trouble with the clutching when it locked up and mtce personnel were called to troubleshoot the reason. Troubleshooting the clutching, the mtce personnel were in the basement and realized an air operated valve was likely stuck in a position that did not allow the clutching mechanism to function properly. The decision to remove the valve and attempt to free it was made and the air supply shut off to the brake panel that contained the suspect solenoid valve. Once the air was bled down, the hoist free wheeled approx. 120 feet until the brakes came on. No injuries or damage. This pressure switch was programmed, tested and a management of change to reflect this programming was written. The hoist was tested and put back into service.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1098885	HS	09-Apr-06	Inco Ltd. - Copper Cliff North Mine

Incident:

Hoistman was lowering #6 skip down the shaft during a routine lengthening out exercise when the skip hoist stopped due to the slack rope detection device being activated.

Cause:

Due to generator settings and adjustment being out of spec, this caused amperage instability. The amperage instability resulted in the skip speeding up and slowing down, which in turn caused it to bounce and the rope became slack enough to trip the slack rope detection device which stopped.

Preventative Action:

Corrective measures taken: 1. Radial adjustment of the brush was conducted. 2. Bus bar adjustments were conducted. This corrective action resulted in unstable amperage and the hoist worked as designed.

Event ID:	1085770	HS	16-Jan-06	Xstrata - Kidd Creek: Metsite Copper

Incident:

Shawbox hoist failure. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1086942	HS	21-Jan-06	Xstrata - Kidd Metallurgical Division

Incident:

Employee was hoisting cathode plates into the dissolving cells when several plates separated from lifting device and fell approx. 3 feet striking her left forefinger causing a laceration.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093331 **HS** **18-Jun-06** **Xstrata - Nickel Rim South Mine**

Incident:

While lowering galloway, crew noticed damage to #3 rope. A 3/8" x 2" piece of chain had travelled around the sheave wheel with the galloway rope. No injuries. The piece of chain was removed immediately. Mechanical site personnel did a visual inspection of the rope. The sheave wheel was inspected and no damage was found. Acuren conducted E.M. testing. Winch rope is acceptable to use and is in service. A detailed action plan will be developed to mitigate a reoccurrence.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087868 **HS** **02-Jan-06** **Xstrata - Fraser Mine**

Incident:

While completing scheduled NDT test on production shat hoist bull gear, several cracks were found in the gear. Initial inspection has identified several cracks in the surface area of the gear. Further analysis of the cracks is required to determine extent and overall condition. Conventional Ingersol Rand hoist. No injuries or damage. Hoist load was restricted. 3rd part has been contacted for inspection analysis and recommendations for repair or replacement of bull gear.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1095241	HS	06-Oct-06	Inco Ltd. - Creighton Mine

Incident:

Cage hoist kicked out with cooling pump problems. Cooling pump was replaced along with flow switch. This did not correct the problem. All 5 employees on night shift were removed from the mine via the skip at 12:30 p.m. No reported injuries or damage. Analysis of occurrence: the hoist drive annunciated a cooling water pump low pressure alarm. The pressure transducer was found to be faulty and was changed. Continued to have problems with various components with hoist drive. Troubleshooting took place until 8:00 p.m. when root cause was determined. Found a cooling water valve (V30) that serves the exciter unit closed - this valve had been left closed inadvertently when the pressure transducer was changed out in the morning. Crews were sent to the refuge stations upon cage hoist initial problems. Hoist specialists performed troubleshooting of problems, and ensured root cause determined prior to putting hoist back into service.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1088474	HS	20-Feb-06	Xstrata - Fraser Mine

Incident:

While doing a hoist rope drum end cut, the rope kinked at 140 meters from the cappel. The mechanics were doing a hoist rope end cut. The conveyance was being double lined down and back to surface. As the conveyance was reaching surface, a kink in the rope was noticed. No injury.

Cause:

Hoist rope kinked due to the location of the kink.

Preventative Action:

The hoist rope is being changed out. Scat will be conducted on incident.

Event ID:	1085182	HS	20-Feb-06	Newmont Canada Limited

Incident:

During removal of the skip hoist, the brake parallel post was prepared for a vertical lift. As the overhead crane was taking the load, the crane cable failed. Crane is a 7.5 tonne shaw-box overhead auxiliary crane, model #DGTR. The approx. weight of the piece being lifted at the time of the cable failure was 3500 lbs.

Cause:

None given.

Preventative Action:

The overhead auxiliary hoist crane was put out of service until such time as the cable is replaced.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088001	HS	23-Feb-06	Xstrata - Thayer Lindsley Mine

Incident:

Broken shaft bell cord entered cage while the cage was traveling down. No injuries. Damaged shaft bell cord. Shaft bell cord was contacted while moving material off of cage. Visual inspection showed the cord to be OK. When the conveyance left the level, the cord broke and fell down the shaft.

Cause:

None given.

Preventative Action:

Shaft bell cord has been replaced.

Event ID:	1086713	HS	24-Feb-06	Inco Ltd. - Garson Mine

Incident:

The cage was on the way down to 3800 level when a noise was heard on the cage. When they arrived at 3800 level, they checked the top of the cage and found a piece of wood. There was no visible damage to the conveyance or to the shaft except for a face plate missing on 1400 level. No injury or damage to cage. They did a trial trip of the cage, counterweights, #3 comp. and #4 compartment. All compartments were free of debris.

Cause:

Upon further investigation, they found that on 1400 level, there was a piece of the face plate missing (at the base of rail, it's part of the apron).

Preventative Action:

None given.

Event ID:	1088972	HS	03-Feb-06	Xstrata - Nickel Rim South Mine

Incident:

The sinking cross-heads chairs at the equipping deck did not activate the sargenson arm and this resulted in the dolly ball/bucket not releasing from the cross-head. The Galloway proving switch did not record the bucket entering the Galloway and tripped the hoist. The proving switch was set to indicate the bucket entered the equipping stage bucket well. The chain installation was slightly miss-aligned. Main shaft sinking hoist, sinking cross head and sinking muck bucket. Production loss only - the proving switch was programmed to indicate bucket entry and exit through the equipping deck. The equipping deck chair was removed, re-installed and tested to confirm alignment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092117 HS 03-Apr-06

Incident:

Inadvertent stopping of conveyance. Main cage "dump" stopped travelling down between 9975 level and 9870 level with 2 personnel in conveyance.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089577 HS 14-Apr-06

Incident:

While attempting to hoist a cottrell hopper in the Indium Plant, a lifting lug failed. The failure occurred immediately upon tensioning the hoist rope, and as a result, the hopper did not fall. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095480 HS 05-Feb-06 Compass Minerals - Sifto Canada Inc.

Incident:

#3 skip, slack rope fault. Skip door jammed in guide causing it to hang-up. Skip taken out of service till investigation and repairs made.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1095479 **HS** **29-Apr-06** **Canadian Salt - Canadian Salt Company**

Incident:

#2 cage overload, overloaded by 2,820 lbs. Case tripped out. A re-set was attempted. Load removed. Conveyance taken out of service for full inspection.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088013 **HS** **02-Jun-06**

Incident:

St. Mary's Cement Co. rented three x two ton electric powered chain hoists. Lifting chains were substituted by supplier to increase lift range from 10 to 40 feet. Employees of the supplier incorrectly assembled the hoists after changing the lift chains from 10' - 40' lift. One hoist failed when lifting a 1300 pound door on the Atox unit. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088083 **HS** **22-Jan-06** **Inco Ltd. - Levack Mine**

Incident:

Removing pipe from service compt. #2 shaft, 14" pipe slung on tugger cable. Cable broke and pipe fell to 2100 ft. level. Minimal shaft damage. Site is secured and they are only doing inspection of shaft at this time.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

IW – INRUSH OF WATER OR MATERIAL

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088881 IW 02-Jul-06 Inco Ltd.-Creighton Mine

Incident:

Worker was in the process of water spraying the face of an accumulation of slimes in #1 sump on 380 level. Although unexpected, an uncontrolled run of slimes occurred, reaching the employee to a height of mid thigh. The face of the slimes was about 7' high and the worker was about 30-35' from the face. No injuries or damage. The water spraying of the slimes will be conducted from an elevated steel platform. Two persons must be present at all times during the water spraying operating. Note: the maximum elevation of the slimes in the sump is 5'. The slimes in the sump are watered down in order to be pumped out instead of mucked out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089472 IW 16-Feb-06 Inco Ltd.-Copper Cliff Smelter

Incident:

A mechanic was waiting to install a crane stop block on the north rail so he could do an inspection on #5 crane. While he was waiting, a large nickel scull slid off of the scrap pile close to where he would have been working.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1092174 IW 29-Mar-06 Inco Ltd.-Copper Cliff North Mine

Incident:

An inrush of water resulted when impounded water was unplugged from the decommissioned crusher water temporarily caused a partial flooding. Access to the area has been restricted.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1101404	IW	23-Sep-06	Creighton Mine - Neutrino Lab

Incident:

Water line broke. Noticed ground was bubbling, water shut off. Contractor that installed the line came in to excavate & exposed broken pipe.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1090501	IW	19-Apr-06	Inco Ltd. - Clarabelle Mill

Incident:

A run of muck occurred. No injuries or damage occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1095240	IW	06-Aug-06	Inco Ltd. - Coleman Mine

Incident:

Water in excess of one cubic meter entered the Coleman Mine shaft. No injuries nor damage. Analysis of occurrence: due to the excessive accumulation of rain in a short period of time, rain water entered Coleman's surface shaft station, eventually making its way into the shaft. Prior to this incident, the area around the shaft had been surveyed. Plans to grade and ditch the grounds around the shaft forcing water to flow into neighbouring ponds and lakes are in progress.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093724 IW 18-Jun-06 Inco Ltd. - Coleman Mine

Incident:

Water in excess of one cubic meter entered the Coleman Mine shaft. No injuries nor damage. Analysis of occurrence: due to the excessive accumulation of rain in a short period of time, rain water entered Coleman's surface shaft station, eventually making its way into the shaft. Prior to this incident, the area around the shaft had been surveyed. Plans to grade and ditch the grounds around the shaft forcing water to flow into neighbouring ponds and lakes are in progress.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093740 IW 29-Jun-06 Inco Ltd. - Coleman Mine

Incident:

A run of muck occurred. Partially burying a haulage truck. A combination of a bypassing air cylinder and a chunk of muck lodged between the arc gate and the chuted caused the door to jam. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101361 IW 11-Apr-06 Goldcorp Inc. - Red Lake Complex

Incident:

Underground diamond driller workers erected a new retention dam to pump water and slimes into. The dam was built on a plank rather than bedrock. The diamond drillers had been pumping slimes and water behind dam for 2 days. When the water level reached 1 foot of height it washed out the muck under the dam wall.

Cause:

Improper construction of dam.

Preventative Action:

Use of dams will be investigated. If use of dams continues in the future, a proper engineered designed dam and procedures will be developed.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1105810	IW	29-Dec-06	Inco Ltd. - Coleman Mine

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1102982	IW	09-Dec-06	Xstrata - Smelter

Incident:

Water entered the slag tunnel when a water valve opened accidentally.

Cause:

Water valve opened accidentally.

Preventative Action:

The valve handle was removed so debris would not strike it.

Event ID:	1104169	IW	18-Dec-06	Xstrata - Kidd Creek - (Lower Mine)

Incident:

A run of slime and water occurred from the 2600 level settling cone, resulting in a multi-level power outage as workers were in the process of unplugging the settling cone. No injuries were reported and the workers retreated to a safe location.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

MM – MOLTEN MATERIALS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1103432	MM	(F)	12-Dec-06	Inco Ltd. - Matte Processing

Incident:

#3 Roaster was started back-up. The bed pressure went to 10.5 and then shot up to 11.2 psi. At that time dust was puffing out of the feed gates on #3 Roaster. The FBR control room operator brought the 15 lbs. Air from 9500 to 8000 SCFM (Standard Cubic Feet per Minute). The dust temperatures were cyclone temp. 1083 and impingement temp 1008. Also the roof pressure alarm came on when the bed pressure reached 11.2 psi. A small fire started at the top of the feed gates from the hot dust that was coming out of the feed gates. The 15 lbs. Air to #3 roaster was shut down immediately by the FBR control. #3 roaster feed belt #126 was started back up in manual and the FBR field operators put out the small grease fire using a hose.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1102977	MM		12-Dec-06	Xstrata - Smelter

Incident:

The skimmer was making his first blow on #6 converter when he noticed that matte started leaking out of the north end bell. He immediately turned the converter down and then back into the blow position to slag in shell. He then turned down the converter and inspected the area where it was leaking. He noticed that the end bell gap was quite different compared to the top of the end bell. Worker took the converter off line until a full inspection could be conducted and the converter springs are re-torqued.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1103130	MM	(F)	20-Dec-06	Xstrata - Smelter

Incident:

The #4 crane was pouring a furnace tap into the #7 converter when a huge fire ball shot out of the converter and reached the crane cab. No injuries to report.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

MS – MISCELLANEOUS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1096490	MS	07-Jul-06	Xstrata - Kidd Creek Mine: #1 Mine

Incident:

A run of unconsolidated backfill aggregate occurred which resulted in partial filling of the 2226 XC and the 2201 DR. NO., north of the ramp access.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093765	MS	22-Jul-06	Inco Ltd. - Clarabelle Mill

Incident:

Process water line from Clarabelle upper pond to Clarabelle Mill developed a leak. Shift coordinator assessed the situation and determined it was leaking from the flange. Booster team leader was called out. He tagged out the pumps and was assisted by tailings patrolman. The leader removed the covering and fibreglass insulation from the top of the flange, and let the fibreglass insulation and covering fall to the ground. He then noticed what looked to be asbestos still around the flange. The job was stopped immediately and the area was roped off. Corrective measures taken: Pipe identification will be corrected. Samples were taken and sent out for proper type classification. Line will be labelled to match the inventory description.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093478	MS	(F)	21-Jul-06	Inco Ltd. - Matte Processing

Incident:

An employee working nearby noted a flame coming from the bearing of #1 rod mill. The rod mill was shut down and the flame self-extinguished.

Cause:

The bearing overheated.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093760 MS (F) 21-Jul-06 Inco Ltd. - Copper Cliff North Mine

Incident:

A contractor received moderate flash burns to right side of neck and face while handling hot liquid tar during repair work to the roof of the mine surface garage and mines research building. While using a pail to transfer hot tar from the tar kettle to the tar hopper, the pail of hot tar flash-ignited. The tar was excessively heated in the kettle beyond the flash point of the tar. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

The temperature gauge on the kettle is suspected of malfunction and/or inaccuracy.

Preventative Action:

None given.

Event ID: 1095095 MS (F) 18-Jul-06 Xstrata - Thayer Lindsley Mine

Incident:

A bolter caught on fire underground. The fire was quickly extinguished and there was nobody trapped underground. One miner was taken to hospital as a precaution to get checked out for inhalation of smoke and dust.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095024 MS (F) 16-Jul-06 Xstrata - Thayer Lindsley Mine

Incident:

An open flame was observed in a battery compartment. Flame was extinguished with a fire extinguisher. No injuries reported.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093474 MS 15-Jul-06

Incident:

Contractor crane is supplied to CMND using a 3/4 inch steel choker. Riggers put choker around steel piece to flip it over. While flipping it over, it gave a shock to the choker and it broke in half. Piece landed on floor. No

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093473 MS 13-Jul-06 Inco Ltd. - Matte Processing

Incident:

Anmar electric removed the conduit on top of #3 / #4 cottrell in the FBR for repair work that was taking place. The flanges were sealed with gasket material. The gaskets had been removed earlier in the week. When a request for new gaskets were made, a piece of the old gasket was found. When the piece was looked at, someone felt it may be asbestos, so it was sent out for testing. The test results showed 50% to 75% chrysotile. No injuries, no damage. Chrysotile asbestos was not recognized and removed.

Cause:

None given.

Preventative Action:

Replaced with a non-asbestos material.

Event ID: 1093734 MS 27-Jun-06 Inco Ltd. - Matte Processing

Incident:

During a lab refurbish, some vinyl flooring containing 0.5 - 5% chrysotile was removed by employees without their knowledge. No equipment used. No injuries or damage. Material to be removed was questioned and tested. Some of the material was previously removed. This material was found to be non-friable asbestos. Continental has been contracted to remove the asbestos contained material.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088229 **MS** **(F)** **07-Oct-06** **Musselwhite Mine**

Incident:

A leather glove had fallen off the scoop tram into the exhaust area. The exhaust system heat caused it to ignite. This fire was minimal due to the scoop being very clean and no build-up of oil or grease around the area. The fire was extinguished using a hand-held fire extinguisher. This was an Atlas Copco 7-yd. scoop.

Cause:

Employees using this scoop displayed poor housekeeping and storing of their gloves.

Preventative Action:

This incident will be reviewed with all crews with the emphasis being put on prevention and proper housekeeping.

Event ID: 1093764 **MS** **(F)** **24-Jul-06** **Inco Ltd. - Matte Processing**

Incident:

A fire was discovered on the top of the cottrell outlet on the 6th floor. A piece of wood found burning was removed along with other combustibles. This piece did not seem to be in contact with any metal and the temp (measured with a heat gun was approx. 120--150 F. The fire was extinguished with the use of a fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096486 **MS** **(F)** **07-Jun-06** **Xstrata - Kidd Met Site**

Incident:

A small smouldering fire was detected on the circulating pump room motor bearing. It appears that the bearing overheated on the motor. An operations worker used a 20lb. ABC extinguisher to ensure that there wasn't any spread of fire. Good work on the part of the worker to take quick action to prevent further spread of the fire.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096487 **MS** **07-Jun-06** **Xstrata - Kidd Creek: Lower Mine**

Incident:

Employee was skipping when he received a high alarm from the #3 head frame ore bin. The employee then switched to manual and brought up remaining muck from the 6200 loading pocket. There wasn't enough void to hold the full volume of the skip and there was a spill of about one wheelbarrow full down the shaft.

Cause:

Operator error.

Preventative Action:

None given.

Event ID: 1096485 **MS** **07-May-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

While skipping, the operator failed to notice that the skip did not cycle. He went to the manual and loaded another 11 tons of top, thus causing muck to go down the shaft. Approx. 4 tons of muck went down the shaft. The #4 production hoist was the equipment being used.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093470 **MS** **07-Apr-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While removing the contents of #1 anode furnace, the shell was rotated to empty the vessel and the entire furnace on west side lifted off the pinion and turned 1/3 rotation then dropped back on the pinion and came to a stop. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096482 MS 07-Mar-06 Xstrata - Kidd Creek

Incident:

054 & 055 Kidd locomotive cars were west bound going to the Kidd Mine to fill 21 empty ore cars. While negotiating a curve at kilometre 29, ore car #24 derailed and was dragged a number of feet until it hit a switch and uncoupled itself from the train. Ore car #33 preceding the derailed car then came in contact with the derailed car and also derailed. There were no injuries to anyone.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094656 MS (F) 30-Jun-06 Inco Ltd. - Frood Mine

Incident:

The operator noticed a small flame while in the process of breaking a chunk. A power cable on the rock breaker was rubbing and shorting out. The short ignited leaking hydraulic fluid. The operator saw a small flame coming from the engine compartment. He shut off scoop and master switch and put out the fire with a hand-held fire extinguisher.

Cause:

Grounded power cable.

Preventative Action:

None given.

Event ID: 1094475 MS 13-Aug-06 Inco Ltd. - Copper Cliff Smelter

Incident:

While the furnace operator was installing #2 burner on #1 furnace, the burner part of the carriage fell approx. 3 ft to the burner platform. The operator was approx. 3 to 5 ft. away on the east side of the burner and a second operator was behind when the burner fell. No injuries or damage to any equipment. Investigate why the swivel bolt backed out of the assembly and repair as required.

Cause:

Preliminary investigation reveals that the bolt at the swivel of the carriage assembly had come out and dropped part of the carriage and burner to the floor.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096493 **MS** **07-Nov-06** **Xstrata - Kidd Met Site**

Incident:

Hydrofluoric acid spill. Approx. 100 litres - HF/lime mixture. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094248 **MS** **08-Mar-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

#630 haulage truck struck and damaged #140 Kubota tractor when backing out of garage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103436 **MS** **12-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While blowing an additional 2 tons of oxygen into the bath of 15 MPV, it was noticed on the monitor that 15 MPV was starting to foam. An emergency burner stop was initiated which in turn rolled the vessel down to safety, resulting in a small spill (1/4 ladle) of molten metal into the slag bay.

Cause:

It appears that some of the bottom build up in west end let go.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1096315 **MS** **(F)** **08-Aug-06** **Xstrata - Smelter**

Incident:

The crane operator heard a strange noise during bridge travel. The operator noticed a large crust had formed. He slowly turned down the converter. The crust did not break. He continued to move the shell up and down. The crust broke, causing molten metal to splash out of the open gas port. A crucible box started on fire and a fire extinguisher was used and replaced.

Cause:

None given.

Preventative Action:

At all times in the future, plug the gas port with clay when trying to break the crust of the converter. Procedure written to break the crust with the linkbelt hammer.

Event ID: 1097848 **MS** **(F)** **08-Jul-06** **Xstrata - Kidd Creek Mine**

Incident:

A conveyor drive belt caught fire and was put out with fire extinguisher. No injuries were reported.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094472 **MS** **(F)** **08-Jul-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

While spreading liquid magnesium on the downramp with a Kubota forklift outfitted with a magnesium spreader, the operator noticed a small flame coming out of the electric motor which runs the magnesium pump. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091705 **MS** **(F)** **08-May-06** **Musselwhite Mine**

Incident:

A 1987 RB-3 Tamrock co-bolter's wiring going to alternator rubbed on alternator pulley and eventually wore out causing a short to occur. There was also an oil and grease build-up that may have contributed to the incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094249 **MS** **(F)** **08-May-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

#3 rectifier for main aisle cranes shorted out and there was evidence of a small fire. Power was off of the crane rails from 4:15-7:30. Method of extinguishment: self extinguished.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090314 **MS** **(F)** **08-May-06** **Musselwhite Mine**

Incident:

An underground Tamrock re-bolter caught on fire when the wiring going to the alternator was rubbing on the alternator pulley and eventually wore out causing a short to occur. There was also oil and grease build-up which may have contributed to the fire. The fire was put out by hand-held fire extinguisher.

Cause:

Wire rubbing on alternator pulley until insulation wore off causing short to alternator. Also build-up of oil and grease in area.

Preventative Action:

Current equipment PM schedule does not include checking of the engine compartment wiring. This will be added to the PM check-list. Correct equipment washing practices do not include the opening of engine hoods and washing of this area. This will be added to the operator's responsibilities in preparing this unit for its weekly PM.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093763 **MS** **(F)** **23-Jul-06** **Inco Ltd. - Clarabelle Mill**

Incident:

Welding on #6 cyclo-pak. They left the area and started to work on #4 cyclo-pak when the fire started on #6 cyclo-pak. Method of extinguishment:

Cause:

Either heat from welding or sparks ignite the rubber lining in the cyclone.

Preventative Action:

None given.

Event ID: 1094247 **MS** **(F)** **08-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

The DCS operator noticed a lot of smoke coming from #2 furnace roof south side. The smoke was coming from oil that had caught on fire. 2 operators and a supervisor used three fire extinguishers to put out the flames. The oil ignited when the craneman was dumping slag into the

Cause:

Oil had been leaking from the hydraulic cylinder for the slag chute door.

Preventative Action:

None given.

Event ID: 1093761 **MS** **23-Jul-06** **Inco Ltd. - Coleman Mine**

Incident:

The #2 chute at the loading pocket failed, resulting in a run of muck which buried the conveyor belt. The anchor bolts attaching the chute structure to the cement bulkhead of the ore bin sheared off causing the chute to separate from the ore bin. No injuries. Damage to loading pocket #2 chute. The failure is under investigation. Loading pocket operations have been suspended. Access to the area has been restricted.

Cause:

The anchor bolts attaching the chute structure to the cement bulkhead of the ore bin sheared off causing the chute to separate from the ore bin.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1097849	MS	08-Feb-06	Kidd Metallurgical Division

Incident:

The operators were removing ACI zinc catalyst 1 tons super sacks from a sea container. The super sacks were double stacked and not on pallets. The operator used the lifting attachment to remove the super sack. The operator checked the engineering jib quickly and didn't notice that the bolt on the Crosby clevis was not screwed in all the way. The top bag fell off. No injuries were reported.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1094109	MS	08-Jan-06	Inco Ltd. - Copper Cliff Smelter

Incident:

The lower spool outlet on the dust shooting tank was plugged. The spool was spun open a little so it could be cleaned. Operator removed various objects at outlet EI. Analysis of occurrence: first pulling of dust post shutdown work with high humidity causing heavy a fuel dust to hang up in tank with lighter C field dust behind. Correctives measures taken: 2 operators used SCBA to enter cottrell area and close doors. Workers who were captive on screw floor and lunch room because of the spill were removed by snorkel lift. Review of dripping bin procedure. Improve sealing building shooting tank room.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093769	MS	(F)	31-Jul-06	Inco Ltd. - Matte Processing

Incident:

Approx. 30' of 6" vacuum hose was burned and two other sections of hose (20') the inner line was damage. Vacuuming of the cyclone dust bin was ongoing but due to upset conditions in the roaster, hot dust had to be deposited into the cyclone dust bin. The vacuuming contractor was told to remove their hose from the bin to allow this dust to be deposited. The vacuuming contractor noticed some dusting and left their hose partially in to provide venting. This hot dust pulled through the hose and was the source of ignition. The fire was fuelled by the vacuum suction which created air flow to fuel the combustion. Method of extinguishment: 4 portable ABC fire

Cause:

Hot dust from roaster. Vacuum hose left on and within cyclone dust bin.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 10956753 **MS** **31-Jul-06** **Xstrata - Smelter**

Incident:

Workers were operating two cranes when both lost power at 01:30 hours. Power was restored at approx. 01:35. #4 crane was racking in to the #8 CSCV to adjust the location of a ladle to allow #8 to slag out. The operator noticed that the other was making a move. As #4 was hoisting up #2, block came in contact with the spout on the vessel. Before #4 crane could lower the block, the armour plate on the block went perpendicular to the ground and 5 of the 5 bolts holding the plate in place sheared off. The crane was put in the corner and the shift millwright was called. He checked the crane and tagged out #2 block. There was evidence of deformation (bends) in a 4 location on the cable. Anticipate that cable and block will need to be changed. Will limit #4 crane's use to #1 hoist for casting only. Injuries/damages: cable and block on #2 hoist #4 crane.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089617 **MS** **30-Jul-06** **Lac des Iles Mine**

Incident:

Accidental release of ethal mercaptan (stench gas into underground environment). There was an electrical power surge. The surge caused the automatic stench system to release into the underground ventilation system. This shift electrician was called to check this out. He found that two of the ethal mercaptan cylinders were still full. He was not aware that there was a third bottle connected in the system. Since it was assumed that there was no release of ethal mercaptan, the pit foreman deduced that the smell must be that of propane. He called all personnel to evacuate the pit as a safety precaution. When it was discovered that the third bottle of ethal mercaptan was activated and propane was not an issue, the all-clear was given to resume operations in the pit. At this time, the underground personnel retreated to the refuge station and sealed themselves in as per standard procedures. All electricians and pit supervision to be given training in the components of the stench system. Investigate the possibility of installing warning lights on the stench system to indicate when it has been activated. The stench system was discharged prior to persons returning to the underground.

Cause:

Believed caused by severe lightning storms in the area.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093768 **MS** **(F)** **28-Jul-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

Minor damage to hoses and burner inspection door damage. The DCS operator was in the process of starting up #2 oxy-fuel burner on #2 furnace. The flames blew back burning several hoses and the inspection door. Self extinguished when operator turned off burner.

Cause:

Build-up in port would not allow flow/flare to enter FCE box creating a "blow back".

Preventative Action:

None given.

Event ID: 1093766 **MS** **(F)** **26-Jul-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While casting #2 anode furnace, a small flame was noticed by anode casting operators in the heat resistant material that covers the limit switches for the cups on the anode casting take off hoist. The take off hoist removed red hot anodes from the casting wheel and places them in a cooling tank. The operator used a fire extinguisher to put out the flame. There was no damage to the equipment. Source of ignition: heat from anodes. Extinguished with 1 portable ABC fire extinguisher.

Cause:

Earlier on day shift, there was a hydraulic leak in the housing where the small flame occurred. The hydraulic oil saturated the heat resistant material and the heat from the anodes during casting caused some of the oil to

Preventative Action:

None given.

Event ID: 1096478 **MS** **(F)** **24-Jun-06** **Xstrata - Kidd Metallurgical Division**

Incident:

A small fire of smouldering concentrate ignited. Fire was quickly extinguished (water hose) by operations. No injuries and minimal damage. Damage to equipment as a result of incident.

Cause:

Investigation has indicated that overheated bearing on transfer screw ND7 was root cause of the fire.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094246 **MS** **(F)** **08-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

Small fire by the west side of skimmer's cubicle. A plastic bag with a piece of clay had ignited. The piece of clay was pushed aside, it was found that the two rubber drain lines for the air conditioner had ignited also. He quickly kicked some fines on the hoses and the fire was extinguished. The front of the cubicle also had a piece of plexiglass that was splashed and ignited - it was also extinguished.

Cause:

Splashing of molten material from the vessel while blowing.

Preventative Action:

None given.

Event ID: 1094691 **MS** **(F)** **06-Jan-06** **Inco Ltd. - Copper Cliff Nickel Refinery**

Incident:

It appears the wooden pallets on which ladle repair materials are stored caught fire. No damage. Fire extinguishers were used.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095035 **MS** **(F)** **06-Aug-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

The east end wall of the converter leaked on to the bottom. The converter was turned down and leak was sealed. The small amount of molten material melted one ground cable and an electrical cord for solenoid. All personnel were notified. Method of extinguishment: 4 portable ABC fire extinguishers.

Cause:

Molten metal cause of incident.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092112 MS 06-Jul-06 Mara Limestone Aggregates

Incident:

Komatsu 600 loader hydraulic pump failed. Lost steering and all hydraulics. Vehicle hit a conveyor and damaged it.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096461 MS (F) 06-Jun-06

Incident:

A small fire occurred in a welding receptacle cable box on S boiler. Operations personnel quickly extinguished the fire. Preliminary investigation indicates arcing and shorting due to improper connection (loose cables).

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094901 MS (F) 06-Jun-06 Inco Ltd. - Copper Cliff Smelter

Incident:

A smoke alarm in the stack building. An electrician was contacted to inspect. Upon his arrive, the building contained smoke. The smoke was coming from #2 stack fan encasement. The fire department was called out and they extinguished the fire.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093320 **MS** **(F)** **06-Jun-06** **Xstrata - Craig Mine**

Incident:

Worker proceeded to blast out a hang up. When he returned, he noticed some material smouldering with a small open flame in the muck. It's been extinguished with a water hose. A sample of material will be brought to surface. No injury or damage. The open flame was extinguished with a water hose.

Cause:

A cardboard box of resin had been left as tramp materials in the muck from a rehab job done previously in the pass above. It is suspected that an excessive length of B-line might have been in contact with the cardboard in the muck which ignited the refuse during the blast.

Preventative Action:

Review incident with crews at first shift back. Meetings and muck pile safety talks on housekeeping practices.

Event ID: 1093318 **MS** **(F)** **06-Apr-06** **Xstrata - Smelter**

Incident:

While testing the converter turn down circuit from #2 powerhouse, #1 rectifier breaker started smoking. The fire department was called and put the melting lacquer out with a dry chemical extinguisher and ventilated the building. Power was isolated to the affected equipment causing cranes and converters to be down.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094902 **MS** **(F)** **06-Apr-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While making up a ladle, a splash occurred that ignited excess grease left from the greasing of #8 converter trunions. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Grease from #8 trunion cause of incident.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094654 **MS** **(F)** **27-Jun-06** **Xstrata - Smelter**

Incident:

During casting at matte granulation, the spout of ladle #4 was made too low, causing molten metal to spill into the tilter cylinder area. This caused a small fire. The fire was quickly put out by the operator with a 5 lb. extinguisher.

Cause:

None given.

Preventative Action:

Tagged out ladle. Spout to be repaired before being put back in use.

Event ID: 1096450 **MS** **06-Jan-06** **Agrium Inc. - Agrium Inc.: Pit**

Incident:

A slough occurred in the stage #2 west pit area between the 230M-240M elevations at the western face. The slough was approx. 10,000 tonnes. There were no workers on the foot area, however there was contact with the equipment. The EX1800 that was working the face was involved in the slough. The extent of the damage was to the catwalks, bending them towards the machines slightly. The maintenance department will make the necessary repairs and return the machine to operation. The standard operating procedures were being followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096468 **MS** **(F)** **06-Sep-06** **Xstrata - Kidd Creek: Metsite Copper**

Incident:

A copper Casting employee was operating a 45 ton crane with a 15 ton ladle attached containing molten copper metal. The employee was dumping the molten metal from the ladle into the holding furnace when some of the metal spilled onto a pallet of cardboard containers containing refractory brick. A small fire ignited which was quickly put out by operations. Combustible material should never have been placed in the area when molten metal is being transferred. No injuries or other significant damage as a result of the incident.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094538 MS (F) 31-May-06 Inco Ltd. - Coleman Mine

Incident:

Levack Fire Department notified Coleman Plant Protection in regard to a trailer that was on fire. Method of extinguishment: fire department.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096449 MS 29-May-06 Xstrata - Kidd Creek: Railroad Mets

Incident:

Kidd locomotive was shunting loaded zinc and copper concentrate gondola cars to the ONR siding. The locomotive was pushing 7 loaded cars when the trainman noticed there was a problem. The trainman stopped the train immediately. When stopped, the trainman and switchman noticed that car 5 and 6 had derailed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093316 MS (F) 27-May-06 Xstrata - Lockerby Mine

Incident:

There was a small electrical fire. The fire started on a scooptram, equipment #851. Wires caught on fire and were extinguished by an employee. Wires have been replaced and the machine is working fine. No injuries resulted from the event.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090251 MS (F) 26-May-06

Incident:

D-10 drill was drilling 8-002 pattern when the compressor oil cooler let go sparking oil onto the hot engine. The oil ignited. The drill operator was able to extinguish the flame with his hand-held extinguisher. No one was hurt in this incident and damage from fire minimal.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090256 MS (F) 26-May-06 St. Andrew's - Holloway Mill

Incident:

Security officer noticed some smoke in the Mill. She called her partner and together they found fire in location noted. Security informed management by phone. Mine manager and three additional employees arrived at the mill site and extinguished the fire. Security officer sustained some minor smoke inhalation. Small amount of plywood framing near electric wall heater scorched and burned slightly.

Cause:

Suspect high heat from heating unit caused glues in plywood to begin burning. Power supply removed from heating unit.

Preventative Action:

None given.

Event ID: 1094118 MS (F) 25-May-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Operator was remote mucking with #59 Toro scooptram. The operator was in the process of switching the unit over to remove operation when he noticed flames coming from the right rear area of the scoop. The operator activated the fire suppression system and left the area. He was unable to determine if the fire was out. The supervisor was notified and the emergency fire procedure was implemented. Method of extinguishment:

Cause:

It was determined that the fuel line had rubbed on the positive post of the starter motor causing the line to ARC and rupture. This resulted in an ignited spray of fuel from the line.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090919 MS (F) 23-May-06 Agrium Inc. - Agrium Inc.: Pit

Incident:

Fire occurred on a caterpillar 777D haul truck. Operator was hauling from pit to the dump when he noticed smoke coming from engine compartment. Operator safety shut down the engine, got out of the truck and noticed flames coming from the right hand side turbo and exhaust. Fire was small and easily extinguished with hand-held fire extinguisher. No injuries or major equipment damage.

Cause:

It appears that the right hand side turbo failed allowing oil to spray onto the hot exhaust system.

Preventative Action:

None given.

Event ID: 1094692 MS (F) 06-Feb-06 Inco Ltd. - Copper Cliff Copper Refinery

Incident:

During the first pour of hot metal to the ladle on the east side in granulation, molten metal splashed onto the lines causing a fire. Damage caused to steel braided hydraulic and air lines. 1 portable ABC fire extinguisher used.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093330 MS (F) 15-Jun-06 Xstrata - Smelter

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093721 MS (F) 22-Jun-06

Incident:

Employee noticed smoke and fire coming from railroad area. Tie and switch were on fire. Employee used extinguisher from Inco truck to extinguish fire with a portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094652 MS 21-Jun-06 Inco Ltd. - Stobie Mine

Incident:

The crew were moving a scissor lift down 2000-2100 level ramp when the service brake failed. The unit freewheeled for about 10-15 feet before the operator had time to push the emergency brake. No injuries or damage. Analysis of occurrence: the crew reported brake problem with the unit and had the mechanic to check the brake prior to use the scissor lift. They then proceeded to do their initial check and break test before going down the ramp. When they approached the working place, the service brake failed. The emergency brake was used to stop the equipment. The unit was escorted by a scoop to a safe location and the mechanic was notified.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093623 MS 20-Jun-06 Xstrata - Smelter

Incident:

While #4 crane was pouring cast matte from a skull ladle, it developed a hole in the bottom and a small amount of metal emptied out onto the aisle floor. There was no other damage to any other equipment. The ladle was immediately taken out of service and tagged out for repair. Took ladle out of service and further investigation will take place.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093981 MS 20-Jun-06 Xstrata - Smelter

Incident:

Operator reported the run-out. After the supervisor visually inspected the run-out, the furnace power was tripped. The electrodes were raised out of the bath and both roasters were shutdown. Further investigation of incident required.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093719 MS (F) 19-Jun-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

The front right tire of the loader ignited when it came in contact with hot metal spill in the aisle caused by the foaming of #2 TBRC.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093723 MS (F) 19-Jun-06 Inco Ltd. - Matte Processing

Incident:

Worker was removing a redundant chimney on the upper level floor when sparks ignited cardboard and debris on the lower floor. A fire extinguisher was used to put the fire out.

Cause:

Sparks from hot work - poor housekeeping.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094651 MS (F) 18-Jun-06 Inco Ltd. - Stobie Mine

Incident:

The compressor was located outside the hoist room when the employees noticed smouldering coming from the engine compartment. Fire extinguishers were used to put out the fire. The fire department responded to the call and did an inspection of the area. Method of extinguishment: 2 portable ABC fire extinguishers.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096466 MS 06-Aug-06 Agrium Inc. - Agrium Inc.: Pit

Incident:

The slough was approx. 8,000 tonnes. There was no work taking place in the area at the time nor was there any equipment parked in the immediate area. Mucking operations in this area had been suspended for two shifts (24 hrs.) in order to work another area of the pit. The slough was noticed when the equipment was returned to resume mucking. The standard operating procedures were followed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093729 MS (F) 16-Jun-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Employee cutting a piece of steel on a wooden box. The box caught on fire and the employee was observed putting the flame out by tapping it with a piece of plate steel.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1096465	MS	06-Aug-06	Agrium Inc. - Agrium Inc.: Pit

Incident:

A cut off was discovered 215 bench of stage #2 north on the west side of the pit. A row of six blast holes did not fire as planned. All personnel and equipment were immediately removed from the area. The location of the holes were determined by survey and marked out. The blast crew identified all holes in the blast pattern that did not fire as wells as verified that the other holes did fire. The row of blast holes was fired following all procedures and regulations and all holes were verified as fired by the blasting crew.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093716	MS	15-Jun-06	Inco Ltd. - Copper Cliff Smelter

Incident:

The Acid Plant tripped on what appears to be a power bump. As a result of this power failure, SO2 gas coming from unknown source collected inside the booster fan building and eventually escaped outside the building. Approx. eight contractors and one SO2 plant operator went for treatment at 1st aid.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093725	MS	(F)	15-Jun-06	Inco Ltd. - Creighton Mine

Incident:

Employees working on 6800L in and about the switchroom reported smelling an acidic type substance along with seeing smoke. Power to the switchroom was shut off. Inside the switchroom the smell of acid was too strong to remain inside, so an air mover was used to clear the area. Once the air was cleared, the smell was still too strong. The area was then roped off until the source could be determined. 3 Inco employees and 1 SCR employee were treated for smoke inhalation. Appropriate precautions were taken to protect all personnel. All crews have or will be informed of this occurrence. Subsequent preventive measures will be taken upon completion of the joint

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093726 MS (F) 13-Jun-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Cutting and burning at an upper elevation caused sparks to ignite a cardboard box below. The burning cardboard box was extinguished immediately with the use of a fire blanket.

Cause:

Poor housekeeping.

Preventative Action:

None given.

Event ID: 1095423 MS (F) 06-Dec-06 Inco Ltd. - Coleman Mine

Incident:

Damage to wire insulators. Power line for red strobe was grounded, causing sparks and flames.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093333 MS (F) 06-Dec-06 Xstrata - Smelter

Incident:

A cardboard box containing filter from bag house was on fire. Fire was extinguished with 1 ten PD ABC fire extinguisher.

Cause:

None given.

Preventative Action:

Cleaned up area.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1033329 **MS** **06-Nov-06** **Xstrata - Smelter**

Incident:

The power house turndown alarm came on in the Falconbridge Smelter Converter Aisle. At this time, all 4 converters could not move. A burnt smell was noticed in #11 MCC behind #7 converter and the control fused for #7 converter were found to be burnt. This caused the breaker to trip for the converter power at #2 power house. No injuries occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096467 **MS** **06-Sep-06**

Incident:

Contractors were installing new support beams into the copper concentrate bins from the north side to support the copper concentration bin roof structure. The beams were placed into the bin and into position. When the beams were in place, the 2 tonne hoist was moved off of the side of the scaffolding allowing the maintenance room to finish their installation. Maintenance personnel went for their break. Upon returning to the job site, it was noticed that the chain bag for the hoist that contains the chain had fallen to the NQ floor - approx. 20'. This hoist was then locked out. The following morning, Sling Choker was called out to inspect and repair the hoist. No injuries and minimal damage as a result of the incident.

Cause:

It is possible at the time of installation of the beams, a beam may have struck the chain bag weakening the support for the bag.

Preventative Action:

None given.

Event ID: 1096313 **MS** **14-Aug-06** **Xstrata - Smelter**

Incident:

Operator was raising the drawbridge platform for #8 converter and the winch assembly cable broke. No one was hurt during this incident. The cable was repaired and an SIR was submitted to investigate the failure

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093717 **MS** **16-Jun-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

Blower fan went down and nothing was released in the air. Electricians are currently working on the unit. No gases had entered the atmosphere.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102454 **MS** **11-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

An operator was taking a cast sample on #6 converter. He tried to bring the shell back into the safe position and the shell wouldn't move. He tried to bring the shell up or down a couple of times before it finally moved up, close to the safe position. The converter was just sitting there with the power on when the shell moved into the blowing position on its own. While in the blowing position, the operator hit the emergency roll-to-safe and nothing happened. He also tried using the joystick, but there was no response. The converter finally rolled out and the power was shut off. Converter is 45' long and is refractory lined to hold molten material. No injuries or damage to

Cause:

None given.

Preventative Action:

Troubleshooting was done on the converter and nothing obvious was found. The material in the converter will be transferred to another converter in a safe manner by following company procedure for transferring matte. The investigation (troubleshooting) will continue after the converter is empty.

Event ID: 1103651 **MS** **09-Dec-06** **Xstrata - Kidd Creek - Mill/Concentrator**

Incident:

As two workers decided to use a thermic lance to speed up process of demolition, smoke from performing this task set off smoke detectors which resulted in the release of halon fire suppressant from 2 halon fire protection systems. No injuries as a result of this incident.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1103429	MS	12-Aug-06	Inco Ltd. - Coleman Mine

Incident:

The cylinder used to close the gate failed due to it being continuously over extended or operated beyond its range of stroke.

Cause:

None given.

Preventative Action:

Stop blocks are being installed to prevent the cylinder from being over extended.

Event ID:	1099153	MS	(F)	11-Aug-06	Goldcorp Inc. - Hoyle Pond Mine

Incident:

A small electrical fire occurred in the 560M refuge station. Crew heard loud noises from the transformer, lights went out, there was smoke coming from main disconnect. They shut the power off and opened the box and found flames from burning fuse which they put out with hand held fire extinguisher. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1102478	MS	11-Jul-06	Agrium Inc. - Agrium Inc.

Incident:

There was an unexpected release of natural gas from a supplier pipeline relief valve. Site employees were evacuated to a safe area. No injuries reported. The release of natural gas was reported to the MOE.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102468 MS (F) 11-Jul-06 Inco Ltd. - Levack Mine

Incident:

New loco received the previous day. The loco was being used for the first time. The clutch overheated and an open flame was caused. The fire was extinguished immediately with the on board extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101168 MS 11-Jun-06 Xstrata - Kidd Cree: Deep 7000

Incident:

Scooper mucking on remote control in the 63-746 st draw point was buried in a run of muck. Scoop has not been recovered so extent of damage unknown. Stope has not been surveyed, so impossible to determine if fog at this time.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101182 MS (F) 11-May-06 Xstrata - Fraser Mine

Incident:

Worker was driving mini bolter. He stopped to let another vehicle go by when he noticed an open flame on the engine compartment. He immediately extinguished the flame with a 20lb hand held fire extinguisher. No injuries or damage to equipment.

Cause:

A box of rebar resin was stored on top of the engine compartment. Some of the resin came in contact with the turbo and an open flame occurred.

Preventative Action:

The engine compartment was cleaned. Communicate to crews not to store flammable material on top of the engine compartment of equipment. Incident will be reviewed at crew safety meetings.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1098904	MS	(F)	26-Oct-06	Xstrata - Kidd Metallurgical Division

Incident:

Smoke and fire witnessed around drive system for 2nd stage tailings pump F55A2, A GIW rubber lined 10 x 12 x 26 pump. V-belts burned off the drive pulleys in the concentrator for as yet an undetermined cause, but likely the pump seized. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1102455	MS	(F)	11-Mar-06	Inco Ltd. - Copper Cliff Smelter

Incident:

While troubleshooting #17 MPV drive due to restriction in the vessel rotation, the vessel was rotated approximately 2 inches past the bath line. There was less than 1/2 a ladle in the vessel at the time. A small amount of molten material was spilled into the slag bay. There was a discarded rubber hose in the slag bay that ignited when it came in contact with molten material. The hose extinguished itself and was contained in the slag bay.

Cause:

Rubber hose source of fuel: molten metal cause of incident. Restriction to vessel rotation. Method of extinguishment: self-extinguished.

Preventative Action:

None given.

Event ID:	1102460	MS		11-Oct-06	Inco Ltd. - Copper Cliff Smelter

Incident:

While removing the first load of 10 anodes from the anode bosch tank with #271 forklift, the anode casting trainee backed away from the tank. As the load was lowered to the ground, the carriage portion of the mast disconnected from the fixed rails on the mast causing the anodes to slide off the forks.

Cause:

Suspect that the hydraulic cylinder was damaged from loading scrap anodes into the ladle return. This forklift will no longer be used to load scrap anodes in the ladle return.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1100855 MS (F) 11-Feb-06 Xstrata - Smelter

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103807 MS (F) 11-Feb-06 Dufferin Aggregates

Incident:

Worker using excavator to load dock when he felt heat on the back of his head. He turned around and saw flames. It happened quickly. Worker left cab then reached in back for his hard hat. Fire department called to put out fire. No one was injured.

Cause:

None given.

Preventative Action:

An investigation is being done to determine the cause of the fire.

Event ID: 1101362 MS 11-Jan-06 Goldcorp Inc. - Red Lake Complex

Incident:

A crew was assigned to clean drift ditch slimes. An unexpected and uncontrolled run of rock and slimes occurred. Preventative measures: Immediate - incident communication to all workers at pre-shift safety huddle.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102453 **MS** **11-Jan-06** **Inco Ltd. - Creighton Mine**

Incident:

One load of wet rock from a 40 ton haulage truck was dumped into the ore pass and went through the crash gate. Crusher creating a spill of rock on the walkway. No injuries were reported as there was no operator in the area at the time of the incident.

Cause:

Approximately 40 tons of wet rock was the cause of this occurrence.

Preventative Action:

None given.

Event ID: 1100715 **MS (F)** **31-Oct-06** **Xstrata - Craig Mine**

Incident:

Worker had plugged into the jumbo extension and when the power was activated, it tripped. He proceeded to reset the power again and he heard a loud noise and noticed an open flame on the jumbo end of the plug. No injuries. To communicate to workforce practice of multiple resets after circuit trips without having proper personnel investigate.

Cause:

It is suspected that the moisture in the plug caused a phase to phase short, which in turn caused a heating condition.

Preventative Action:

None given.

Event ID: 110716 **MS** **31-Oct-06** **Inco Ltd. - Garson Mine**

Incident:

Methane was intersected. Diamond drill drilling on hole. No reading of methane in the atmosphere. The area not cleared at the time of the report but will be monitored throughout dayshift and will continue until the hole is clear and the area deemed safe. All methane procedures were followed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094531 MS 08-Nov-06 Xstrata - Kidd Met Site

Incident:

Small transformer failed causing loss of power to leach/indium/electrical shop and zinc service building. Leach and indium plants were evacuated during outage. Upon restoration of power, plants were evaluated by ERT and re-entry authorized.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102456 MS 11-May-06 Inco Ltd. - Coleman Mine

Incident:

A small amount of Amex was spilt on the ramp from a ripped tote bag. No injuries or damage.

Cause:

None given.

Preventative Action:

The Amex was cleaned up and area washed down.

Event ID: 1109924 MS 24-Nov-06 Goldcorp Inc. - Campbell Complex

Incident:

A drain line on 10 level plugged causing water to enter the ore pass on 10 level. This resulted in a run of muck further down.

Cause:

Drain line plugged on 10 level.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101677 **MS** **02-Dec-06** **Inco Ltd. - Stobie Mine**

Incident:

A scoop was buried in a draw point from a run of muck. The muck ran in between the bucket and the front wheels leaving the scoop stuck at the draw point.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101914 **MS** **(F)** **02-Dec-06** **Xstrata - Craig Mine**

Incident:

Open flame. Driveline disc brake created heating condition igniting oil and grease around drive line of unit. Mechanic had been called in to the heading to release the brakes on MB018 Maclean bolter. The brakes were released and a decision was made to move the bolter up to the mechanical shop for further trouble-shooting and repairs.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103483 **MS** **01-Dec-06** **St. Andrew - Clavos Mine Project**

Incident:

Worker jumped off truck when truck he was operating started to slide down the decline.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102655 MS 01-Dec-06 Xstrata - Fraser Mine

Incident:

The driver of a truck was in the process of unloading a portable compressor when the compressor fell off the truck. The deck of the tilt and load was sticking and when the load did release the operator continued to elevate the load. When it did release it moved quickly shock loading the support chains. The shock of the stop kicked the bed of the truck out its normal rails causing the compressor being transported to fall off the truck to the ground.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103433 MS (F) 30-Nov-06 Inco Ltd. - Coleman Mine

Incident:

A dozer had a small electrical fire under the floor panel in the operator's compartment source of ignition.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103435 MS 30-Nov-06 Inco Ltd. - Copper Cliff Smelter

Incident:

A furnace tapper cut out on the bottom east side spilling the contents onto the converter aisle floor. There is specific procedures in place that restrict any employees from being in the converter aisle.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101171 MS (F) 12-May-06 Agrium Inc. - Mill

Incident:

Welder performing hot work on the frame of a conveyor noticed a small flame on a fire blanket that was used to catch slag. A small amount of grease on the fire blanket ignited. Fire was extinguished immediately.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101296 MS (F) 11-Aug-06 Xstrata - Fraser Mine

Incident:

Worker noticed smoke coming from dash of JB123 jumbo. He notified the mechanical personnel in the shop who extinguished the open flame with a water hose. Maintenance and welding had been done on the unit prior to the occurrence. Specific cause is still under investigation.

Cause:

None given.

Preventative Action:

The unit has been tagged out. Further investigation to determine the cause.

Event ID: 1101169 MS 24-Nov-06 Xstrata - Kidd Creek: Deep 7000

Incident:

Workers were drilling on the face of the 70-GW acc. A slab fell from the upper LHS of the face, damaging the LH boom of the jumbo.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1101295	MS	11-Sep-06	Xstrata - Strathcona Mill

Incident:

Hole drilled through tailings fill plant tunnel. A mobile drill unit used to install 6 inch vertical I beam supports for the installation of a guard rail system drilled into a concrete service tunnel and in close proximity to a 5kv electrical cable. The area was secured and inspected for structural damage. There was no damage to the electrical cables. The hole that penetrate the service tunnel was in the battery limits of the digging permit but was out of the initial work scope. This hole was outside the original scope of work but within the battery limits of the original permit. Review site plans before proceeding with the additional work would have identified the hazards. A proper inspection of the area was conducted with the drawings that ID the service tunnel.

Cause:

None given.

Preventative Action:

The incident was reported as a serious incident for crews to review. The procedure requires review and revision to include, but not limited to, utilities complete an inspection the areas, tools are upgraded to identify buried services and color coded paint is determined and service locates ground painting is adopted.

Event ID:	1110034	MS	(F)	24-Nov-06	Goldcorp Inc. - Red Lake Complex

Incident:

Smoke in the underground worker's furnace dry coming from crawl space under the dry trailers. Worker opened the skirting to the side of the trailer and used a hand-held extinguisher to extinguish flames. After a short period of time, fire re-ignited and was again extinguished using a hand-held extinguisher. The power was removed from the electrical circuits.

Cause:

It is believed that heat tracing wire was the caused of fire.

Preventative Action:

Skirting removed from trailer and bottom to be insulated. Installed two GFIC receptacles under trailer. Install ceramic heaters.

Event ID:	1103900	MS	13-Dec-06	Xstrata - Kidd Creek

Incident:

A locomotive de-railed at the D-rail device when it skidded on wet rails. There was no damage to the locomotive

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1105261 MS 22-Nov-06 Williams -Williams Mine

Incident:

A cable on the skip was being changed when a clamp let go from the tugger. It slapped the head frame but hurt nobody.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103336 MS 22-Nov-06 Xstrata - Kidd Creek - (Lower Mine)

Incident:

There was a "runaway" of a Kubota 6800 tractor on the internal ramp. The unit is tagged out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102464 MS 16-Nov-06 Inco Ltd. - Copper Cliff South Mine

Incident:

A Kubota RTV 900 personnel carrier was being driven down 1900l ramp and was suddenly pulled to the right due to a possible wheel seizure. The unit then contacted and partially climbed the ramp wall causing the unit to tip onto the driver's side. Operator sustained a bruise to the right elbow. All RTV units at the plant are temporarily grounded until an investigation is completed to determine if mechanical failure contributed to the incident.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102703 MS 13-Nov-06 Xstrata - Kidd Metallurgical Division

Incident:

Two locomotives and 17 cars were travelling westward towards mine site load-out when derailment occurred. Two cars derailed but remained on track. No injuries, minimal damage to railcars and sections of rail will need to be replaced.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102459 MS 11-Nov-06 Inco Ltd. - Copper Cliff Smelter

Incident:

While transferring the ladle to the aisle in 2 east matt haul, the ladle cut out burning the car puller cable and causing a spill. The hole is located on the bottom east side of the ladle emptying the whole ladle inside the matt haul. The ladle stopped approximately 10 feet from the aisle. The matte haul is a tunnel underneath and to the side of the furnace where the ladles get filled in with molten matte. The end of the matte haul tunnel is isolated with a guillotine gate.

Cause:

Suspect that the hydraulic cylinder was damaged from loading scrap anodes in the ladle return.

Preventative Action:

The fork lift will no longer be used to load scrap anodes into the ladle return.

Event ID: 1102450 MS (F) 26-Oct-06 Inco Ltd. - Copper Cliff Smelter

Incident:

During test start up of the sulzer, smoke was observed coming from the breaker. At this time it was advised to trip incoming power to kill the power and an extinguisher was used to put out the smoke at the breaker trip coil. Source of ignition: undetermined. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102472 MS (F) 27-Nov-06 Inco - Copper Cliff Smelter

Incident:

When the flash furnaces go down for quench cleaning, the burners also get cleaned while the furnace is down. While #2 flash furnace was down for quench cleaning the furnace operators cleaned #3 & #4 burners. The operators had extra work to do on #3 & #4 burner and had not yet cleaned #1 burner. The control room operator started #1 burner to keep heat in the furnace and with the end not clean this caused a blow back on the burner.

Cause:

Source of ignition: blow back from oxy/fuel burner. Source of fuel: rubber on pendant and plastic voering solenois. Cause of incident: burner was started before the end was cleaned.

Preventative Action:

Method of extinguishment: self extinguished.

Event ID: 1098516 MS (F) 24-Aug-06 Porcupine Joint Venture

Incident:

A small fire was detected in the engine compartment on D14 drill. The fire was put out by the operator with a hand-held extinguisher. There was no damage to the drill resulting from the fire. The maintenance department will be repairing the oil leak before the machine is put back to work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089914 MS (F) 09-Jan-06 Lac des Iles Mine

Incident:

A fire occurred in a Toro underground haulage truck (60 ton) liner of air box. The haulage truck had been taken out of service as a result of a suspected turbo failure. Mechanics replaced the Turbo and cleaned excess oil out of the air box. It was decided to load the truck and try it on surface to test the integrity of repairs. During the testing, the liner in the air box caught fire. The fire was put out using a hand-held fire extinguisher.

Cause:

It is believed that excess oil in liner box caused fire.

Preventative Action:

In future when conducting such repairs, all excess oil will be cleaned off and liner box to be thoroughly checked to ensure there is no residue of oil.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1097486	MS	31-Aug-06	Xstrata - Smelter

Incident:

Attempted to start #1 roaster to the acid plant. Had water flow to the gas cooler but could not get temperature control.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1096956	MS	(F)	31-Aug-06	Inco Ltd. - Creighton Mine

Incident:

Operator noticed that the end of the maul was glowing red from the heat generated while attempting to break a chunk. He lifted the hammer and noticed a small flame coming from the tip of the maul. He extinguished the fire with a hand-held extinguisher. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Improper type of lubrication was used.

Preventative Action:

None given.

Event ID:	1101407	MS	29-Aug-06	Inco Ltd. - Creighton Mine

Incident:

Approx. eleven tons of displaced material was discovered.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1097484 **MS** **(F)** **27-Aug-06** **Xstrata - Smelter**

Incident:

A small amount of matte splashed behind #7 converter when the crane operator was pouring the ladle. This resulted in a small fire (instrument cable). The fire was put out with a fire extinguisher and the converter operation was tested and found to be fine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095960 **MS** **26-Aug-06** **Inco Ltd. - Copper Cliff Nickel Refinery**

Incident:

Train crew was in the process of pushing 48 empty ore cars to sprecher with INCX2007-INCX2001 double headers. The train collided with the parked loads. Three cars derailed and damaged the east track. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1097006 **MS** **(F)** **25-Aug-06** **Xstrata - Smelter**

Incident:

The operator was in the process of hauling slag with the kress hauler. On the way to the slag dump, the steam blew off the Kress hauler, causing the hauler to lean to one side. This caused the slag to spill over. The operator dumped the slag to the closer matte pit and used a fire extinguisher to put out the grease fire.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1103215 **MS** **(F)** **27-Oct-06** **Canadian Salt Co. - Canadian Salt Co.**

Incident:

Worker was about to go into the field to scale when he smelled smoke, then he saw flames coming from the oldenburg mechanical scaler. Fire was put out with a hand held extinguisher and fire suppression.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1097005 **MS** **(F)** **24-Aug-06** **Inco Ltd. - Stobie Mine**

Incident:

There is smoke into the head frame of the #7 shaft. Mine rescue has been called and is going to be deployed underground to determine the cause. Four people were underground at the time of the incident - they are all accounted for and are now at the Refuge Station.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101116 **MS** **(F)** **15-Sep-06** **Xstrata - Kidd Creek: #1 Mine**

Incident:

Travelling down ramp, the operator realized there was something wrong with the left front wheel of the Toyota truck. Upon investigation, it was realized there was a failure to the bearing assembly and grease had ignited into a small fire. The fire was quickly put out by the on board fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098428 **MS** **22-Aug-06** **Xstrata - Kidd Creek: Railroad Mets**

Incident:

The railroad crew was in the process of shunting rail cars at acid load-out when a full acid car prox #60238 derailed (one wheel off track). No injuries or equipment damage as a result. Car has been re-railed.

Cause:

Investigation has indicated no defective equipment associated to root cause of incident. Root cause determined to be operator error.

Preventative Action:

None given.

Event ID: 1088385 **MS** **(F)** **21-Aug-06** **Musselwhite Mine**

Incident:

While driving out of the 645 metre level, a Tamrock 40D haulage truck operator noticed that the brake light came on. He stopped the truck and called a mechanic. The mechanic gave the operator permission to move the truck out of the way. When the operator moved it about 30 metres, he noticed that the drive line brake was smoking and began to flame up. He put the fire out with a hand-held portable fire extinguisher. A review of this incident will be done with all crews and mechanics stressing the importance of inspecting the reported problems prior to moving a disable piece of equipment.

Cause:

The brake cylinder hose had broken off spraying oil on the heated-up drive line brake. The operator should not have been given the OK to move the haulage truck until a mechanic had inspected the problem.

Preventative Action:

None given.

Event ID: 1095279 **MS** **(F)** **19-Aug-06** **Inco Ltd. - C.C. Transp. & Traffic**

Incident:

Security noticed smoke at the upper diversion switch area and discovered a grass fire approx. 40 ft. from the tracks. Method of extinguishment: hose.

Cause:

Source of ignition: likely a spark from the slag pots. Dry grass cause of incident.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1095562 **MS** **16-Aug-06** **Xstrata - Strathcona Mill**

Incident:

Failure of a section of canopy over mill band saw. An operator found the canopy over the band saw had broken and collapsed in one section. He barricaded the area and reported it in the morning. It was found that the canopy had a couple of inches of new build-up caused by the cell removal work overhead on the good section of canopy. This was not the cause of failure. The failed section had a build up of approx. 3" to 8" of relatively new concentrate ranging from soft to hard and scaly. This canopy was cleaned off 2 months ago. The section failed where two of the hanging supports were corroded at the canopy roof connection and broke under the weight of the build up. Band saw canopy. No an engineered covering. It was intended to protect the band saw from slurry spillage from the cells above. No injuries or damage to other equipment. The hanging section of canopy was removed. Mechanical Dept. will review options to either move the band saw to another area to have an engineered approved cover that can be cleaned easier and support spillage until it can be cleaned.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096314 **MS** **15-Aug-06** **Xstrata - Smelter**

Incident:

Large sections of cladding found on ground below the expansion joint. Remaining pieces to be removed and/or secured.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1095278 **MS** **15-Aug-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

An unexpected and uncontrolled run of fill material occurred from the previous filled 9632 stope into the adjacent 9671 stope that was being mined. This created an open hole condition. Corrective measures taken: are barricaded. Access to the areas of concern is prohibited until an agreed upon plan of action has been developed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1095961 MS 15-Aug-06 Inco Ltd. - Copper Cliff North Mine

Incident:

A run of muck occurred. Material sloughed off the walls of 9990 return air raise and came out onto 3880 level. Corrective measures taken: the brow of the entrance into the return air raise is almost choked off and in the meantime, access is restricted. A plan of action for retrieving the reamer head off 3880 level is required.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1097003 MS 24-Aug-06 Xstrata - Lockerby Mine

Incident:

Boom truck stalled. Employee tried to jump start it with wrench. Brakes weren't on, no wheel chocks and the vehicle was in gear. Employee was dragged approx. 20 ft. down ramp. Injuries: bruising to shoulder and arm. Employee was released from hospital - no broken bones or blood loss.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099907 MS 13-Oct-06 Inco Ltd. - Stobie Mine

Incident:

While employee was in the process of placing a full slurry tanker on the inbound track to the headframe, the forks came in contact with the inlet/discharge valve and snapped the plumbing off the tanker causing slurry to leak onto the ground. Tanker was removed to safe area, spill cleaned and tanker emptied by Dyno Nobel.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094374 MS (F) 24-Oct-06 Goldcorp Inc. - Campbell Complex

Incident:

A track drift worker was getting gear from storage for a heading when he noticed smoke going by him. When he looked back and realized that an u/g track locomotive was full of smoke that he was operating. The worker used a hand-held fire extinguisher to extinguish the fire. It was discovered that the wire going to the light of the locomotive battery had burned off.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098900 MS 23-Oct-06 Agrium Inc. - Agrium Inc.

Incident:

Unexpected rotation of foundation material for a dam under construction at the mine site. Project was suspended, the area was cordoned off and measures communicated to workforce. Engineers are assessing conditions. No release of materials occurred. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101429 MS 20-Oct-06 Inco Ltd. - Copper Cliff Smelter

Incident:

After charging up #11 converter with 3 ladles of matte, three tonnes of flux were added on first blow and at 1230C the converter started to foam. Converter was rotated out of stack with air on and approximately 1 ladle of slag spilled onto the floor in front of the slag bay. Converter is 45' long and is refractory lined to hold molten material. No injuries or damage to equipment. Corrective measures taken: Ensure the proper amount of matte and flux added before and during the first blow. Verify pyrometer is correct to ensure cooling to correct temp on previous charge and/or that skimming at the correct temperature.

Cause:

It is possible that some slag came with the matte and that the build-up in the converter shell had flux and frozen slag inside causing the converter to foam.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1100712 MS (F) 10-Jan-06 Xstrata - Strathcona Mill

Incident:

173 sample pump return line was plugged and started to back-up and spill to the floor below. The operator shut down the sample. Directly underneath was a receptacle where a hanging light was plugged into it which had started to arc and a small flame was noticed. The operator used an extinguisher to put out the flame. Automatic sampler and associated sample lines. Overflow of return lines is not uncommon. No injuries or damage to other equipment to report. The incident was reported on SIR for crews to review. Follow up of this area to determine what can be done to avoid another occurrence.

Cause:

Slurry from the sample line contacted the receptacle. The wiring insulation burned. Breaker tripped as per normal protection. The open flame would not have sustained combustion and would have gone out momentarily. An extinguisher was used the operator as called for in his fire extinguisher training.

Preventative Action:

None given.

Event ID: 1100713 MS 18-Oct-06 Inco Ltd. - Stobie Mine

Incident:

Collision between a scoop and the emulsion loading truck. The scoop pushed in the boom and bent some handrail. No injury but damage to the emulsion truck. The parking procedure in a haulage way were reviewed with operators.

Cause:

The operator drove past the intersection with the loading truck and stopped to move a vehicle that was parked in the way. The scoop rounded the corner and couldn't stop fast enough and hit the truck.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093039 MS (F) 17-Oct-06 North American - Lac des Iles Mine

Incident:

An underground worker was instructed to bring a scissor lift to surface for repairs. The worker noticed as he was driving up the ramp flames in the exhaust area of the engine compartment. The workers attempted to put the fire out using a hand-held extinguisher but the extinguisher failed to operate. The hand-held extinguisher was checked and it was assumed that the actuator was not struck hard enough to puncture the nitrogen bottle.

Cause:

It is believed that a rag or some type of paper product was left near the exhaust system.

Preventative Action:

Crews are to make sure that all flammable material is removed from engine area when work or repairs are finished on mobile equipment.

Event ID: 1099909 MS (F) 16-Oct-06 Xstrata - Thayer Lindsley Mine

Incident:

Detected smoke at surface from an unknown source. Company has injected stench underground and are currently treating as a fire drill until they confirm source of smoke. It is possible that the smoke may have been from a brush fire. Situation all clear. There was no underground fire. It appears that it was a brush fire at the surface.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099137 MS (F) 13-Sep-06 Esker Aggregates Pit

Incident:

Truck was traveling empty when the operator noticed smoke coming from the front portion of the engine. The operator attempted to put the fire out with his extinguisher. He could not gain control, and had to back away. Extensive damage to the cab compartment. Minor smoke and heat damage to the trailer. Mechanical failure is suspect.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098114 **MS** **(F)** **13-Oct-06** **Goldcorp Inc. - Hoyle Pond Mine**

Incident:

Report of smoking batteries at level 440 battery changing station. All mine personnel called for (reported to refuge stations). Mine will be dispatching Mine Rescue.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101395 **MS** **14-Sep-06** **Inco Ltd. - Matte Processing**

Incident:

It was noted that just over 1 cubic metre of nio material was put on the floor with an approx. weight of 3 tons. The spill occurred over time because of a 1/2" diameter hole at the bottom of the surge tank. Nio was diverted from this route until a patch was welded on the bottom of the surge tank.

Cause:

A hole developed over time because of wear.

Preventative Action:

A patch was welded on the tank.

Event ID: 1101420 **MS** **13-Oct-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

After reporting for D/S and waiting for their suspecting the clay bulb kicked out of the tap hole. Several operators responded to find the matte ladle overfilled and the hole still running, resulting in the ladle being frozen in the matte haul. The operators then budded up the tap hole to stop the flow of matte. Approximately 3 tons of material overflowed out of the ladle. Damage to the matte haul cable and matte haul rails.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093041 **MS** **(F)** **10-Sep-06** **Goldcorp Inc. - Red Lake Complex**

Incident:

The #2 compressor kicked off an alarm system. Workers reset alarm and restarted the compressor for test purposes and it ran for a few minutes then kicked off on high discharge. A small fire broke out above the separator tank. This was extinguished using a hand-held fire extinguisher. The compressor (sullair model TS450) sustained burnt hose.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099626 **MS** **(F)** **10-Aug-06** **Xstrata - Xstrata Smelter**

Incident:

During #6 converter's 2nd blow, it foamed 10 minutes into the bow causing a spill in front and behind converter. Two fire extinguishers were used and replaced. The area was cleaned and production resumed. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101401 **MS** **21-Sep-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

A leak occurred above #1 tuyere. The furnace operator rolled the furnace to the safe position to remove the tuyere from the bath and stop the leak of molten copper. Approx. 3-4 tons of copper leaked into the slag bay and out into the aisle in front of #1 Anode Furnace. The splashing from the copper burnt the combustion air hose. Method of extinguishment: self extinguished.

Cause:

A leak occurred above #1 tuyere.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094370 **MS** **(F)** **21-Sep-06** **North American - Lac des Iles Mine**

Incident:

Fire occurred on one of underground 60-tonne haulage trucks. The operator started the truck and approx. 10 minutes later smelled smoke so he stopped the truck to investigate. He noticed a small fire on the starter and used the hand-held extinguisher to put it out. The operator inhaled some of the dry chemical from the fire extinguisher as he was putting the fire out and went to first aid. The starter on the truck had to be replaced.

A follow-up with the supplier will be made to determine what can be done to prevent a reoccurrence.

Cause:

The investigation determined that the solenoid on the starter stayed engaged after the unit was started, causing the starter to continue to run and as a result, catch fire.

Preventative Action:

None given.

Event ID: 1101131 **MS** **(F)** **20-Sep-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

The 8 yard scooptram hanger bearing seized, overheated and grease around it caught fire. The fire was extinguished immediately with hand-held fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101125 **MS** **(F)** **19-Sep-06** **Agrium Inc. - Agrium Inc.**

Incident:

A bobcat being used to remove ball mill rejects from the basement floor when the operator noticed a small flame in the ignition box. The small fire was extinguished immediately and the equipment tagged out for inspection and servicing.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091960 MS (F) 20-May-06 Inco Ltd. - Clarabelle Mill

Incident:

The lightning arrester (surge protector) failed on #2 transformer and a small flame resulted. The arrester was approx. 35 years old and most likely had become fatigued with time. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1092813 MS (F) 14-Oct-06 Goldcorp Inc. - Campbell Complex

Incident:

A worker was operating a locomotive (Warren 82 motor) on track when he noticed flames coming from under the hood of the locomotive battery. The fire was extinguished with a hand-held fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101414 MS 10-Apr-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Material had fallen over previous 24 hours from left wall and back (beyond shotcrete and installed support). Made up of small to large blocks, no pieces seen on pile larger than 3 feet maximum dimension. Minor amount of muck heard running during inspection. Vertical tension cracks on shotcrete on north-east pillar wall hairline to 1mm dilation. 3150 level 1522 vrm brow is open, stope empty. No sloughing of cemented sandfill/rock and cemented sandfill off opposite wall. No reported runs of olivine diabase dyke.

Cause:

None given.

Preventative Action:

A double guardrail is installed to restrict access to the area concerned. The area is under investigation.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086848 **MS** **(F)** **13-Jan-06** **Goldcorp Inc. - Dome Mines**

Incident:

Westmain crusher slimes pump barrel seized and grease on the shaft caught on fire. Extinguished immediately with fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088003 **MS** **(F)** **01-Oct-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

A contractor was performing clean-up by #1 Traylor crusher and they put some dirty rags in a pail. Burning was being performed in the area and a spark landed in the pail igniting the rags. Fire was put out with extinguisher. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Rag not disposed of properly.

Preventative Action:

None given.

Event ID: 1085723 **MS** **01-Sep-06** **Xstrata - Kidd Creek: Railroad Mets**

Incident:

Collision occurred between train and transport. Train was travelling at approx. 4 miles/hour. Extent of injuries unknown at this time. Worker was released from hospital that evening. No visible injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086695 MS (F) 01-Jun-06 Xstrata - Thayer Lindsley Mine

Incident:

Operator noticed small flame coming from plug behind bolter. Flame went out when power was turned off. No injuries. Damage to trailing cable plug. Maclean bolter (MB036), extension cable and plug. Conditions were normal except that the plug was wet. Water reached the inside of the plug and was conducting between wires, reached high enough temperature to ignite interior of plug. Damage plug was removed and replaced with a new one. Operators were reminded to make sure that the trailing cables and plugs are not exposed to water.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086670 MS 01-Apr-06 Xstrata - Smelter

Incident:

A refractory lined ladle was being cleaned at the bumper block when the main bales came off the bale trunions. A DTHE ladle rolled onto its side. The operator of #4 crane then attempted to return the ladle to its upright position by lifting the ladle by the tail hook with the auxiliary hoist and the tail chain. After hooking onto the ladle, the operator racked in towards the bumper block in order to use the block as a support for rolling the ladle back to the upright position. While racking in the cable on the auxiliary, hoist failed. Investigation is ongoing. The procedures for returning ladle to its upright position will be reviewed and subsequently discussed with the crane

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086953 MS 01-Jan-06 Inco Ltd. - Copper Cliff Smelter

Incident:

While in the process of skulling a ladle from the copper smelting circuit containing a skull of copper, the j-hook lug fractured on ladle #270. The fracture occurred during the swing of the ladle. The outcome was 1. the auxiliary hoist went loose with little to no shock loading; 2. the ladle rotated approx. 90 degrees to its natural position on the bales. Since the bales hold the majority of the load, it is believed that it experienced very little shock loading. No injuries. Damage to #270 ladle. Failure mechanism under evaluation by Inco engineering dept. Large copper skull may have been a contributing factor. Crane was inspected for any damage after the incident. The ladle was tagged and taken out of service pending an investigation. A practice has been implemented at the Copper Smelter to return the copper casting ladle every shift to the bulk converters to have the ladle skulled. This will prevent the skull from getting big. In an event a skull becomes too large, it will be chipped down in size prior to skulling.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1099625 MS 10-Jul-06 Xstrata - Smelter

Incident:

One side of the steel roll-up door between the furnaces at the matte end fell to the floor when the welds along the frame failed. The door measurement is 10 feet by 10 feet. Power to the door has been isolated and area made safe for travel. No injuries.

Cause:

Welds on one side and across the top of the door failed causing the door and one side of the frame to fall to the floor level. Area secured.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101396 **MS** **09-Oct-06** **Inco Ltd. - Coleman Mine**

Incident:

262 boom truck hit the 261 shuttle crane. Maclean 13 ton boom truck and shuttle lift carry deck 15 ton mobile crane. Normal conditions. No injuries. Major damage to both pieces of equipment.

Cause:

The operator of 262 boom truck was driving to the shaft station driving backwards (bed first). At the cross over doors area and hit the 261 shuttle crane causing damage.

Preventative Action:

Ensure proper parking of the crane to prevent recurrence of this incident.

Event ID: 1101149 **MS** **(F)** **10-Jun-06** **Agrium Inc. - Agrium Inc.**

Incident:

An outdoor cigarette ashtray caught fire. The ashtray is a labelled container and designed as a cigarette extinguishing container. The small fire was extinguished immediately.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1085773 **MS** **(F)** **16-Jan-06** **Victor Diamond Project**

Incident:

A fire broke out in a sea container which contained various tools and equipment. The fire destroyed the sea container and contents. No one was injured during the occurrence. The fire was monitored closely until such time the fire self extinguished.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101415 **MS** **10-Apr-06** **Inco Ltd. - Clarabelle Mill**

Incident:

After mechanics completed repairs to drive sprockets on course ore feeder in crushing plant, they began to bump feeder to ensure there was no more movement in the sprockets and it was suitable to run. The feeder was bumped several times and the muck coming down from the bin appeared dry at this point. When attempting to bump feeder again, the muck began to run out of the feeder uncontrollably and buried 24-BC-101 conveyor, spilling out to the floor in a wet soupy consistency. No injuries or damage. Area secured and investigation initiated. Clean up of area completed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098452 **MS (F)** **10-Jan-06** **Xstrata - Craig Mine**

Incident:

Worker noticed smoke flame coming from the frame area of the truck. No injuries or damage. All similar units will be checked for potential of re-occurrence.

Cause:

A Kimtowel had fallen in the frame area and it is believed the exhaust caused a heating condition in that area igniting the Kimtowel. The flame was extinguished by the operator with his water jug.

Preventative Action:

None given.

Event ID: 1101409 **MS** **10-Jan-06** **Inco Ltd. - Coleman Mine**

Incident:

The #3 arc gated closed gate proximity switch failed due to water entering the switch. Water was introduced by a 2" rupture water line at the pocket. When the switch failed, the arc gate remained in a partially opened position.

Cause:

None given.

Preventative Action:

Replaced defective proximity switch and tested. Made all necessary repairs to safety devices. Cleared shaft of any muck repaired brattice.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098450 MS 28-Sep-06 Xstrata - Lockerby Mine

Incident:

Piece of equipment ran away. Nobody was hurt - no 1st aid. Damage to John Deere grader.

Cause:

None given.

Preventative Action:

JHSC recommendation to install an isolation switch or button.

Event ID: 1093040 MS (F) 28-Sep-06 Goldcorp Inc. - Musselwhite Mine

Incident:

An operator a Toyota jeep (2015) was driving on a flat section of the 150 metre level near the shaft when the operator noticed a burning smell. The operator stopped and inspected the vehicle and noticed a small open flame underneath the cab where the drive line brake was located. The operator extinguished the flame using a hand-held fire extinguisher. The vehicle was escorted to surface.

Cause:

Preliminary indications show that the drive line brake was partially engaged while the vehicle was being operated, resulting in the fire. All indications seem to point to a mechanical failure due to a loss in hydraulic pressure.

Preventative Action:

None given.

Event ID: 1101408 MS (F) 26-Sep-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

A fire in the NIM box on the hill outside of NRC building. Source of ignition: self ignited (pyrophoric material). Source of fuel - clydach residue. Method of extinguishment: fire department tanker.

Cause:

Auto ignition.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090926 MS 23-May-06

Incident:

Collision occurred between tandem truck and locomotive engine. Locomotive engine was travelling in westerly direction moving at a speed of less than 5 mph. Tandem truck was travelling north towards crossing when collision occurred. No injuries sustained by either operator. Minimum damage to box of tandem truck.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101147 MS (F) 10-Jun-06 Goldcorp Inc. - Dome Mines #8 Shaft

Incident:

A fire occurred on a battery loco while it was charging. It was quickly extinguished with a hand-held extinguisher.

Cause:

Internal investigation indicates that the fire was caused by a short.

Preventative Action:

None given.

Event ID: 1087425 MS (F) 29-Jan-06 Inco Ltd. - Stobie Mine

Incident:

The crusher bearing and toggle were damaged and the resulting friction of the components generated heat that started a grease fire in the crusher pit.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088475 MS 20-Feb-06 Xstrata - Smelter

Incident:

The black plate was being moved from #1 matte transfer car to #2 matter transfer car to complete the installation of #2 transfer car. Just as the plate was being set into position on the back of the transfer car, one of the two cable slings used for lifting the plate broke. The break occurred right at the end of the wire rope, where the cable is attached to the lifting ring. The sling broke just as the back plate was set into position. No injury or damage to equipment occurred (other than the broken sling). The cause of the sling failure is to be investigated. Proper storage and inspection of slings is also

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091110 MS (F) 19-Feb-06 Canadian Gypsum

Incident:

There was a small fire in an underground mine - all people have been accounted for - 1st rescue team is checking the situation. No injuries.

Cause:

Unknown.

Preventative Action:

None given.

Event ID: 1091316 MS 19-Feb-06

Incident:

One 6' piece of drill steel fell out of the cage while travelling in the shaft striking the bell signal cord at 5 level. The hoistman stopped the cage immediately upon hearing the bell signal. Underground operation was stood down and a shaft inspection was done. The steel was found at 6 level catch pit. There was no damage to the shaft. The cage was released for service after completing the shaft inspection.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089470 **MS** **18-Feb-06** **Inco Ltd. - Coleman Mine**

Incident:

Electrician stopped his jeep on the side of drift to let scoop go by him. The scoop operator was not made aware of his presence and hit the front passenger side of jeep with scoop bucket. There are no injuries but substantial damage to jeep.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087006 **MS (F)** **18-Feb-06** **Porcupine Joint Venture**

Incident:

A small fire in the cab of a D-16 drill when the 12V converter shorted out and ignited. The fire was put out by the operator with a hand-held extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088856 **MS** **02-Feb-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While travelling west, the #4 main aisle crane inadvertently came into contact with the stop blocks on the west end. After hitting the stop block, the crane bounced back and then proceeded back into the stop block. It did this one more time before it came to a complete stop. The crane operator received minor lacerations to his face and left thigh, a minor abrasion to his right leg and a bruised right thumb. There is damage to the crane, the north runway girder column connections and to the west end wall. The west end on the sand floor was roped off as well as the west end at ground level. Structural engineers are assessing the building and the cranes. Along with the structural assessment, the crane crew will be performing a full check of the crane before it is put back into service.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088711	MS	(F)	02-Jan-06	Inco Ltd. - Copper Cliff Smelter

Incident:

Converter number 6 was blowing scrap was being added when the burner port hole cut out with matte. The operator noticed the leak right away and stopped the scrap belt before turning down to safety. Some small amount of matte leaked out and fell to the garbage bin below causing a small fire (two cardboard boxes). Leader was notified and put the fire with the water hose located behind 6 converter. Method of extinguishment: hose.

Cause:

Source of ignition: small leak of molten matte. Source of fuel: cardboard boxes in a garbage bin. Cause of incident: had a cut out by a burner port.

Preventative Action:

None given.

Event ID:	1086832	MS	(F)	13-Jan-06	Xstrata - Nickel Rim South Mine

Incident:

The heat trace cable that protects the load out containment tank from freezing burnt. Approx. 10 inches of heat trace cable melted / burnt where the cable comes out of the ground. A workman was walking past he area, noticed sparks and a small flame coming from the cable. The power source was shut off and the cable immediately quit burning. Early investigations indicate that the cable failed somewhere in the portion that was under the ground which allowed an overheating condition to take place. 120 volt heat trace system. Heat trace cable was in normal use with no visible damage. No injuries. Heat trace cable requires replacement. Power shut off to cable and cable taken out of service until root cause of failure identified and corrected.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1086989	MS	(F)	30-Jan-06	Xstrata - Kidd Creek: Lower Mine

Incident:

Oil ignited equipment no. 33919 cat grader when it came in contact with hot turbo. Fire occurred while grading the main ramp. A hydraulic hose leak caused oil to fall onto hot turbo exhaust. Fire was extinguished using onboard extinguishing equipment. Operator received 1st aid for inhalation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088005 MS (F) 14-Jan-06 Inco Ltd. - Coleman Mine

Incident:

Kiruna truck 1059 was loaded with rock at location 69. There was a small amount of scrap (shotcrete plastic wrap and wire mesh screen) on the top of the loaded truck. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

The scrap material came in contact with the trolley line.

Preventative Action:

None given.

Event ID: 1085894 MS (F) 28-Jan-06 Xstrata - Fraser Mine

Incident:

While operating T2 water truck, the operator was attempting to turn the truck into a crosscut at 34-2-643 when the truck became hung up. The operator called for a scoop to help free the truck. Upon arrival, the scoop operator noticed an open flame on the rear tire of the truck opposite the operator. The flame was extinguished with the use of hand-held 20 lb. extinguishers. Tire to be sent out to Goodyear for analysis to identify if tire had separated from the rim. No injuries.

Cause:

Replaced tire. Tire to be sent to Goodyear for analysis. Review incident with all crews at crew safety meetings.

Preventative Action:

None given.

Event ID: 1090698 MS (F) 28-Jan-06 Williams Corporation - Williams Mine

Incident:

Operator noticed smoke and flame coming from the exhaust area of truck. Operator stopped and shut down the truck and activated the fire suppression system. The combination of these 2 actions extinguished the fire. The operator and another person in the area checked truck to ensure fire was extinguished. Truck was moved out of the main haulage way into a parking area and was tagged out pending more detailed investigations. The stench warning system was not activated and mine rescue personnel were employed at the time.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086988 MS (F) 25-Jan-06 Xstrata - Kidd Creek: Deep 7000

Incident:

Employee was drilling when he noticed smoke rising from under floor behind core bench. Employee stopped the drill and noticed there were some old rags under the floor that had caught on fire. Employee extinguished the fire. Removed old rags and contacted CPCR to advise them of fire. Employee stated other contractor was cutting pipes with torches and they left the area around 15:30.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088862 MS 24-Jan-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Contractor removed a loose 2 ft x 2 ft piece of flooring from the ladies washroom. The piece of flooring contained some small amounts of asbestos. No injuries or damage to equipment. The contractor was not aware that the flooring contained small amounts of asbestos when they were hired to do the work. The contractor who removed the small piece of flooring is not trained or licensed to remove or dispose of asbestos. The contractor had the area wet and he was wearing a respirator when he placed the flooring in a plastic bag so that he could have it disposed of.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088545 MS (F) 22-Jan-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

When tapping #1 converter, molten metal splashed onto the pallets of remaining bricks from the last converter reline. This caused the plastic wrapping and paper to catch on fire. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Improper housekeeping and storage of combustible material.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086940 MS (F) 19-Jan-06 Xstrata - Kidd Creek: Lower Mine

Incident:

Employees were going to install vent brattice. Going into 01, brakes on 671 9 yd. scoop came on. Alternator light came on but no brake light. Partner exited and saw a flame was a match box size and 1 1/2 in height. Put out with fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088006 MS (F) 16-Jan-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

While in the process of cleaning out slag pit, a hydraulic line ruptured. Hydraulic oil sprayed onto the hot slag resulting in a reported open flame condition. No injuries. Method of extinguishment: self extinguished.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101388 MS (F) 09-Aug-06 Inco Ltd. - Copper Cliff Smelter

Incident:

A fire was observed on a lunch room roof near #8 converter area. Iron workers were welding and cutting on top of the newly installed #8 off-gas flue line which is above and to the side of the lunch room roof. Although fire blankets were in place and a fire watch was present, some sparks managed to bounce off the some beams and reached the roof which is below and to the side. Source of ignition: sparks from cutting and welding. Source of fuel: wooden roof.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087646 **MS** **(F)** **31-Jan-06** **Xstrata - Smelter**

Incident:

Furnace operators were moving a hot lancing rod when it contacted an empty cardboard box. A fire extinguisher was used to put out the small fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091029 **MS** **(F)** **24-Mar-06** **Inco Ltd. - Clarabelle Mill**

Incident:

the pressure relief device on an SO2 cylinder ruptured causing the liquid SO2 to escape into the workplace. This is a small cylinder used to transport samples of SO2 from the SO2 plant to the laboratory for analysis. Cylinder and carrying case had been placed into the min-plant at the main lab. No personnel were present until approx. 1 hour later when the analyst returned to the area and noted the SO2. No injuries or damage.

Cause:

Pressure relief device ruptured.

Preventative Action:

None given.

Event ID: 1089839 **MS** **29-Mar-06** **Xstrata - Craig Mine**

Incident:

Remote scoop brake failure. Operator reported intermittent loss on link on remote and intermittent release of brakes on both manual and remote while operating LHD 1002. The harness which feeds the remote control brake release system was wired through a military style pin connector. The plug was loose and the wire was allowed to twist to the point where two wires on the pins were able to short together intermittently causing the brake release.

No injuries, no damage. The wire and military style pin connector has been disconnected for the time being. Other units being checked for similarities.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088739 MS 29-Mar-06

Incident:

Employee was putting bushing into end of drill when piece of bushing came off and struck him on his inner right forearm. Puncture wound.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091031 MS 29-Mar-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Surface contractor haulage truck contacted overhead power wires in the South mine yard, pulling the wires and one hydro pole down. No injuries. Damage to several overhead power wires and one hydro pole. Inco Power Dept. isolated power in the damaged lines. The area has been secured and barricaded with restricted access until repairs are completed.

Cause:

Contractor haulage truck operator completed dumping a load of ore at the surface stockpile and drove off with the box of the haulage truck still raised. The raised box contacted overhead power wires and pulled down the wires and one of the hydro poles the wires were connected to.

Preventative Action:

None given.

Event ID: 1088887 MS 27-Mar-06 Xstrata - Fraser Mine

Incident:

Electricians were in the process of racking out the #1 fan starter when the starter failed. After doing maintenance to the vent building main transformers, electricians tried to restart the fans. The #1 intake fan would not start. They were in the process of racking out the starter to the problem. Electrician examined by 1st Aid and returned to work. Damage to starter.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088200	MS	27-Mar-06	Xstrata - Kidd Creek; Railroad Mets

Incident:

Employee was shunting empty rail cars into position. Another worker noticed residual sulphuric acid spraying out of one of the rail cars and yelled to co-workers in area what was happening. Switchman at time of incident began to exit area by running but was partially sprayed with the acid. He proceeded to safety shower, then, after water availability was used, was accompanied to another safety shower by co-workers. Then brought to OH centre and he was treated in emersion tub. Worker then transported to where he was assessed and released.

Cause:

Preliminary investigation indicates cap on education cap was either not secured or not secured properly.

Preventative Action:

None given.

Event ID:	1089402	MS	27-Mar-06	Xstrata - Smelter

Incident:

Maintenance crews went to repair paste hoist and found evidence that the chain had come into contact with #1 electrode and repair platform. Hoist chain received damage.

Cause:

None given.

Preventative Action:

All insulators have been cleaned and checked for conductivity. Hoist replaced.

Event ID:	1088800	MS	(F)	24-Mar-06	Xstrata - Craig Mine

Incident:

Workers were drilling with Jumbo when electric power was lost to jumbo and heading ventilation fans. Upon investigation, the substation transformer supplying power to the workplace was found on fire.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1099624 MS 24-Sep-06 Xstrata Nickel - Xstrata Smelter

Incident:

The matte end car became stuck in the matte end tunnel with a full ladle of matte on it. The slings broke when trying to pull out with the crane and pulley. Ordered larger slings and initiated a new procedure to pull car with a loader if this event happens again.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089574 MS 24-Mar-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

There was a loud explosion in the sluice. Injuries and damage: no injuries. Bulged sluice and damaged damper louvers.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086821 MS (F) 31-Mar-06 Goldcorp Inc. - Musselwhite Mine

Incident:

The seal on the turbo of a Toro model 40-D haulage truck (1997) failed, causing the engine oil to be drawn into the hot turbo charger causing ignition. The fire was extinguished with a hand-held extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087205 MS 17-Feb-06 Inco Ltd. - McCreedy West Mine

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086977 MS 16-Feb-06 Xstrata - Kidd Creek: Railroad Mets

Incident:

Train engine #052 cars 12 & 13 derailed. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086976 MS (F) 15-Feb-06 Xstrata - Kidd Metallurgical Division

Incident:

Contract employees were welding on the top floor of the concentrator load out area. After completion of the welding, there was one hour (3-4 pm) of fire watch. One site fire crew was summoned to extinguish fire using water smouldering concentrate in this area. No injuries as a result.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086823 **MS** **15-Feb-06** **Goldcorp Inc. - Red Lake Complex**

Incident:

A raise bore experienced drill string failure.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087325 **MS** **14-Feb-06**

Incident:

Employee hoisting material bucket when lifting lug failed causing bucket to fall approx. one foot to ground floor.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089062 **MS** **02-Dec-06** **Inco Ltd. - Copper Cliff Copper Refinery**

Incident:

A worker was exposed to chrysotile asbestos when he tried on a pair of insulated coveralls that were stored in the plant. Upon removing the coveralls, the worker noticed that the coveralls insulation was damaged. A white powdery substance was noticed on his inner garments after removing the coveralls. Testing confirmed the presence of chrysotile asbestos. Aluminized asbestos insulated coveralls tag identifier ALM ASB. Coveralls were in the shop for an unknown length of time. The shop area was roped off as per CCNR policy. Continental Insulation was called in to vacuum the shop area. The worker's clothes were bagged. An audit of all these types of coveralls in the plant will be done.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087136 MS 02-Sep-06 Xstrata - Kidd Creek: Railroad Mets

Incident:

Train derailment causing significant damage to end of building.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089080 MS (F) 24-Mar-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Rental case matte breaker grease unit caught fire. Operator put the fire out with an extinguisher.

Cause:

Grease unit mounted too close to the engine.

Preventative Action:

None given.

Event ID: 1092450 MS (F) 04-May-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Employees noticed a fire under the parker scale. The fire was put out using a fire extinguisher stored in the scale shack.

Cause:

Preliminary investigation indicates the pyrotenix heat trace insulation corroded and shorted.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101390 MS (F) 09-Aug-06 Inco Ltd. - Clarabelle Mill

Incident:

The control room started #2 rodmill and noticed a haze above the ball mill circuit. Upon investigation, it was determined that the clutch on #2 rod mill had caught fire. Outvac was sounded and all personnel were evacuated and accounted for. The fire was put out with fire extinguishers by control room operator. Fire trucks arrive but were not needed.

Cause:

Heat from start-up source of fuel - rubber on clutch.

Preventative Action:

None given.

Event ID: 1097491 MS 09-Jul-06 Inco Ltd. - Frood Mine

Incident:

Three 25 kg bags of anfo slid out of their initial shipping package and fell off the boom truck onto the ramp. No injury or damage.

Cause:

The tote bags made of farina are too soft and during transportation underground, it allowed the bag of Amex to slide out.

Preventative Action:

Need a more rigid package to contain the bag of explosives. In discussion with the supplier to have a different shipping arrangements. Looking for a way to secure the load on the boom truck.

Event ID: 1098884 MS (F) 09-Jul-06 Inco Ltd. - Copper Cliff Nickel Refinery

Incident:

Duration of conductor de-electric covering resulting in heating and flash over. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1101389	MS	(F)	09-Jul-06	Inco Ltd. - Copper Cliff Smelter

Incident:

A fire occurred in a 16" rubber lined abandoned pipe on the 3rd floor of the crane aisle. Smoke was detected in the upper areas of the building. The fire alarm was sounded and the building evacuation alarm was activated. Source of ignition: undetermined as no hot work activity was conducted in the area and no sign of burnt electrical apparatus/wires. The group agreed the likely source of ignition was a cigarette butt. Source of fuel: rubber liner of abandoned pipe and flammable refuse in pipe. Method of extinguishment: hose.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1101392	MS	(F)	09-Jul-06	Inco Ltd. - Clarabelle Mill

Incident:

Booster operator was at the nickel underflow sump when smoke was noticed and some flames on the electrical lines at the entrance to 2A thickener. The smoke and flames ceased upon the electrical power tripping out. Method of extinguishment: power tripped fire self extinguished.

Cause:

Upon investigation it was found that an electrical receptacle box had shorted out due to water dripping on it from a leak.

Preventative Action:

None given.

Event ID:	1096957	MS	(F)	09-Mar-06	Inco Ltd. - Copper Cliff Smelter

Incident:

Copper circuit operator noticed a small fire in a pile of scrap in the main aisle in front of #1 anode furnace against the north wall. The scrap pile was cleanings from under the anode furnaces (copper and barite) and mixed in with the scrap were remains of used temperature probes and the cardboard boxes they came in. The flames were very small and there was minimal smoke. On top of the pile was an anode pour box skull that was still warm. Source of ignition: a warm anode pour box skull. Source of fuel: temperature probes and cardboard boxes. Method of extinguishment: cardboard removed from pile, flames put out.

Cause:

Cause of incident: placing of hot skulls too close to combustible.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098883 **MS** **09-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

While putting the ladle on #1 east out into the converter aisle, it was noticed the matte was coming out of the bottom of the ladle. Crane operator picked up the ladle right away and the transfer car was brought into the matte haul right away to get the car out of the hot metal. There was a spill of about 15 tonnes of matte into the converter aisle. No injuries and damage to the ladle only. Corrective measures taken: possibly increase the matte grade, lower the temperature and increase the rotation of the ladles on the matte cars.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088037 **MS** **29-Mar-06** **Xstrata - Kidd Creek: Metside Copper**

Incident:

Worker's foot broke through the roof. He was able to remove himself to a safe place. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093551 **MS** **(F)** **04-May-06** **Sifto Canada Inc.**

Incident:

Underground fire. The is minimal damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1089556	MS	30-Mar-06	Xstrata - Smelter

Incident:

Worker was in high pressure washing and vacuuming feed from an emptied 011 filter feed tank to prepare it for repairs to the agitator shaft. Worker was called and informed there was an incident reported. Two workers had taken over from the previous crew. As one worker was vacuuming on the north side of the tank (approx. 20 feet to the right of the man door), a piece of material came down and hit the bottom of the tank approx. 7 feet to the left of the door. Worker told them to remain outside the tank and went to the platform at the distributor box level. Worker noticed a section of the box was bare. He used a chipping bar and removed the remaining material that had built-up with time in the box and clearing it from the gap that exists between and the tank. They resumed their work.

Cause:

None given.

Preventative Action:

Scaled remaining build-up from area and inspected platform for other.

Event ID:	1092177	MS	04-Apr-06	Inco Ltd. - Copper Cliff Smelter

Incident:

A piece of insulation found lying on a beam in FBR building. The electrician who found the insulation was concerned that it was asbestos. The Inco authority was notified and it was tested. The analysis came back positive for asbestos. The material was bagged and the beam vacuumed in an approved manner. A check of the area did not reveal any more pieces or the source. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1089074	MS	(F)	04-Apr-06	Agrium Inc. - Agrium Inc.: Mill

Incident:

Welding machine was being used when sparks from cable ignited the insulation around cable. Welding cable was on top of segregated grating and was damaged from continuous walking over the cable causing it to ARC. Small fire was extinguished immediately. No damage and no injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1090061	MS	04-Apr-06	Inco Ltd. - Copper Cliff Smelter

Incident:

The crane operator was operating #6 crane. The crane operator picked up the ladle and attempted to dump it onto the scrap pile. The skull was not coming out so he then placed the ladle back down. At that point he noticed something fall off #6 crane. Crane operator never heard any noises indicating that something might be wrong prior to seeing it fall. The crane operator notified his supervisor immediately. Upon investigation, it was discovered the part that fell off is the stop block for the auxiliary rack. The purpose of the stop block is to prevent the auxiliary track from going past its north limit. Further investigation shows that the stop block (which fell) and the area which makes contact with the stop block (attached to the main rack), has damage. The crane crew is preparing to install a like part which is identical to the original stop block. No injuries and damage to the stop block. Inspected the crane and the other stop blocks on the crane. Installed new stop block. Continue to investigate.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1088247	MS	(F)	04-Mar-06	Agrium Inc. - Agrium Inc.: Mill

Incident:

Torches were being used to cut a steel plate when the sparks ignited some nearby grease. The small fire was extinguished immediately and the grease was cleaned up. No one was injured and no property damage resulted from this fire.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1090062	MS	(F)	04-Mar-06	Inco Ltd. - Copper Cliff Smelter

Incident:

A fire started in a revert dump box. The fire extinguished with a water hose and the box was then moved outside. The material in the revert dump box was waiting to be dumped into one of the converters.

Cause:

The revert ox was placed too close to the converter. Hose was used to extinguish.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088635 **MS** **(F)** **04-Jan-06**

Incident:

Employee was operating a Tamrock 413 truck #425 when he noticed flames coming from left side of operator's compartment. Extinguished small flame with hand-held fire extinguisher. Mechanic cleaned area and replaced fire extinguisher and truck was put back into service. Main fire suppression line was rubbing on wire for a solenoid switch (for transmission) causing the wiring for the switch to short out catching a small amount of grease on fire. No damage to switch or wiring.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091810 **MS** **31-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

After skimming the second pot on #2 furnace, the operator had budded up the slag hole so he could move the train to the third pot. While moving the train to the third pot, the hole began to leak slag. The operator went to the operator's booth so he could add more clay to the hole with the skim gun in order to stop the leaking slag, the flow of slag still did not stop. The operator called for help and moved the train to the third pot. While taking the skim gun off the hole, the clay fell out into the flow of slag in the chute and plugged it. Slag began to pour onto the floor and the hole could not be plugged because the skim gun had no clay left in it. When help arrived, they got clay into the gun and the hole budded up. No injuries or damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088476 **MS** **20-Feb-06** **Inco Ltd. - Stobie Mine**

Incident:

A scoop operator was about to enter the x-cut to muck out hammered chunks when a small bump knocked some large slabs off of the left wall as well as about a 200 lb. piece from the back.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1097487 MS (F) 09-Jan-06 Xstrata - Strathcona Mill

Incident:

Contractors were cutting up an old set of Denver floatation cells inside the mill when they were asked to stop burning because of the strong sulphur smell. While they were gone to the far end of the row to set up the vent fan (approx. 50 ft. away), a mill employee leaving the CCR noticed fire inside the old cell. He extinguished the fire with a water hose. There was another contractor employee underneath the cells watering the immediate area above. No injuries or damage to other equipment to report.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090500 MS (F) 13-Apr-06 Inco Ltd. - Coleman Mine

Incident:

A welder had cut lifting lug from view Kirun box on 1079 truck and was in process of cleaning slag from base of box when it was noticed the wiring harness under the box along truck frame was smouldering and ignited creating a 2-3" flame. Source of ignition: hot slag from cutting with torch. Method extinguishment: 1 portable ABC fire extinguisher.

Cause:

Cutting with torch.

Preventative Action:

None given.

Event ID: 1090943 MS 05-Aug-06

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091478 MS 05-Jul-06 Inco Ltd. - Copper Cliff Copper Refinery

Incident:

Concern over forklift rated for 9000 lbs. of 10,300 lbs. and put on tow truck.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091033 MS (F) 05-Apr-06 Inco Ltd. - Clarabelle Mill

Incident:

While investigating power outage, open flame was discovered on pole.

Cause:

Likely electrical ARC and the cause is likely lightning strike.

Preventative Action:

None given.

Event ID: 1088384 MS 05-Apr-06 Goldcorp Inc. - Campbell Complex

Incident:

Approx. 200 tonnes of paste fill came out of a weeping tile which had failed inside of the 1521 stope. The plug in 1521 stope was poured 1 week earlier and before this was done continuous draining (weeping tile) were installed in this location. The ends of the weeping tile came out of a shotcreted bulkhead and were open-ended. It appears that the weeping tile separated inside and the paste came out of four of the six weeping tiles installed.

Cause:

Weeping tile failed inside.

Preventative Action:

In the future, no weeping tile will be installed through the bulkhead.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1091848	MS	(F)	05-Feb-06	Xstrata - Fraser Mine

Incident:

Jumbo operator was preparing to drill when he noticed an open flame at the jumbo plug connection with the power cable extension. The operator plugged in J-8 jumbo, drove the jumbo to the face. He had hooked up the water hose to the jumbo and the jumbo kicked off. He reset the power to the jumbo to drill and heard some popping. He then noticed the open flame on the jumbo plug. The open flame was then extinguished with the hand-held fire extinguisher. No injuries, damage to jumbo plug and extension plug. Removed and replaced plugs. Electrical Dept. investigating incident. Will examine plugs for cause of flame and inspect starter on jumbo and the 600 volt starter at electrical sub prior to jumbo being put back into operation.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1090502	MS	(F)	18-Apr-06	Inco Ltd. - Creighton Mine

Incident:

Jumbo unit was en route to garage for some repairs. The operator noticed a small fire in engine compartment and proceeded to extinguish it with a 20lb. fire extinguisher. It was discovered at this point that the fan belt had broken and this caused the engine to overheat. The operator did not realize the engine was overheating due to a faulty engine temperature gauge.

Cause:

Fan belt broke causing engine to overheat.

Preventative Action:

None given.

Event ID:	1089842	MS		17-Apr-06	Inco Ltd. - Stobie Mine

Incident:

The blaster boss was lined up to prime a heading. From an inspection, the blaster boss determined that more mucking was required. When climbing down from the muck pile, a primer and a nonel fell from his powder bag into the mucking horizon below. The nonel and the primer were recovered without incident. No injury or damage. The explosives were returned to their respective magazines. All procedures were followed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088477 **MS** **(F)** **20-Feb-06** **Inco Ltd. - Stobie Mine**

Incident:

An operator noticed thick smoke coming out from the engine compartment. The operator got off the unit to investigate the source of the smoke and saw the flame. He then shut off the master switch and used a fire extinguisher to put out the fire.

Cause:

Defective equipment.

Preventative Action:

None given.

Event ID: 1092558 **MS** **(F)** **15-Apr-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

Hot slag fell into the pit in front of #11 converter and ignited residual hydraulic oil. A hydraulic line on the guardrail had failed the previous day resulting in a spill of hydraulic fluid in the area.

Cause:

Slag splashed out of a ladle. Sand was spread over the area.

Preventative Action:

None given.

Event ID: 1089912 **MS** **(F)** **05-Sep-06** **Xstrata - Kidd Creek Mines: Met Site**

Incident:

An employee using cutting torches to cut scrap steel. A spark from this process ignited old insulation from a previous roof repair that was lying on the ground. Fire extinguisher used by employee by using available fire water line close by. No injuries or damage to equipment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092557 MS (F) 04-Dec-06 Inco Ltd. - Copper Cliff North Mine

Incident:

During renovation work in a storage, an oxy/acetylene torch was used to cut away some steel plates from the wall. It is believed hot slag came in contact with the pressed board causing the materials to smoulder. Smoke was observed in an adjacent office by the cleaning staff. Source of ignition: slag from cutting steel plate with oxy/acetylene torch. Fire extinguished by fire

Cause:

What was believed to be a concrete wall was actually pressed board.

Preventative Action:

None given.

Event ID: 1089760 MS 04-Nov-06 Outokumpu Mines Ltd.

Incident:

A new recapped 11 yd. scoop tire was stored in surface lay down horizontally when the sidewall rupture occurred. No injuries. No damage other than tire itself. Supplier was called to remove tire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089841 MS 04-Sep-06 Inco Ltd. - Stobie Mine

Incident:

While crushing at #11 crusher, operator encountered a run of wet muck and mud from 1380 O/P that spilled out around the slide and openings in the gate at the feeder. The gangway around the crusher needed a major clean up. No injuries, no damage. Stopped pulling 1380 O/P until a remote station can be set-up at a safe location. The bin below the crusher was emptied to prevent impounded water.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090064 MS (F) 04-Sep-06 Inco Ltd. - Copper Cliff Smelter

Incident:

Sparks from turning down the shell on #5 converter caused a minor fire on the gradall which was put out by the mobile operator. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Preliminary investigation indicated proximity of gradall when shell turned

Preventative Action:

None given.

Event ID: 1090066 MS (F) 04-Sep-06 Inco Ltd. - Copper Cliff North Mine

Incident:

A hydraulic hose in the engine compartment rubbed on the torque converter housing and wore through causing oil to be sprayed throughout the engine compartment. It is assumed that the oil ignited on contact with the exhaust manifold.

Cause:

The hydraulic hose was incorrect length (too long) and incorrectly routed.

Preventative Action:

None given.

Event ID: 1090063 MS (F) 04-Aug-06 Inco Ltd. - Copper Cliff Smelter

Incident:

When opening burner port hole, a piece of hot clay/matte fell into scrap box under west gun end igniting a small piece of cardboard on fire. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

While opening burner port hole, a small piece of red hot material fell into scrap bin.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092449 **MS** **04-Jun-06** **Inco Ltd. - Clarabelle Mill**

Incident:

Run of muck on 33-BC-101 (sag conveyor belt). Material was primarily contained on the belt. However, approx. 1-2 cubic meters of material were displaced onto the floor beside the belt. No injuries or damage.

Cause:

Wet material in bin is suspected.

Preventative Action:

None given.

Event ID: 1090612 **MS** **17-Apr-06** **Xstrata - Smelter**

Incident:

Worker opened the end wall of #8 converter and there was no slag pot placed under chute conveyor molten metal to flow in aisle. Worker closed the hole immediately after noticing what happened.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088940 **MS** **21-Apr-06** **Xstrata - Kidd Creek - (Upper Mine)**

Incident:

Slough age from NE corner of open pit wall as a result of frost / freeze thaw action along pre-existing joints / geologic structures. Rock mass previously disrupted due to 1997 HSW wedge failure.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087025 **MS** **02-Aug-06** **Xstrata - Kidd Creek: Railroad**

Incident:

Minor derailment of an ore train comprised of locomotive plus 7 cars. No injuries, minimal damage to track.

Cause:

Snow build-up on the track was contributing factor.

Preventative Action:

None given.

Event ID: 1094114 **MS** **20-May-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093312 **MS (F)** **19-May-06** **Xstrata - Craig Mine**

Incident:

The crew had come up behind a bolter in the ramp and stopped the Toyota. They were in the process of exiting the vehicle when flames were noticed coming from behind the passenger's seat. Flames extinguished with a 20 lb. fire extinguisher. No injury. Minimal burning to rear of seat. Damaged wires.

Cause:

A paper towel had ignited in the vicinity of the hydraulic brake pump. It is suspected that a pair of boot cutters might have caused short in the hydraulic brake circuit which ignited the oily rags.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091477 **MS** **16-May-06** **Inco Ltd. - Creighton Mine**

Incident:

Worker going down in cage and passed out. Checked by EMS and went to hospital.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090132 **MS** **16-May-06** **Xstrata - Kidd Creek: Metsite Copper**

Incident:

Moving a fan seal for boiler, equipment was 35 ft long and about 6 inches from the ground, using 2 forklifts at each end and 2 slings at each end. Due to friction, one sling broke. The load dropped 6 inches to the ground. No injuries and minor equipment damage.

Cause:

Root cause: improper rigging.

Preventative Action:

None given.

Event ID: 1091476 **MS (F)** **14-May-06** **Inco Ltd. - Copper Cliff Nickel Refinery**

Incident:

After a pour-back to #2 converter, molten matte splashed onto the floor under the hoe-ram machine which ignited the accumulated oil under and on the machine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1092280 **MS** **(F)** **14-May-06** **Xstrata - Fraser Mine**

Incident:

While an electrician was troubleshooting the #4 trolley, a large ARC and subsequent burning of the 250 volt feeder cables was observed coming from the main electrical panel behind the operator's seat. No injuries, damage to the feeder cables.

Cause:

None given.

Preventative Action:

Replaced damaged cable. Installed a rubber cushion the frame of the trolley where the feeder cable is located.

Event ID: 1089641 **MS** **05-Aug-06** **Xstrata - Kidd Met Site**

Incident:

A web sling failed during a lift. As a result, a hydraulic cylinder fell approx. 3 feet. No injury and minimal damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089763 **MS** **25-Apr-06**

Incident:

Train locomotive pulling total of 10 cars. Train was exiting Copper Refinery at a speed less than 5 mph. The flat bed car loaded with tote boxes de-railed. Tote boxes slid off car falling on ground area beside the track. Scrap anodes from ground area picked up and reloaded into tote boxes.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091474 MS 05-Sep-06 Inco Ltd. - Clarabelle Mill

Incident:

Maintenance crew and crane operator were working on #5 primary screen installing bolts on pedestal. The crane which was attached with both hooks to #5 primary screen at the time was in the rest position. The crane started to lift unexpectedly and the crane man grabbed the control box to stop the crane. One bolt that was already in place snapped before the crane was stopped. No injuries, minimal damage.

Cause:

None given.

Preventative Action:

Crane tagged out of service pending investigation.

Event ID: 1090626 MS (F) 21-Apr-06 Inco Ltd. - Oxygen Plant

Incident:

Fire occurred on the 10 inch low pressure oxygen pipeline to the oxygen compressors. These compressors supply high pressure oxygen for the Nickel Refinery. While there were no physical injuries, an operator was in the vicinity of pipeline at the time of occurrence, and experienced symptoms of stress as a result of the incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089735 MS (F) 18-Apr-06 Goldcorp Inc. - Hoyle Pond Mine

Incident:

Small fire occurred on Izuzo service vehicle. Mechanic noticed small flame and extinguished fire without use of fire extinguisher or fire suppression system. No injuries. No damage to equipment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089761 **MS** **(F)** **18-Apr-06** **Agrium Inc. - Agrium Inc.**

Incident:

Welding machine being used when sparks from welding ignited a pallet of supplies on level below. Fire was extinguished immediately. No injuries. A sling and employee's jacket were damaged as a result.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090074 **MS** **(F)** **14-May-06** **Xstrata - Kidd Creek: Metsite Copper**

Incident:

Employees were ARC airing up at top of S boiler when small fire ignited. Hot work precautions had been taken by contractors. Investigation identified a small hole in gas line for AB burner that was root cause of incident. No injuries or equipment damage.

Cause:

Repairs made to gas line. A 3" stainless steel block valve developed a pinhole in the valve body causing a stream process solution to escape the piping system of the autoclave. The process was immediately shut down.

Preventative Action:

None given.

Event ID: 1092047 **MS** **05-Nov-06** **Xstrata - Craig Mine**

Incident:

Cagetender noticed a bulk emulsion loader hose neatly loaded on a pallet in the dump box outside the headframe. An emulsion loader along with a pump and accessories had been hoisted to surface destined for another line. It is suspected the pallet on which was attached the emulsion loader hose was misinterpreted as being scrap and was put into the dumpster by mistake. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091475 **MS** **(F)** **05-Nov-06** **Inco Ltd. - Creighton Mine**

Incident:

A scoop tram was on fire (loader). It is a piece of diesel equipment. The fire is ongoing and is 1.5 miles underground. There have been no injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089934 **MS** **05-Oct-06** **Xstrata - Kidd Creek: Metsite Copper**

Incident:

Maintenance personnel were replacing defective return rollers on NB-32 conveyor. At the time of incident, 2 contractors were attempting to install top roller. The roller slipped out of the holder on one side of conveyor and out of hands and off maintenance employee's shoulder, falling backwards about 4 feet, bouncing off a ledge then down into the opening over the slag bin falling a distance of approx. 55 feet to the bottom of bin. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087224 **MS** **(F)** **22-Mar-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

#729 1 yard scoop was started for use when the operator noticed an open flame coming from the engine compartment. The operator shut the unit down and turned off the master switch. The flame self-extinguished when the master switch as turned off.

Cause:

Wear through due to vibration.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1091845 **MS** **26-Apr-06** **Xstrata - Craig Mine**

Incident:

#3 chute was heavily damaged after blasting hang up. Workers were sent to blast hang up. Upon returning after blast clearing, the chute was found to have received major damage. The lip hinge was broken, the press frame and cylinders were damaged. Chute received major damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086975 **MS** **25-Feb-06** **Xstrata - Smelter**

Incident:

The #6 finishing converter was nearing the end of its blow on cast #177. The skimmer noticed a small leak at the back of the shell. The vessel was turned to the safe position and the back of the shell was inspected. Evidence of a small matte/slag leak around the #6 tuyere body was found. The vessel was emptied and the tuyere line was inspected from the skimming platform. A piece of brick was found to be missing between tuyeres #5 and #6. the tuyere line was measured and it was found that a total of 6 tuyeres were shorter than 5 inches. At this point, the converter was taken offline. The tuyere line on the converter has neared the end of its useful service life.

Cause:

A recent shutdown of the #7 converter likely contributed to a reduction in the build-up inside the #6 converter.

Preventative Action:

A review of tuyere line measuring frequency guidelines will be undertaken, particularly when the operating conditions in the finishing vessels change.

Event ID: 1089078 **MS** **23-Mar-06** **Inco Ltd. - Copper Cliff Smelter**

Incident:

During commissioning, prior to start-up of the new FBR wet gas cleaning plant, cooling water was being circulated to test the cooling water loop. The wet gas plant was not in operation at the time of the test.

Cause:

A sudden over pressurization of the cooling system is believed to be the cause of damage to some pipeline components.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1087202	MS	03-Apr-06	Inco Ltd. - Creighton Mine

Incident:

Operator drove the rugged terrain vehicle (RTV) 900 unit from 4000L to 3950L temporary oil storage to get two pails of oil. He backed the unit up to the storage located on the ramp. The operator shut the unit off and placed oil in back of unit. The operator could not restart the unit because the gear selector was jammed in reverse. The operator tried to release the jammed gear selector, another employee stopped to give a hand unsuccessfully. The operator then shook the roll bar on the unit and the unit started to roll down the ramp then he climbed in and tried to stop the unit but was unsuccessful and the unit travelled down the ramp approx. 210 ft. striking the wall. The operator jumped out of the unit approx. 170 ft. down the ramp. Minor injury to worker. Damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1088971	MS	03-Mar-06	Xstrata - Smelter

Incident:

CCR received a nozzle low pressure alarm - slag granulation system - then the slag launder broke, causing molten metal to enter the slag tunnel. At this point, a lot of steam was evident at the slag end. The furnace operator closed the slag hole. No injuries resulted from this incident. Upon further investigation, the field supervisor found that a drain valve off the nozzle manifold had blown apart. General communication to furnace operators about proper draining of waterlines during winter months.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1087198	MS	03-Mar-06	Inco Ltd. - Clarabelle Mill

Incident:

While dumping cars at tipple, a knuckle fell off one of the cars being dumped. The rotation of the tipple allowed the knuckle to be caught in the gap between the tipple and the floor. The knuckle was projected approx. 10 feet in the air from pressure being released. No injuries occurred. Damage to rail at tipple.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088201 MS (F) 03-Feb-06

Incident:

PMI crew was burning seized bolts on an air slide cover. Hot bolts and slag fell down 60' on skids of packaged brick which caught fire. Workers extinguished fire before fire dept. arrived.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087199 MS 03-Feb-06 Inco Ltd. - McCreedy West Mine

Incident:

Worker was driving mine mule 8410 down the ramp when she felt some loose steering capability, but continued to proceed down the ramp. Just below 1350 level access drift, she felt she had little or no throttle control and tried to slow the vehicle with the foot break and the emergency break. The vehicle would not properly respond and she made the decision to run the front end of the vehicle into the wall on the flat portion of the main haulage at 1403 x-cut to bring the vehicle to a stop. She states that she left the vehicle running and that it was running at what she felt was an accelerated rate. She was not injured and continued to perform her job for the rest of the morning, but she did attend to 1st aid on reporting the incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1085966 MS (F) 28-Feb-06 Campbell Complex

Incident:

An underground haulage truck operator was proceeding down the 33 level ramp when he noticed his lights were blinking. He stopped the truck and observed the battery compartment glowing orange. He opened the battery compartment and observed flames. The operator extinguished the fire using a hand-held fire extinguisher.

Cause:

The battery moved and ground faulted causing cable to burn.

Preventative Action:

Mechanical Dept. have work orders to check all trucks on the ramp. They will ensure that the batteries are held in a stable position so that they do not move. Safety contact to the mine for the operators to check the battery compartment when they are doing their pre-op checks.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087201 **MS** **(F)** **03-May-06** **Inco Ltd. - Copper Cliff Copper Refinery**

Incident:

A low pressure instrument air alarm was heard. Upon investigating, smoke was seen coming from the #1 B&M compressor. A portable ABC fire extinguisher was used to extinguish the fire.

Cause:

Fire may have started due to one or more of the following possibilities: 1) insulation breakdown due to fatigue; 2) oil contamination within the windings; 3) dust.

Preventative Action:

1) implement motored Pam's (periodic cleaning, rewinding, insulation checks); 2) operators will add periodic checks of screens.

Event ID: 1085633 **MS** **(F)** **26-Feb-06** **Goldcorp Inc. - Musselwhite Mine**

Incident:

A small fire occurred in the surface mechanical shop when a worker was using an oxy-acetylene torch to gouge a scoop bucket during routine maintenance. Slag from this process ignited a cardboard box containing empty new oil sample bottles. The box was approx. 8 to 10 feet away. The fire was extinguished using a hand-held 20 lb. ABC fire extinguisher.

Cause:

Poor housekeeping and improper storage of materials.

Preventative Action:

Clean-up of area. Review with all welders the importance of performing walk-arounds prior to any hot work.

Event ID: 1088973 **MS** **(F)** **03-May-06** **Xstrata - Smelter**

Incident:

A rental portable compressor overheated and caught fire. Komatsu rental #4273. The compressor was staged outside, it only ran to 10 minutes. An extinguisher was used to extinguish the fire. Compressor taken out of service, replaced with another.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087875 **MS** **25-Feb-06** **Xstrata - Fraser Mine**

Incident:

Operator was driving U43 getman anfo loader when left rear tire fell off. Worker was driving U43 getman anfo loader when he felt a sudden jar. Upon inspection, he noticed the left rear tire from the operator's compartment had fallen off. The worker lifted the rear of the machine onto its jack and called the shop supervisor. The wheel and hub assembly had separated from the axle. No injury, broken axle.

Cause:

Replace rear axle and assembly. Broken axle will be sent to supplier for analysis.

Preventative Action:

None given.

Event ID: 1088706 **MS** **24-Feb-06** **Xstrata - Strathcona Mine**

Incident:

Operator was driving HT020 haulage truck down ramp when he had to come to an abrupt stop to prevent hitting electricians working in the ramp. Worker was driving a 30 ton haulage truck hauling waste. Electricians were sent in the 568 access area to run cable for two 40HP fans. The electricians were working from a tractor with a man basket and had moved into the middle of the ramp between one of the haulage trips. As the truck operator was going back down the ramp, he started to turn the corner just above 568 sump (90 degree corner) and was forced to come to an abrupt stop to avoid hitting the electricians working in the ramp. No injury and no damage to equipment.

Cause:

None given.

Preventative Action:

Heighten awareness with all crews regarding following procedures when working in travelways. Barricades must be in place prior to working in the travelway.

Event ID: 1088704 **MS** **23-Feb-06** **Xstrata - Smelter**

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088193	MS	23-Feb-06	Xstrata - Fraser Mine

Incident:

The trammers were proceeding to the 4600 O.K. dump from the production side of the dump when they noticed 4 (45 feet) sections of fallen 30 inch diameter corrugated steel ducting just beyond the dust collector elbow. The support rock bolts were still attached to the segments. All the support rock bolts appeared to have rotted at the anchors and fallen to the ground. The section of the drift was barricaded off until the ground control dept. inspected the area. No injury, replace 45 feet of vent pipe.

Cause:

None given.

Preventative Action:

Drift being rehabbed with rebar and new anchors for the pipe are also being installed.

Event ID:	1087481	MS	(F)	22-Feb-06	Goldcorp Inc. - Hoyle Pond Mine

Incident:

While in the process of using a cutting torch to aid in the removal of a seized steering cylinder pin, grease on an EJC 60 series scooptram caught fire. Fire was extinguished with fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1087640	MS	22-Feb-06

Incident:

Collision occurred between loader and 1/2 ton vehicle. Loader operator moving slowly in reverse motion and 1/2 ton vehicle was entering custom feed pad from east roadway entrance. Loader operator stated he checked side mirrors not seeing anything reversed direction and struck oncoming vehicle. Truck driver stated he had seen loader stopped and noticed loader starting to back-up. He tried to communicate to loader operator via radio but was too late. No injuries, however, substantial damage to front end of vehicle.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088539 **MS** **21-Feb-06** **Xstrata - Craig Mine**

Incident:

Worker was brushed over by a 50 ton haulage truck that entered a fuel bay. Two workers were in the process of performing rehab work on the walls of a fuel bay when a haulage truck came in and approached the workers from its blind side. One of the workers indicated that he was brushed by the front tire. Toro 50 ton haulage truck worker reports soreness in shoulder and back from being struck and tumbling while running to safety. Investigation ongoing. Barricade standard to be written and adopted. Accident to be reviewed with all crews.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093313 **MS** **20-May-06** **Xstrata - Smelter**

Incident:

A punch de bar got stuck in #6 tuyere body. When trying to remove stuck bar, tuyere body became loosed. During the converter blew, a small amount of matte was leaking between converter shell and affected tuyere.

Cause:

None given.

Preventative Action:

If a bar gets stuck, they will cut bar near face of tuyere and will leave in tuyere body until converter is empty.

Event ID: 1087005 **MS (F)** **27-Feb-06** **Xstrata - Smelter**

Incident:

A part ladle of revert was being added through the mouth of #5 converter using #3 crane. The revert had been brought in from outside earlier in the day. Although the revert had been inspected and was not visibly wet, the cold conditions likely resulted in some frost on the revert. As the revert was being added to the converter, some of the material was blown back out of the vessel along with some molten slag. The slag splashed onto a garbage bin on the charge floor across from #3 converter which resulted in a small fire. A fire extinguisher was discharge to extinguish the small fire.

Cause:

The small fire was caused by the slag ejected from the wheel.

Preventative Action:

Revert that is brought into the aisle during winter months will be pre-heated prior to adding to a converter.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088248 MS (F) 03-Dec-06 Xstrata - Fraser Mine

Incident:

Worker was fuelling scooptram when he noticed an open flame on the exhaust side of the scoop. He immediately shut the fuel off and went to the operator's compartment and hit the fire suppression to extinguish the flame. No injury, no damage.

Cause:

Upon investigation, fuel had leaked from the fuel vent housing onto the exhaust 9 yd. Toro scooptram.

Preventative Action:

Recharge the fire suppression system on the scoop. Repair fuel vent on scoop. Fuel vents on all other scoops with the Wiggins system will be inspected and repaired as required. Review incident with all crews.

Event ID: 1087245 MS 20-Feb-06 St. Mary's Bowmanville Quarry

Incident:

Portable conveyor overturned when middle support leg collapsed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087942 MS 22-Mar-06

Incident:

Control room unable to reach loader operator on radio. Person in charge of shift investigated and loader was found in the work area and operator seemed to be in difficulty. Described as sharing back and fourth in his seat. ERT called to assist. Employee was removed from loader and sent to hospital via ambulance.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087219 MS (F) 19-Mar-06 Inco Ltd. - Oxygen Plant

Incident:

The fire alarm on the Edwards panel alarmed. The operator immediately tripped 39B turbine and crew entered the room wearing SCBA's to investigate. The doors were opened to vent the room and some smoke continued to come off the inboard side of the motor. A fire extinguisher was used as a precaution. Put out with portable fire extinguisher (number used 1).

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087225 MS 19-Mar-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Caller was climber with over loaded tractor-trailer. Truck started to roll back as it was cresting the hill. Caller kept truck straight as long as he could - applied brakes. Turning on the emergency brake. The caller later found out that other employees have refused to drive that truck. The safety office was advised and the caller was let go as a result of the incident. When the truck jack knifed, the inside of the cab was partially crushed and the windshield popped out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087218 MS (F) 16-Mar-06

Incident:

Tow man crew installing a new steel bridge on top an existing concrete platform. Worker drilling in crawlspace removed hardhat and put it 2 feet behind him. Spark from hot work ignited the head straps. Immediately extinguished.

Cause:

None given.

Preventative Action:

Hard hat to remain on at all times. When hot work is underway, all combustibles in direct path will be removed.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086819 MS (F) 15-Mar-06 Goldcorp Inc. - Musselwhite Mine: Mill

Incident:

A worker was using oxygen-acetylene cutting torches and a spark from the torches caught a tool bag and box of rags on fire. Discussion with workers concerning storage of material.

Cause:

Flammable material left near worksite.

Preventative Action:

None given.

Event ID: 1087214 MS 14-Mar-06 Inco Ltd. - Copper Cliff North Mine

Incident:

A power cable, communication line, and hydro-pole was pulled down by a contractor tri-axle haulage truck. During the initial inspection of a tri-axle haulage truck, the box of the truck was lifted up into the dump position. While performing the brake test, the operator failed to lower the box before moving the unit forward. The box contacted and pulled down the power line and hydro-pole, knocking out power to the mien site. No injuries. Access to area restricted and the Inco Power Dept. was notified. Power Dept. isolated all electrical hazards and repaired damage to power pole and cables.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1086820 MS (F) 03-May-06 Goldcorp Inc. - Musselwhite Mine

Incident:

An underground 40-D Toro truck operator forgot to press the reset button to release the drive line brake. As he drove with the brake on, it created friction on the brake pads. He noticed the smoke and stopped to investigate. The operator observed four to six inch flames, which he extinguished using a hand-held ABC extinguisher.

Cause:

Operator drove the truck without disengaging the drive-line brakes.

Preventative Action:

Review incident with all operators and refresher training for the operators involved.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093357 **MS** **(F)** **13-Mar-06**

Incident:

Level service operator was operating a scoop converted to forklift (EJC130 4YD). The unit was travelling up ramp (forks first with a load of rebar plates). While travelling up ramp (=15%), the operator noticed what appeared to be smoke. The operator immediately pulled into the entrance of the 6A sub level. Shut the unit off, grabbed the 5lb. Extinguisher and left the cab. The worker went to the back of the unit and noticed antifreeze bubbling around the exhaust. At this time, the operator was turning off the master switch the material that had been bubbling ignited to open flame. The fire was put out with the hand-held extinguisher. The operator then wheel chocked unit and monitored unit and notified supervisor. Supervisor arranged for mechanic to go to site, do a preliminary inspection of the unit.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090293 **MS** **(F)** **23-Mar-06** **Inco Ltd. - Central Process Tech Lab**

Incident:

While welding on the D6 dozer, a small fire started underneath the back of the machine on some old oil or diesel fuel on the ground. The small flame was immediately extinguished with an ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087213 **MS** **03-Nov-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

During the process of loading a haulage truck at the surface ore load out, #2 chute entirely detached from the concrete foundation. A run of muck buried the haulage truck and load-out area temporarily trapping the chute operator inside the cubicle control station. No injuries. #2 ore chute is completely detached from the concrete foundation. An uncontrolled run of material buried and heavily damaged trailer of haulage truck and wall of chute control station. #2 and #3 loading chutes are damaged and in-operational. Area has been guardrailed off with restricted and authorized access only.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087212 MS (F) 03-Sep-06 Inco Ltd. - Clarabelle Mill

Incident:

During the operation of #2 pump on PO line, the barrel failed (seized). The caused the barrel to heat up enough to ignite the lubricant on the end bearing. An open flame was noticed and extinguished immediately. 1 portable ABC fire extinguisher used to extinguish fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087204 MS 03-Aug-06 Inco Ltd. - Copper Cliff South Mine

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088194 MS (F) 03-Aug-06 Xstrata - Craig Mine

Incident:

Open flame from welding. A welder had set-up to weld on Maclean bolter MB018 when a park from the work fell onto oil soaked floor dry. No injuries, no damage. Flame was extinguished with 20 lb. extinguisher. Housekeeping issues to be stressed with mechanical crews.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089060 **MS** **(F)** **03-Aug-06** **Xstrata - Smelter**

Incident:

Fire was noticed inside an 8' x 10' garbage bin. This bin is used for cardboard. Fire was extinguished and area was secured. "Day" bin paint damaged. Security has planned follow-up inspections - bin has base of snow inside.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087792 **MS** **03-Aug-06** **Porcupine Joint Venture**

Incident:

Caller driving by Pit and states loader was under cutting muck pile.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088192 **MS** **03-Jul-06** **Xstrata - Craig Mine**

Incident:

Haulage truck tire blew out. The shift supervisor had stopped the haulage truck in the ramp and was in the process of reviewing a 5 point safety card with the worker when the left rear tire blew out causing enough concussion to cause the window on the truck door to shatter. The tire had been replaced the previous shift and only had 3 loads on it. The truck was empty at the time. The tire was a repaired tire which had previously seen service. No injuries. 1 blown haulage truck tire and 1 truck door window shattered.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089058 MS (F) 03-Jun-06 Xstrata - Thayer Lindsley Mine

Incident:

Operator was doing ramp maintenance with scoop when he noticed smoke coming from the engine compartment. No injuries. No damage to scoop. Vent hose from valve cover was routed alongside the exhaust instead of the frame. It came in contact with the hot exhaust pipe and burned a hole in the vent hose causing it to ignite. Scoop has been taken out of service pending repairs.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087215 MS (F) 13-Mar-06 Inco Ltd. - Copper Cliff Smelter

Incident:

A worker advised that there was a fire in the tank being worked on. The crew then proceeded to the Inco outvac assembly area. The Inco outvac alarm was activated. The cause is either from a malfunction of the light being used or the extension cord supplying power to the light. Any combustible materials will not be stored on or adjacent to rubber products in case of malfunction. The fire watch will extend into lunch hours and coffee breaks. The model of lighting used will not be replaced. All power will be disconnected at the end of the shift.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

MV – MOTOR VEHICLES

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102981 **MV** **15-Dec-06** **Inco Ltd. - Stobie Mine**

Incident:

A scissor truck free wheeled down the 3000 level ramp while the operator was performing a pre-ramp entry service brake test. The service brake did not completely hold and caused the unit to jump forward which in turn caused the operator to accidentally pull the transmission into the neutral position. The worker attempted to engage the transmission but was unsuccessful. The service brake was applied and did not effectively slow the unit down. The emergency brake was activated to stop the unit. The unit travelled approx. 75 feet down ramp. The service brake was tested during the pre-operational check earlier in the shift and had worked properly. No injuries. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103901 **MV** **15-Dec-06** **Agrium Incorporated**

Incident:

A bus transporting workers to the mine site for day shift left the mine access road and came to rest about 65 metres in the bush, approximately 2 km from the mine site gate. Twenty four workers were taken to the hospital and treated for miscellaneous injuries, none of which were life threatening.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103129 **MV (F)** **09-Dec-06** **Xstrata - Lockerby Mine**

Incident:

A small fire occurred on a fuel truck in the 5600 level fuelling bay. An extinguisher was used to put out the fire. No injuries resulted from this.

Cause:

Fuel from the nozzle dripped onto the hot exhaust.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

RM – ROCK MOVEMENT

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1088063 **RM** **24-Jun-06** **Goldcorp Inc. - Musselwhite Mine**

Incident:

A fall of ground occurred. It is estimated that 1.5 metres of the foot wall fell into the open stope. A block of approx. 30 tonnes that was undercut as a result of the wall failure, then fell and hit the front of the scoop. The 11-yd scoop was being operated remotely when the incident occurred.

Cause:

Poor wall rock conditions.

Preventative Action:

Stope sequencing will be altered to decrease the minimum HR of the next cycle to 6.5.

Event ID: 1101400 **RM** **16-Sep-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

A magnitude event was felt throughout the mine causing a run of rock.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1097489 **RM** **31-Aug-06** **Inco Ltd. - Stobie Mine**

Incident:

Two miners were on the back of a scissor truck. They were in the process of preparing a previously drilled area for shotcreting. They had just scaled the back when they noticed some material trickling from the back. The immediately left the scissor truck. Shortly thereafter, a fall of ground occurred. Approx. 3 tons of material fell on the bed of the scissor truck with an additional 5 tons falling behind the scissor truck. A visual inspection to the scissor truck did not reveal an significant damage, however the scissor truck has been sent to the garage for inspection.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1090498	RM	24-Aug-06	Musselwhite Mine

Incident:

A fall of ground occurred in an active open stope. Approx. 900 tonnes of waste fell from the west wall and into the stope and slid down the muck pile into the draw point. The chunk was approx. 5 metres wide x 12 metres long x 8 metres high with a planar surface along the foliation.

Cause:

The probable factor is the stope being undercut on a plane of weakness along the foliation.

Preventative Action:

A CMS will be taken to determine the extent of failure. Loading pattern will change to avoid blasting the undercut. Backfilling before the next blast will also be considered.

Event ID:	1090315	RM	19-Aug-06	Musselwhite Mine

Incident:

A fall of ground occurred in a non-active open stope. The air movement from the failure was felt in the 150 metre shop and was reported. There were no injuries or equipment damage sustained during the incident. A CMS will be taken to determine location and extent of failure. Access to this area will continue to be restricted.

Cause:

Unknown.

Preventative Action:

None given.

Event ID:	1093963	RM	31-Jul-06	Inco Ltd. - Copper Cliff South Mine

Incident:

A 2.5 magnitude seismicity event occurred.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1095133 **RM** **28-Jul-06** **Xstrata - Thayer Lindsley Mine**

Incident:

Fall of ground causing damage to equipment. No injury. Damage to both booms on JB-211. Employee was in the process of drilling his lifters when a slab of higher grade ore with a friable appearance peeled off the upper right side of the face. The loose struck both booms causing some damage to the boom assembly.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103434 **RM** **29-Nov-06** **Inco Ltd. - Creighton Mine**

Incident:

A major seismic event was felt throughout the Sudbury Basin. There were no injuries but minor damage to mine services. The major event resulted in the evacuation of underground workings on the graveyard shift and restrictions for access below 5400.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1093414 **RM** **07-Feb-06** **Kidd Creek: Lower Mine**

Incident:

Approx. 1000 tonnes of ore fell from the walls/back of the 61-825 stope, partially burying a remote scooptram in the stope drawpoint. Unknown damage to the scoop.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1096502	RM	20-Sep-06	Goldcorp Inc. - Dome Mines #8 Shaft

Incident:

Slide of material.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093722	RM	17-Jun-06	Inco Ltd. - Creighton Mine

Incident:

An 8yd. Scooptram was removing rock and was in a scoop length past a newly reconditioned area when the left wall gave way. Approx. 80 tons of material came down trapping the operator in the cab. He was let out through the side window. No injuries. Minimal damage to equipment. Area guardrailed and incident is under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1095242	RM	06-Nov-06	Inco Ltd. - Copper Cliff North Mine

Incident:

A magnitude was felt at the mine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1093710	RM	06-Oct-06	Inco Ltd. - Creighton Mine

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093327	RM	06-Jul-06	Xstrata - Fraser Mine

Incident:

Fault slip rockbursts. Majority of failure was below support. Screen and strapping contained significant amount material. Mining completed. A decision will be made whether to fill the stop or rehab the intersection for a diamond drill access. Seismically active area with no apparent precursor events. Area cooled down with no significant after shock activity.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1093326	RM	06-May-06	Xstrata - Thayer Lindsley Mine

Incident:

Rockburst blew out wall in temporarily closed and barricaded 3 zone stope 3 M from an open stope which has sat empty since closing zone. Some broken rebar (not all). Area will remain barricaded with unsupported ground sign.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1093319 **RM** **06-Mar-06** **Xstrata - Craig Mine**

Incident:

A back failure of approx. 1200 tonnes occurred. The fall occurred with the blast (rings 1 to 6) which was fired from the over cut on 47-0.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089643 **RM** **07-Apr-06** **Williams Corporation - Williams Mine**

Incident:

An employee was hit with a piece of loose while installing found support. The employee has a broken leg.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102449 **RM** **25-Oct-06** **Inco Ltd. - Coleman Mine**

Incident:

The first bulk blast was taken at the end of dayshift. The blast encompassed 3 lines (14 holes). During a vent inspection after the blast, displaced material (9 tonnes) was discovered.

Cause:

None given.

Preventative Action:

Prior to blasting, any additional rings recondition back area contained bagged loose - just ahead of the safety bay Cut screen and remove loose. Install new rebar to replace mechanical bolts with bent plates. Re-screen. Recondition left was (burst area) remove hanging loose and install wall support (split sets) down to B.R. prior to drilling. Recondition wall area around the corner from burst zone, once muck pile is removed. May need to consider shotcreting corner ground control to assess once muck pile is gone.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1102875 RM 23-Dec-06 Inco Ltd. - Garson Mine

Incident:

A rockburst occurred on the 5000 level in the 2861 and 2901 crosscuts and in the #1 shear east forward drift. Approximately 140 tons of material was displaced from the pillars and back of both sills and from the north wall of the #1 shear east forward drift. The support consisted of #6 GA WWM and 8 foot long resin grouted rebars in the back and shoulders and 6 foot long resin grouted rebar bolts in the walls that were screened and bolted to 5 feet above base of rail. Parts of the affected areas were also shotcreted with a 3-inch thick layer of shotcrete. The affected drifts were de-stressed during development. No injuries or damage to equipment resulted.

Cause:

The area was affected by the burst. The ejected material was of irregular variable size, consistent with prevailing jointing.

Preventative Action:

Access to the area was restricted, the 5000 level was closed for 24 hours and re-opened the next day at the start of the dayshift when the double barricade was moved just east of the affected area to restrict access until reconditioning commenced. Reconditioning will consist of shotcreting with SFRS, bolting and screening with a mixture of 8 foot, 6 foot long rebar bolts and 10 foot long super swelled, followed by a final layer of regular shotcrete. Cable bolts and/or cone bolts may also be installed. Reconditioning procedure will be reviewed as the reconditioning progresses.

Event ID: 1102465 RM 17-Nov-06 Inco Ltd. - Copper Cliff South Mine

Incident:

Fall of ground occurred. No injuries. Damage occurred to the topsoil ground support systems. High grade ore fell from a hanging pillar on the right wall of the topsill. Access has been restricted to the area. A ground control assessment has been performed and a reconditioning plan has been developed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1103430 RM 09-Dec-06 Inco Ltd. - Coleman Mine

Incident:

Three pillars (11-34, 11-32, 11-30) had been damaged, with the ground support that was installed on the sides of the pillars failing - allowing material to be ejected from the sides of the pillar into the x-cut. No injuries. A bolter was installing support at the face of 11-31 crosscut, when the ground started working. With the initial onset of seismicity, approximately 15 tons of material was displaced from the west side.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102461 RM 11-Jul-06 Inco Ltd. - Coleman Mine

Incident:

Rockbursts. Material displaced from the right side shoulder. Rockburst area. Recondition shoulder and wall in the immediate rockburst zone with mechanical bolts and screen following the standard ground support standards.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102110 RM 11-Mar-06 Xstrata - Kidd Creek: Deep 7000

Incident:

Rockburst with extremely high ES:EP ration (226) occurred in north end of abutment due to fault slip on the north G fault.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1102219	RM	11-Mar-06	Xstrata - Kidd Creek: Deep 7000

Incident:

Rockburst occurred in southern abutment, possibly due to fault slip on the north fault as a result of stope blasting in 61-786 stope. Blasting in 68 sill may also have triggered.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1101398	RM	16-Sep-06	Inco Ltd. - Copper Cliff South Mine

Incident:

A magnitude event was felt throughout the mine causing a run of rock.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1100714	RM	28-Oct-06	Xstrata - Fraser Mine

Incident:

A large fall of ground (more than 100 tonnes) occurred hours after taking the final long hole blast at end of the day shift. Material displaced mainly from the brow area at the wide section in the stope, at ore/waste contact and location of strong geological structures in the back. No damage to equipment. Brow support failure. Wall and back sloughing in the open stope at time of inspection. Damage to ground support (stripped and displaced 6M cable bolts, slipped and broken rebar, and damaged screen) damage to excavation / brow area. No injuries. Area was roped off.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1101118 **RM** **16-Sep-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

Fall of muck down shaft. No personal injury or damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102451 **RM** **25-Oct-06** **Inco Ltd. - Creighton Mine**

Incident:

A seismic event measuring 2.0MN occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102448 **RM** **22-Oct-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

An estimated 1000 tons of material was displaced from the pillar. The adjacent stope was lined and filled with cemented rock but a section of the sill pillar was undercut due to the failure of the cemented rock from the top portion of the stope, leading to a hanging pillar. The hanging portion of the pillar fell down into the open stope after the crown blast. The sills were also supported with a minimum of shotcrete back and walls to base of rail. The affected area of the mine is within the open and access is restricted.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1102452	RM	22-Oct-06	Inco Ltd. - Copper Cliff North Mine

Incident:

An estimated 1000 tons of material was displaced from the pillar during or shortly after the crown blast of stope.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1101184	RM	10-Dec-06	Xstrata - Lockerby Mine

Incident:

Fall of ground inside blast hole stope.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1101421	RM	10-Nov-06	Inco Ltd. - Coleman Mine

Incident:

Rockburst occurred after completion of retreat recovery of cross-cuts. Displaced material originated from the unsupported walls (adjacent to mined out crosscuts) of three post pillars. No material was displaced from the supported walls of the post pillars.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098448 **RM** **22-Sep-06** **Inco Ltd. - Stobie Mine**

Incident:

A seismic event occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094690 **RM** **26-Apr-06** **Canadian Gypsum Co.**

Incident:

Fall of ground - about 3 tons and 1 injured worker. Not believed to be critical at this time.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102220 **RM** **11-Mar-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

Suspected rockburst occurred in south end abutment as a result of blasting 69-821 stope in 68 sill pillar. Suspected burst triggered FSOG in excess of 100 T from walls of adjacent dev on multiple levels.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1097490 **RM** **09-Jan-06** **Inco Ltd. - Stobie Mine**

Incident:

Rockburst occurred. The majority of the displacement occurred in three areas. The activities in the division were stopped and employees brought up to surface. No injuries. Damage to 2990 fresh air raise access drift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094120 **RM** **21-May-06** **Inco Ltd. - Creighton Mine**

Incident:

Approx. eight tons of material was displaced. No major damage was observed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1084997 **RM** **01-Aug-06** **Xstrata - Thayer Lindsley Mine**

Incident:

Report of rockburst.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087184 **RM** **01-Mar-06** **Inco Ltd. - Copper Cliff South Mine**

Incident:

Approx. 700 tons fell from back and left wall ahead of 1900 x-cut / 1850 sill drift corner and from HW nose 1850/1900. Made up of small to large blocks, some pieces up to 10-foot maximum dimension. Persistent joint left wall vertical dip and other parallel joints present in back along with low-lying joints. 700 tons fell from back and left wall. Rock pile consisting of small to large blocks. New tension cracks in shotcrete at intersection. No injuries or damage to equipment. Area guardrailed and access restricted. Beat geologist to visit site to determine if wall sloughing has exposed Creighton fault. Monitor 1900 BSILL new brow area shotcrete cracks. Cover assess ground support requirement for new brow area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101413 **RM** **10-Aug-06** **Inco - Coleman Mine**

Incident:

Damage occurred immediately in front of completed (one week earlier) back reconditioning resulting from ME-100 reportable rockbursts. A series of micro seismic events occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101417 **RM** **30-Sep-06** **Inco Ltd. - Creighton Mine**

Incident:

A seismic event measuring 2.1mn occurred 24 minutes after a production blast slash.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1098447 **RM** **09-Dec-06** **Xstrata - Thayer Lindsley Mine**

Incident:

None given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1085733 **RM** **01-Nov-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

Stope back failure triggered by blasting in adjacent stops of 1200-1500 T area previously filled and inactive. Area was fenced off prior to discovery.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1101391 **RM** **09-Jul-06** **Inco Ltd. - Coleman Mine**

Incident:

Rockburst. 8 tons of total displaced material has included the 7.5 tons of material contained by installed ground support. Corrective measures taken: removed bagged loose and recondition damaged back with 8 foot rebars. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1085736 **RM** **13-Jan-06** **Xstrata - Kidd Creek: Lower Mine**

Incident:

Failure occurred. Stope back wall failure of 250 T failed onto top of paste fill. Area previously filled and inactive was fenced off prior to failure.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089053 **RM** **04-May-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

Blast triggered MN 2.8 seismic event. Event caused damage to opening/support in the fresh air raise access.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1096270 **RM** **04-Apr-06**

Incident:

A small ground fall was reported in an inactive/restricted area. There was no risk or damage to personnel or equipment. Area is roped and signed off, as is over cut.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1086822 RM 30-Mar-06 Goldcorp. Inc. - Musselwhite Mine

Incident:

Fall of ground occurred. The fall of ground was due to a wedge structure. The area was deemed in need of re-conditioning and was no-man access at the time. The area will continue to be "no-man access" until a re-condition plan is formulated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089079 RM 25-Mar-06 Inco Ltd. - Copper Cliff North Mine

Incident:

The hanging pillar on the bottom sill fell down causing 1200 tons of displaced material. Access to the area was denied at the time of occurrence, as it was confined to the open stop. The area was inspected. A reconditioning plan has been developed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088799 RM 24-Mar-06 Xstrata - Lockerby Mine

Incident:

Fall of ground - more than 50 tons. Scoop inside of stope. Letting it sit until they are able to access it.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087228 RM 23-Mar-06 Inco Ltd. - Copper Cliff North Mine

Incident:

Fall of ground occurred within the open stope limited. No injuries or damage. Access to the area was denied at the time of occurrence as it was confined to the open stope.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089077 RM 23-Mar-06 Inco Ltd. - Copper Cliff North Mine

Incident:

After a production blast of the stope, the hanging pillar between bottom sill fell down causing 1200 tons of displaced material.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1098910 RM 09-Sep-06 Porcupine Joint Venture

Incident:

A section of rock toppled / unravelled from pit wall into the pit floor. No injuries reported.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1087564 **RM** **03-Dec-06** **Kidd Creek: Upper Mine**

Incident:

Fall of approx. 5.6 tons of ore down the #2 shaft from the 2800 ft. level south loading pocket. No injuries. Damaged 4 brattice panels.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089063 **RM** **15-Feb-06** **Inco Ltd. - Copper Cliff North Mine**

Incident:

An estimated 150 tons of material was displaced.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090630 **RM** **25-Apr-06** **Inco Ltd. - Creighton Mine**

Incident:

Approx. 16 tons of material displaced.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090624 RM 20-Apr-06 Inco Ltd. - Copper Cliff South Mine

Incident:

An approximated 4000 tons of high-grad ore fell in the open stope and adjacent 950 sill on 2550 level. The scoop operator was mucking chunks stored at the end of the 950 sill using remote procedure when the fall of ground occurred. The scoop operator reported the occurrence to his supervisor.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091472 RM 05-May-06 Inco Ltd. - Copper Cliff South Mine

Incident:

An estimated 5000 tons of high grade material fell from the back of 0950 sill on 2550 level burying a second scoop (unit #37) when trying to muck the ore to recover the previously buried scoop (unit #69). The 1000 sill was completely mucked out of the 0950 sill being mucked at the time of the occurrence causing damage to equipment. As recommended after the previous fall of ground, the 0950 sill was bolted and screened before mucking from the sill occurred and there is no evidence of any damage to the supported area of the sill as a consequence of this fall of ground. Incident under investigation. Access to the area is restricted until a plan of action is drafted.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089253 RM 15-Apr-06

Incident:

Fall of ground from southeast wall of pit above 3295 elevation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1090067 **RM** **04-Sep-06** **Inco Ltd. - Creighton Mine**

Incident:

A seismic event measuring 2.5 MN occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1088004 **RM** **01-Oct-06** **Inco Ltd. - Creighton Mine**

Incident:

A fall of ground occurred with the 3351 SS blast.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087879 **RM** **20-Mar-06**

Incident:

Fall of ground from southeast wall of pit beneath the pit ramp. No injuries. Ramp width above the failure area has been reduced to a single lane. Frequency of visual and prism monitoring at the site has been increased.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1094117 **RM** **20-May-06** **Inco Ltd. - Creighton Mine**

Incident:

Approx. fifteen tons of material was displaced.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087787 **RM** **03-Sep-06** **Xstrata - Kidd Creek: Deep 7000**

Incident:

MN 2.6 burst in 6000L sill, which was triggered by blasting in 61-785 St. Event happened 2 hours and 18 minutes post blast. No injury or equipment damage. No one underground.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1089479 **RM** **22-Feb-06** **Inco Ltd. - Creighton Mine**

Incident:

Fall of ground.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID: 1089469 RM 18-Feb-06 Inco Ltd. - Coleman Mine

Incident:

Rockburst occurred in the ramp. The majority of displaced material came from the back with minor displacement from the walls. No injuries and there does not appear to be any equipment damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090700 RM 27-Jan-06 Williams Operating - David Bell Mine

Incident:

A small ground fall was reported in an inactive / restricted area. The area was inspected at this time and the fall of ground was estimated at less than 50 tonnes. Subsequent follow-up revealed that, over the weekend, additional material unravelled from the back, elevating the total fallen ground to approx. 100 tonnes. Failure was restricted to the ore zone and as no one is permitted within 5 meters of the open stope, there was no risk or damage to personnel or equipment. Area is roped and signed off.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1085181 RM 27-Jan-06 Goldcorp Inc. - Musselwhite Mine

Incident:

While mucking at the underground stope (425 A050 stope) remotely, a 10-yd Tamrock scooptram became trapped. There was a fall of ground from the footwall side (east wall) of the stope. The rock fell covering the front end of the scooptram. As the scooptram is still trapped inside the stope, damage is unknown at this time.

Cause:

None given.

Preventative Action:

Continually assess ground conditions while mucking on remote. Pull out and let ground settle down if there is any sign of deteriorating ground conditions.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2006

Event ID:	1088077	RM	16-Jan-06	Inco Ltd. - Creighton Mine

Incident:

Seismic event measuring 2.7 MN occurred.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1085772	RM	16-Jan-06	Xstrata - Kidd Creek: Deep 7000

Incident:

F.O.G. from stope wall into open slot. F.O.G. included floor area immediately in front of long hole drill which was drilling as easer ring to pick up ground where previously drilled rings had been damaged by slot blasting. Failure is under investigation at this time.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1087223	RM	21-Mar-06	Inco Ltd. - Copper Cliff North Mine

Incident:

An estimated 60 tons of material was displaced from the west wall of the open stope.

Cause:

None given.

Preventative Action:

None given.



SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

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EN	EXPLOSIONS (replaced) (see appropriate categories for Explosions such as Explosives, Molten Materials and Miscellaneous)	33 – 35
EX	EXPLOSIVES (including explosives, primers, detonating cords, blasting caps, etc.; careless handling, unplanned explosions due to explosives, etc.)	36 – 52
FG	FLAMMABLE GAS (including methane gas from the rockmass only)	53 – 94
HS	HOISTING (including head-frames, sheaves, ropes, shaft, shaft conveyances, shaft sinking equipment, shaft furnishings, hoist controls, counterweights, etc.)	95 – 112
IW	INRUSH OF WATER OR MATERIAL (including run of backfill or gravel)	113 – 126
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RM	ROCK MOVEMENT (including rockbursts and falls of ground)	214 - 233

NOTE: For occurrences resulting in a fire, (F) is added to the subscript.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

EF – EQUIPMENT FAILURE OR DAMAGE

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105819 **EF** **04-Jan-07** **Copper Cliff Smelter**

Incident:

At approximately 9:00 a.m. control was lost for a split second at the DCS Control Room. This disruption caused the diesel pump to activate. The surge of the pump caused an increase in water pressure in the system leading to 2 water line failures causing water to go on top of #1 FF roof.

Cause:

Disruption of control caused the diesel pump to activate.

Preventative Action:

None given.

Event ID: 1105814 **EF (F)** **04-Jan-07** **Copper Cliff Smelter**

Incident:

Scupper line expansion joint caught fire on #2 furnace. Source of ignition: Patch on the scupper line. Source of fuel: Heat from off gases through the duct caused the incident. The expansion joint developed a split in it a week ago and a temporary patch was put on.

Cause:

A power trip shut down the pumps required to cool the scupper line. The line got hot enough to set the patch on fire.

Preventative Action:

None given.

Event ID: 1105818 **EF (F)** **04-Jan-07** **Copper Cliff Smelter**

Incident:

Natural gas hoses feeding the casting spoon burners developed leaks in three locations. When a temperature probe was taken at the cast spoon, the probe passed by the leaks causing them to ignite. The area was roped off to ensure no one would enter the area. It was decided to stop the cast and have the hoses repaired.

Cause:

Hot probe source. Hoses often develop leaks and are repaired following the cast. The hoses are subject to wear due to their location. Method of extinguishment: shut off the fuel supply.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108286 EF 16-Jan-07 Copper Cliff Smelter

Incident:

When one of the four furnace fugitive fans was down for emergency maintenance while skimming slag from the #2 flash furnace, a second fan failed and that led to high concentration levels of SO₂ at the slag skimming area. No injuries.

Cause:

Belts on fugitive fan 32-430 failed.

Preventative Action:

None given.

Event ID: 1103132 EF (F) 22-Jan-07 Kidd Mine: Surface

Incident:

A brand new single battery pack (16 volt) caught fire on surface outside the #2 head frame. Battery was strapped to a pallet and was waiting to be moved underground. Put out with hand held fire extinguisher. No physical damage apparent. Battery will be examined by the manufacturer.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109813 EF 23-Jan-07 Mussewhite Mine: Underground

Incident:

A report of an alarm on the fire water supply line in the underground conveyor system drift was received by security. At the time the alarm sounded, no workers were underground. Investigation is ongoing.

Cause:

Believed that the recent sub-zero temperature may be a factor for the activation of the conveyor alarm system.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108832 EF (F) 30-Jan-07 Clarabelle Mill

Incident:

During emergency pull cord checks, an opportunity was used to switch pumps. To avoid plugging lines, the rod mills and crushing lines were dropped to flush the lines. After the pumps were switched, the sag / rod mills and crushing line were restarted. At this time, #10 ball mill went down. When attempting to restart #10 ball mill, the clutch smoked. This was investigated and the clutch was found to be red hot, so an outvac was called. Personnel used fire extinguishers and a water hose to cool the clutch.

Cause:

Heat from clutch slipping. Low air pressure for clutch.

Preventative Action:

None given.

Event ID: 1109053 EF 17-Feb-07 Red Lake Complex Mine Shaft

Incident:

While hoisting (slinging) a 1000 volt tech cable up from 43 level to 42 level, the cable pulled out of the Kellem grip (used a slinging attachment) and fell to the deck at the 43 level. This caused no injuries to employees or damage to shaft. The cable was brought to surface and scrapped. An 11-tonne windtel tugger hoist was used for the installation of electrical cable.

Cause:

It was reported that the Kellem grip was not installed according to manufacturer's recommendations and it was also reported a lack of planning and communication between all parties involved caused this incident. It was also reported there was a lack of understanding as to how high the cable was to be pulled for installation purposes.

Preventative Action:

The practice of slinging cables in the shaft using this type of Kellem grip has ceased pending the outcome of a full investigation. A safety contact to be issued to all Goldcorp and Cementation personnel pulling / installing cables in shaft. All remaining cables at #3 shaft will be installed with engineered attachments. Goldcorp will develop a procedure for vertical cable lifts.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104414 **EF (F)** **23-Feb-07** **Halloway Mine #3 Shaft Site: Surface**

Incident:

MG set motor caught fire after shut down. Fire was detected by alarm. Fire put out by hand held extinguisher. No injuries. No damage except to motor itself.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104682 **EF** **01-Mar-07** **Xstrata Nickel - Sudbury Smelter**

Incident:

Smelter Convert Aisle. Operator was taking out a ladle of molten metal. When she turned her converter up, she heard something and at the same time #4 crane operator told her that the ventilation duct had fallen off. she stopped the converter to go investigate and found the end wall ventilation elbow section on the floor behind the converter. There was no other damage or injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182026 **EF (F)** **05-Mar-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

Shortly after a lift of blanks had been placed into cell 30 in the tankhouse, the operator noticed smoke rising from a (red) hot crossrod that was shorted due to it not being positioned properly in the spaceboard. The rectifier feeding the section was tripped and a small flame at the crossrod was extinguished. The cross rod was realigned, the section was checked and power was restored.

Cause:

Electrical short of crossrod causing heating.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182049 **EF (F)** **06-Mar-07** **Copper Cliff Smelter**

Incident:

While high pressure washing the scupper line / primary reverse jet scrubber, the temperature got too hot to continue. Upon visual inspection of the scupper / primary tank, little blue flames were observed on the transition of the scupper line and tank. CO gas ignited when it reached the scupper line transition.

Cause:

Lack of ventilation. Bell damper opening is not opening is not large enough, therefore lack of draft.

Preventative Action:

None given.

Event ID: 1181081 **EF** **09-Mar-07** **Shallow Lake Quarry**

Incident:

The roof in the gut stone shop collapsed. There were no workers in the building and no one was injured. Pictures have been taken. There is currently a 20 x 40 foot hole in the roof. Update from inspector: The building has been shut down. Snow has been cleared from the remainder of the roof. Engineering assessments are currently being done. Inspector has been in contact with the plant and will make a field visit.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108927 **EF** **13-Mar-07** **Montcalm Project - Outokumpu Mines Ltd.**

Incident:

Fine ore accumulated on outside of roof of crushed ore storage bin causing excessive weight and several panels of roof structure collapsed. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182052 **EF (F)** **14-Mar-07** **CVRD Inco - Matte Processing**

Incident:

The Matte Processing electrician contacted via radio to the RS view operator about smoke coming from 1A Rod Mill and to have an operator check it out. 2 operators went to investigate 1A Rod Mill and discovered a small visible flame coming from the north bearing of the bull gear. A fire extinguisher was used to put out the small flame. 1A Rod Mill was shut down immediately. Source of ignition: grease. Source of fuel: heat from the bearing.

Cause:

Bearing overheated. Extinguished with portable ABC fire extinguisher.

Preventative Action:

None given.

Event ID: 1109021 **EF (F)** **18-Mar-07** **Hoyle Pond Mine: Surface**

Incident:

An insulator on a 27.6 KV pole line to Bell Creek broke causing the top phase to drop and short out to the 2nd phase. This caused heat and a short circuit condition and heat was intense enough to start the pole to smolder. The local fire department was called.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108606 **EF** **01-Apr-07** **Falconbridge Ltd. - Kidd Mine**

Incident:

A 2000 lb. capacity electric hoist failed during a lift causing an agitator shaft to fall approximately 8 feet into the tank it was being lifted from. No injuries or equipment damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1058311 **EF (F)** **01-Apr-07** **Coleman Mine: U/G**

Incident:

While using an Oxy/Acetylene torch, flames were noticed coming from between the quick connect fitting and the flashback arrestor. Immediate shut down of both bottles was initiated. The flame continued to burn due to fuel in the line until the quick connects were disconnected from the torch. The nut for the quick connect coupling came loose from the flash back arrestor during regular use.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191693 **EF** **04-May-07** **Copper Cliff Smelter - Converter**

Incident:

The DFR (down for repair) crew was assigned the task of replacing the journal brass on #10 converter. They were in the process of jacking up the converter (west side) when a hydraulic fitting let go on the power pack. A pre-use check was conducted prior to the use of the unit. The failed swivel fitting was found to be loose and tightened prior to equipment use. When the swivel fitting broke, the weight of the converter caused the hydraulic fluid to be forced out the valve assembly under pressure allowing the converter to drop back onto the trunions. No employees were injured, although one employee's leg was bruised by the valve assembly. Damage to hydraulic swivel fitting. The swivel fitting cracked and failed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191695 **EF** **07-May-07** **Strathcona Mill**

Incident:

In preparation for summer maintenance, worker was cleaning the rakes #3 thickener. When he attempted to re-position the rakes, the worker was unable to start the rake mechanism.

Cause:

Troubleshooting by the maintenance department identified the main support structure of the support bridge had corroded and the bridge had failed at the end and had dropped ~ 1 ft.

Preventative Action:

None given.

Event ID: 1109887 **EF** **09-May-07** **Falconbridge Ltd. Midd Mine**

Incident:

It was discovered by a dewatering operator that a 3x3x7 long piece of steel angle iron was found lying across the floor at the entrance to copper 2 under flow pipe. The angle iron was supporting a 6" plastic pipe and fell with a pendulum effect to the floor at the joint of the plastic pipe. It had fallen from the thickener support tseams approximately 12 - 15 feet. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202009 **EF (F)** **11-May-07** **Clarabelle Mill**

Incident:

Mechanics had been working on No. 1 Rod Mill replacing liner bolts. Control room was notified when job was completed and started mill. Upon starting of Rod Mill, the clutch started smoking and the Mill was immediately shutdown. Visible flames were extinguished using hand held fire extinguishers and water hose. Clutch overheated due to manual engagement during repairs.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202028 **EF** **19-May-07** **Xstrata Nickel Sudbury Smelter**

Incident:

At 1:20 a.m. workers noticed a substantial water leak from #6 Electrode. The CCR supervisor immediately broke electric power to the 3rd phase of the furnace. The operator shut both supply water valves off supplying the contact pad to #6 Electrode. At 2:00 a.m., the Roasters were shut down and at 3:20 a.m., all furnace power was shut down. Maintenance was called in to repair. At 6:00 a.m., the operator turned on the supply water to determine where the leak was originating from. The leak had fixed itself. No maintenance was needed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202046 **EF (F)** **30-May-07** **CVRD Inco: Matte Processing**

Incident:

1B Rod Mill was observed slowing down. The feed had been taken off the Rod Mill approximately 10 minutes earlier to deal with other process issues and the Rod Mill clutch had disengaged from the motor after the feed had been off for 5 minutes. The operator went to inspect why the Rod Mill was turning and saw smoke coming from the clutch. He then pressed the manual disengage for the clutch and shut off the motor. Inspecting the clutch once again the operator noticed a small fire coming from the clutch. The operator then reported the fire to his foreman who went to investigate. A fellow operator used a fire extinguisher and a water hose to attempt to put out the smoldering clutch. Once smoldering stopped, the Rod Mill was locked and tagged, the clutch guard was removed and the shift mechanic inspected the clutch for damage. Very little damage to the clutch.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1202059	EF	07-Jun-07	Copper Cliff Smelter

Incident:

#6 crane was travelling east from #6 converter to cast #10 converter. The hood came totally off of its tracks landing on the adjacent platform. No injuries. Damage to the auxiliary hoist, damage to some equipment on the platform and damage to the hood. Under joint investigation. Roped the area off. Crane will be inspected by an engineer. PHR will be done prior to any repairs being done.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1135673	EF (F)	18-Jun-07	Falconbridge Kidd Met Site

Incident:

A set of gaskets overheated causing a minor fire on a heating unit at #56 mist precipitator in the zinc roaster during start-up operations. The fire was extinguished with a portable fire extinguisher and there were no injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1162148	EF	18-Jun-07	Red Lake Complex: Underground

Incident:

A raise bore being operated by Cementation Canada Inc. underground at the 2300 level at the Red Lake Complex Mine had a failure while reaming a 13 foot 4 inch vent raise from 3700 level. A raise bore machine failed resulting in 840 feet of drill rod steel and the 13.4 inchy reamer to fall 1,072 feet to the vent raise cutting chamber on 3700 level. There were no injuries sustained by any workers as no one was present at the bottom of the raise when incident occurred. Orders were issued to Goldcorp. Canada Ltd. and to Cementation Canada Inc. A new procedure has been received for mucking raise bore cuttings.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202095 **EF** **23-Jun-07** **Xstrata Nickel Sudbury Smelter**

Incident:

#6 converter operator was lowering #6 converter hood and during this process, it was observed that the hood was not lowering in a normal manner and then the hood dropped 3 to 4 feet. #6 converter hood was tagged out until a complete inspection and repairs were carried out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202125 **EF (F)** **22-Jul-07** **Xstrata Nickel Sudbury Smelter**

Incident:

Stored custom feed spent catalyst self ignited causing a fire. Fire required extinguishing.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1208124 **EF** **07-Aug-07**

Incident:

During the annual maintenance inspection of the thickener, the tank is emptied and cleaned. The operator started the electric rake lift and a bolt broke on the drive frame and bent it.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202158 **EF (F)** **08-Aug-07** **Copper Cliff Smelter**

Incident:

While chipping the uptake on D floor, a hydraulic seal was lost on the versa hoe boom causing hydraulic fluid to leak. The heat inside the uptake was sufficient to ignite the fluid causing a small fire at the boom. No injuries.

Cause:

Keeping the versa hoe boom inside of the furnace uptake for too long will cause the hydraulic cylinder seals to fall.

Preventative Action:

None given.

Event ID: 1202168 **EF** **10-Aug-07** **Xstrata Nickel Sudbury Smelter**

Incident:

While jacking a furnace spring, a furnace jacking spindle broke unloading pressure on spindle, not the spring.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202171 **EF (F)** **13-Aug-07** **Xstrata Nickel Sudbury Smelter**

Incident:

#5 converter foamed 23 minutes into its 1st blow while adding batteries. A small fire was put out using a fire extinguisher. The extinguisher was replaced.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202182 **EF (F)** **15-Aug-07** **Coleman Mine: Underground**

Incident:

An employee from Machine Roger turned on the power at the G/F panel for the ITH. The power kept tripping and the employee went to investigate at the drill. The employee noticed a small flame at the plug on the end of the power cable and extinguished the fire with a hand held extinguisher. Short in the electrical plug.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202196 **EF** **20-Aug-07** **Copper Cliff Smelter**

Incident:

The site for the balloon flue removal was being reviewed when a small flame was noticed on the inside of the old flue at the bottom. An old rope had caught fire from the burning sparks. A fire extinguisher was used to extinguish the fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135691 **EF** **22-Aug-07** **Falconbridge Kidd Met Site**

Incident:

The support bolts broke off gear and agitator of motor (bix mixer). It sits on grading floor and motor and gear box shipped about 2 ft. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1095193 **EF** **25-Aug-07** **Falconbridge Kidd Met Site**

Incident:

The gearbox on the #3 oxidation tank failed again this morning at 6:30. The gearbox (weighing 2 tonnes) twisted around and stopped when it hit a piece of steel. The same issue occurred on Wednesday, but was repaired. Presently, the gearbox is down and the scene is secured and tapped off. No employees were injured during either failures. Caller states that the loss of operatable equipment will affect repairs to the gearbox can begin. Update: IHSP on call instructed caller to do a proper lock out and get an engineer (with seal of approval) to submit a report and to follow the engineer's recommendations.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135703 **EF** **07-Sep-07**

Incident:

Caller reports that on a lifting device a 1/4" thick wire rope jammed on the pulley or failed. No injuries. All work was stopped.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204747 **EF** **17-Sep-07** **CVRD/INCO Oxygen Plant**

Incident:

While lifting a 12 ton rotor from the No. 3 main air compressor motor, the overhead crane failed with the load suspended approximately 14' from the floor. The load remained suspended and did not drop. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204749 **EF** **18-Sep-07** **Clarabelle Mill**

Incident:

Craneman and mechanics were in the process of lowering the standard bowl from #3 standard crusher down to the main floor when the crane started to move in the south direction on its own, hitting the floor handrailing. No injuries. Minimal damage to floor handrailing. Crane was shutdown. Crane operating controls to be fully tested prior to putting crane back into operation. Incident being investigated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191599 **EF** **10-Oct-07** **Copper Cliff Smelter: Bulk Furnaces**

Incident:

While pulling a box of dryer bedding from #1 dryer, the control gate failed to open. The entire bed was dumped on the floor. No injuries or damage.

Cause:

Gate failed due to wear and tear.

Preventative Action:

None given.

Event ID: 1076986 **EF (F)** **20-Oct-07** **Williams Mine: Surface**

Incident:

Operator heard loud noise on the south side of crusher wall. The dust collector fan shaft twisted off. Evidently the heat caused the bearing grease to catch fire. A portion of a 20 lb. fire extinguisher was discharged to ensure the fire was out.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1148901	EF	22-Oct-07	Creighton Mine: Underground

Incident:

While assembling a jumbo mobile drill using a crane, caller reports that the crane command / function to rotate was stuck, causing the crane to rotate and drop the jumbo drill approximately 1 foot of its stands. No injuries. Two broken lights on jumbo. Process of installing the valve bank on the right side of the new Atlas Copco jumbo that was being assembled in 7200L garage. The raised the valve bank assembly to the unit with the overhead crane and installed one bolt through the mount. They then proceeded to shift the crane to the side to line up the other mounting bolts. At this point, the side direction control of the crane stuck causing the valve bank to be drawn into the jumbo chassis forcing it off the stands. Electrician checked the unit over and found that the pendant control switch was B.O.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191603	EF	25-Oct-07	Xstrata Nickel Sudbury Smelter

Incident:

Broken retainer pin (30" x 2") on the ear of ladle #208. The pin sheared at the inside thread of the locking nut that was welded in place. The pin is used to hold the ear from slipping out of the ladle. Locking nuts at both ends of the pin hold it in place. No injury involved. When the craneman sat the ladle on the aisle floor, the ear slipped out of the saddle.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1120480	EF	26-Oct-07	Falconbridge Ltd.: Kidd Site

Incident:

Millwrights working on 12" line supported by hanger. Once elbow was removed, the hanger broke and the pipe swung to the floor. No injuries. Scene frozen.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1191613	EF	06-Nov-07	Clarabelle Mill

Incident:

The discharge from pump #4 ball mill tripped on variable frequency drive (VFD). An operator and a mechanic checked it out and an attempt was made to restart the pump in the field. After several unsuccessful attempts, the VFD was by-passed and the operator tried to re-start the pump in local. One of the three leads in the junction box arced significantly. A fair amount of black smoke was seen coming from the junction box and motor. The motor was 300 HP, 575 V. No injuries, pump motor needs to be replaced. Under investigation.

Cause:

Overheating of electrical conductors over time within connector box located on motor.

Preventative Action:

None given.

Event ID:	1205191	EF	20-Nov-07	Dufferin Aggregates

Incident:

A 150 foot long "Assinack" tower stacker converter collapsed while being lowered to the ground. No injuries. Investigation on-going.

Cause:

The support cables failed due to the breakage of the sheave pin that had had excessive wear and lack of lubrication.

Preventative Action:

None given.

Event ID:	1120484	EF	22-Nov-07	Kidd Metallurgical Division

Incident:

Operator was using 1.5 ton hoist to lift a bag of soda ash material. Tote bag weighed approximately 1 ton and was lifted to a height of 10 ft. when the hoist cable broke resulting in bag being dropped to the floor. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191639 EF 22-Nov-07 Copper Cliff Transportation

Incident:

The slag crew went to dump slag car #26. The conductor pressed the white button o the remote control box as had been the practice on previous trips in the shift. when he pressed the button, he noticed that the PCT began to dump back towards him. At this time, he stopped the operation. He then tried the black button and found the bowl dumped away from him. After dumping one bowl with the black button, he dumped the seocnd bowl with the black button. Once the second bowl reached its maximum dumping position,t he two bowls started coming back towards the conductor side all by themselves with no buttons being pressed. The rotated to the opposite maximum dumping position and stopped. Failure of remote dumping controls for twin bowl slag car #26 during its first use in the field since being converted to remote control. None injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1211040 EF 24-Nov-07 Lake Erie Steel Gp Inc.

Incident:

A bustle pipe failed. There were no injuries or no fire. The furnace was brought down under controlled conditions and will remain down until a full repair is completed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191648 EF 26-Nov-07 CVRD/INCO Matte Processing

Incident:

The upper floor operator went to the second floor and opened the elevator at approximately 17:00 hours. The door opened but the car was not yet at the location. The operator closed the door and guarded the door. He contacted the matte processing foreman and the door was roped off denying access. Kone was contacted to repair the elevator.

Cause:

There was a spring missing that actuates the release for the floor door as the car approaches the landing.

Preventative Action:

The spring was replaced by a stronger spring so the door could not be opened with the car not in position.

Event ID: 1191650 EF 29-Nov-07 Copper Cliff Smelter Converter

Incident:

While making a lift in the casting building with #1 crane, the hand joy stick controller came apart. The crane was moved to the west end of the building and parked. The crane crew electrician was called in on #1 casting crane to repair the main hoist controller. No injuries or damage.

Cause:

Normal wear and tear on the controller.

Preventative Action:

None given.

Event ID: 1191657 EF 07-Dec-07 Coleman Mine: Underground

Incident:

While lifting the back end of a 430 haulage truck in the 3370 main garage, the crane cable broke causing the load to come to a rest on the floor and allowing the pulley block assembly to fall off the cable. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120486 EF 07-Dec-07 Falconbridge Ltd.: Kidd Site

Incident:

1 ton hoist lifting guillotine in crushing plant. Guillotine wedged in track and broke hoist ropes. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139833 EF (F) 08-Dec-07 Island Gold Project: Surface

Incident:

Diesel compressor caught fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191672 EF (F) 17-Dec-07 Copper Cliff North Mine

Incident:

The cubex driller observed the compressor #10146A was on fire. The fire was observed in the drive belt area of the compressor and was extinguished using 1 - 10 lb. hand held fire extinguisher. At this time, it is believed the drive belts of the compressor were burning. The incident is under investigation. Source of ignition: friction. Source of fuel: drive belt rubber. Under investigation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

EL – ELECTRICAL

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105823 EL (F) 15-Jan-07 CVRD Inco: Matte Processing

Incident:

Inco mechanics were working on 2nd floor Matte Processing when they noticed an electrical outlet sparking and begin to catch fire. They discharged an ABC extinguisher to put the small fire out and reported the incident. Source of ignition: electrical short. Source of fuel: light fixture.

Cause:

Unknown other than fixture somehow got wet.

Preventative Action:

None given.

Event ID: 1104312 EL 08-Feb-07

Incident:

Electrical panel flashed an electrician. sustained minor burns to face.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182040 EL (F) 14-Mar-07 CVRD Inco: Matte Processing

Incident:

At approximately 12:30 a.m., the foreman from Auburn called the Matte Processing foreman to report that the electrical cord on a light fixture in the new thickener end had been smouldering. He also reported that there was a small flame at the receptacle. His crew went to get a fire extinguisher but when they got back, the small flame was out. The plug was inspected and the end prongs had completely melted off. An electrician was called to inspect the plug.

Cause:

Unknown.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182051 **EL (F)** **14-Mar-07** **Coleman Mine: Surface**

Incident:

Stench injected. Burnt cross-arm on pole carrying a 96 KV line. Insulation on cross-arm failed causing power to track through cross-arm to ground creating heat and eventually burning cross-arm. Fire was extinguished due to weather conditions and increased clearance between conductor and cross-arm. Source of ignition: electricity. Source of fuel: wood.

Cause:

Failure of insulator.

Preventative Action:

None given.

Event ID: 1201306 **EL** **23-Mar-07**

Incident:

2 workers were driving by the track drift entrance on 580 level when they thought they saw smoke. There was a very strong odour. The vent fan was off so it was turned on and the battery was unplugged when it was clear. No fire. Limit switch did not work.

Cause:

None given.

Preventative Action:

Are to be vented - fan to be on while charging batteries. Electrician to check more while on charge. Battery motors and track drift not in use. Tagged out.

Event ID: 1193987 **EL** **25-Mar-07** **Eagle River Gold Mines**

Incident:

Power outage/damaged transformer due to lightning storm.

Cause:

Power outage.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139096 **EL (F)** **01-Apr-07** **Red Lake Complex Mine #3**

Incident:

A raise bore operator located on surface near the #3 shaft reported that smoke was coming from a blower motor on the 123-R raise bore drill. The operator shut down his machine and the blower motor continued to smoke and flamed up for a short period of time. The main power was shut down and an electrician was contacted. No fire extinguisher was shut down.

Cause:

Electrician reported a loose wire shorted out on the side of the blower motor casing.

Preventative Action:

Wire was replaced and a new motor was installed.

Event ID: 1084483 **EL (F)** **10-Apr-07** **Copper Cliff Smelter**

Incident:

Transportation loaders called the control room to report smoke originating in the vicinity of #4 loading station (underneath catwalk). All loading permissive were removed and an operator was dispatched to investigate. Upon the operator's arrival at the load out, there was no longer any flame or smoke. Source of ignition: cable. Cause of incident: under investigation. Method of extinguishment: self-extinguished.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1084486 EL (F) 13-Apr-07 CVRD Inco: Matte Processing

Incident:

A hole was discovered on 2A mill discharge pump discharge line. The pump was shut down so that a repair to the line could be done. The pump in question conveys slurried feed from the track aisle (basement) up to the fourth floor primary magnetic separator. When the pump is stopped, there is always a certain amount of feed (head) remaining in the line. Opening the drain valve on the pump empties this feed. Even with the drain valve opened, feed was sprayed from the hole in the pipe. The direction of the spray was such that the feed hit an electrical outlet (twist type). Flames were seen coming from the outlet. The flames self-extinguished and the lights along the east end of the track aisle also went out. Source of ignition: receptacle. Source of fuel: electrical short.

Cause:

Worn discharge line sprayed slurry on the receptacle.

Preventative Action:

None given.

Event ID: 1191592 EL 01-May-07 Creighton Mine: Underground

Incident:

Sub station tripped. No injuries. Tracking occurred in core of transformer.

Cause:

Ground water seeping into bore hole located above and beside mine power centre caused tracking to occur inside the transformer, leading to failure.

Preventative Action:

Isolated power from transformer. Divert any water. Replace mine power centre.

Event ID: 1202030 EL (F) 23-May-07 Coleman Mine: Surface

Incident:

After cleaning the lunchroom floor with a water hose, the employee noticed an open flame on the wiring side of the electric heater. The employee extinguished the flame with a hand held extinguisher and had the surface electrician isolate the power to the heater.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135674 **EL** **18-Jun-07** **Falconbridge Kidd Met Site**

Incident:

A piece scrap zinc metal wedged between two buss-bars causing a short circuit and arcing while washing the work area with water. There were no injuries resulting from this event and equipment damage was minimal.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202084 **EL** **18-Jun-07** **Copper Cliff North Mine**

Incident:

The 175 orebody 600 volt electrical transformer located on surface was struck by lightning during a thunderstorm. The transformer severely damaged as a result of the lighting strike and power was lost to the orebody complex. No injuries. Damage occurred to the 600V transformer. Under investigation.

Cause:

Electrical transformer was struck by lightning.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202097 EL 23-Jun-07 Lockerby Mine: Surface

Incident:

The main electrical feed. Located on surface on the 4160 volts side which feed the Lockerby underground and surface complex was subjected to an unexpected shutdown as a result of one of the 750 MC electrical cables receiving damage resulting from an apparent arcing propelled outwards of the cable casing causing a ground failure shutting down all electrical feed to the mine site. The failure impacted telephone and leaky feeder systems rendering communications ineffective. Upon further assessment, stench was released at 12:50 a.m. Crews reported to the refuge stations and at the 40L shaft station. Electrical supervision and electrical crews were dispatched to identify the cause of the power interruption and to isolate the electrical system. At 7:25 a.m., repairs and troubleshooting were ongoing and a decision was made to cancel the day shift as power restoration was being tentatively targeted for 12:30 p.m. At approximately 09:30 a.m., crews observed a hole in the ground at the transformer station where the cable distribution system is routed from the transformer to assess if damage had occurred at the location. Several of the day shift crews were kept on site in order to assist with the work which included digging a trench to reach the MCM cables for observation.

Cause:

Four cables were unearthed and observations determined that one of the cables had been subjected to an electrical arcing which resulted in a ground failure causing damage to the cable and a complete shutdown of the mine's power electrical distribution system.

Preventative Action:

None given.

Event ID: 1202096 EL 24-Jun-07 Xstrata Nickel Sudbury Smelter

Incident:

#2 Furnace power was off due to changing a dip rod on P5. When workers tried to close the breaker with the kirk key at 12:30, power to the skip was tripped. The shift E/I reported that all breakers at #3 substation were open. They had to be reset to regain power. One electrode in each phase was raised in excess of 40 CM's prior to restoring power.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202141 **EL (F)** **28-Jul-07** **Onaping Mine**

Incident:

There was an open flame fire due to a short in a jumbo extension plug. The flame went out on its own but a worker discharged an extinguisher on it as a precaution. There were no injuries. Investigation revealed the male end of the plug (100 amp #2 cable plug) had a three inch cut in it. It is suspected moisture entered here and caused a short between two screws inside which secure the wires within.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202149 **EL** **02-Aug-07** **Coleman Mine: Surface**

Incident:

At 6:40 a.m., the breaker 13CM3B11 was energized from transformer T2. At 6:55 a.m., there was a loud bang and the T2 transformer tripped. Injuries and damage: the cover from relay #89 and #63 was blown off. Smoke was coming from the P.T. cabinet and from breaker 13CM3B11.

Cause:

The P.T. failed causing a flash across all 3 phases.

Preventative Action:

The P.T. were removed and will be replaced.

Event ID: 1135685 **EL** **08-Aug-07** **Armstice Resources Ltd.**

Incident:

The main electrical cable blew. There was an explosion in the main feed close to the building that houses the hoist. It cut all power and underground miners had to walk up. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1096043 EL (F) 10-Aug-07 Madsen Red Lake Mine: Underground

Incident:

Employee doing checks found an odour (electrical smell, overheating) from the shaft. No smoke found. This incident was underground. Treated this as a fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1208568 EL (F) 20-Aug-07 David Bell Mine: Underground

Incident:

Small electrical fire on Miller tractor. No injuries. Wire to safety strobe light had to be replaced. Supervisor driving in the ramp noticed a small flash behind him. On closer inspection, he identified the flash as a small flame about 2 to 3" high. He shut the master switch off and the flame was extinguished. As an extra precaution, he discharged approximately 1/4 of a 20 lb. dry chemical fire extinguisher in the affected area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202203 EL 23-Aug-07 Levack Mine

Incident:

A contract electrician locked out the 4160 feed. A cable was tied into the 600 volt breaker. The 4160 was re-energized. Everything checked OK on the 600 volt side. The 600 volt breaker was turned on and the breaker blew causing an arc flash. There was a small fire which was extinguished with the substation fire extinguisher. Substation equipment to come to surface. Reason still undetermined.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202205 **EL (F)** **24-Aug-07** **CVRD Inco Power Department**

Incident:

69 KV power transmission (#2 soap) line. Insulator failed resulting in tracking to cross arm. Source of ignition: electrical current.

Cause:

Insulation failure. Self extinguished when line power isolated.

Preventative Action:

None given.

Event ID: 1203197 **EL (F)** **30-Aug-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

#1 TBRC was being reduced when a small fire occurred in one of the electrical motors of the ring gear. The conveyor was stood up and the power was isolated from the motor. Power to the damaged section was kept isolated and the TBRC was re-started.

Cause:

Overheating due to motor failure.

Preventative Action:

None given.

Event ID: 1120469 **EL** **04-Oct-07** **Young Davidson Project**

Incident:

Small electrical jolt occurred by crew installing ground support screen.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: **1120481** **EL** **31-Oct-07** **Holloway - Holt Mine #2**

Incident:

Workers trapped underground in the mine due to power outage. Ontario Hydro trying to restore power. 21 miners rescued and brought up to surface. 23 miners still underground.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1062114** **EL** **04-Nov-07** **Falconbridge Ltd.: Kidd Mine**

Incident:

Operator noticed a light fixture lying on the floor. It was determined it had fallen from the ceiling above. Area taped off and a joint investigation has been conducted. An incident report has been generated by the concentrator production supervisor.

Cause:

It was determined that the light fixture had fallen from the ceiling above.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

EN – EXPLOSIONS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1205241 **EN** **30-Jun-07**

Incident:

Worker lit burn file at 07:00. At approximately 07:40 a.m., the file burned down and ignited caps and paint cans. Worker reported approximately 15 small explosions.

Cause:

Underground worker did not follow proper procedures for the disposal of unused or damaged explosives.

Preventative Action:

Safety meeting was held with all workers to inform them of all hazards. Workers to break down all explosive and cap boxes to ensure no caps present.

Event ID: 1091000 **EN** **27-Jun-07** **Kidd Creek: Deep 7000**

Incident:

A secondary sulphide heat incident occurred in the 62-84 X/C due to a broken water line on 6100. 65 feet of smooth wall vent has melted the heading. Pipe damage and valve closures must be promptly reported to central control.

Cause:

Broken water line on 6100.

Preventative Action:

None given.

Event ID: 1092871 **EN** **19-Jul-07** **Kidd Metallurgical Division**

Incident:

Concussion blast at the Smelter copper dryer duct work - no one around, no injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139184 EN 22-Jul-07 Lac Des Iles Mine Ltd.

Incident:

Premature explosion took place when a short blast hole that was loaded accidentally went off when a secondary piece of rock struck the shock tube of the blasting cap. No injuries. Still under investigation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

EX – EXPLOSIVES

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: **1109815** **EX** **09-Jan-07**

Incident:

Explosive products found in an apartment in Marathon. Mine personnel was informed that the O.P.P. was investigating this occurrence and there was potential that the explosive product came from the Hemlo area.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1109796** **EX** **16-Jan-07**

Incident:

A maintenance worker looking for hidden parts noticed 2 blasting caps lying in an old drill hole in the wall behind the MCC. Caps were returned to the cap magazine on 9175 for proper storage.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1110459** **EX** **31-Jan-07** **Williams Mine: Underground**

Incident:

Improper storage of explosives. Cell supervisor on tour through area discovered several plastic tubes used for remote block holing in power mag. Tubes were loaded with stick powder and primed with long (30 M) nonel caps. Tubes were removed immediately and placed in an idle heading and fenced off with proper explosive signage. The tubes were blasted at the end of the shift Jan. 31/07.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109928 EX 04-Feb-07 Creighton Mine: Underground

Incident:

While looking for track supplies, employees turned over old timber flooring on 4000L in 2640 drift and found two caps. One nonel and one electric cap. No injuries or damage. Caps were immediately returned to the proper storage and the incident notification protocol was followed. Under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1151397 EX 12-Feb-07 David Bell Mine: Underground

Incident:

Mishandling of explosives.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104513 EX 13-Feb-07 Creighton Mine: Underground

Incident:

Worker was loading VRM blast. After loading, a support miner was sent to pick up powder and left 6800 L. On his way to the powder magazine, he did not notice a stick had slipped out of the bag. A mechanic found the stick on the ground and immediately barricaded the area and contacted the supervisor.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104678 **EX** **13-Feb-07** **Norman Mining Project**

Incident:

3 caps (6M nonel) were found in the powder magazine.

Cause:

None given.

Preventative Action:

Briefed crews on the importance of taking extra care when returning powder and caps to the magazine.

Event ID: 1104554 **EX** **14-Feb-07** **Copper Cliff South Mine**

Incident:

Workers blasting at a chute that was hung up, then trucking mud from there and dumping into hole ramp. An employee noticed 1/4 roll B-line at the back of the truck, but it went down the ore pass before he was able to stop the dump.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1100424 **EX** **14-Feb-07** **Williams Mine: Open Pit**

Incident:

2 cone packs found in open pit by operator - not primed. They were collected, removed and stored. Internal investigation will be done and full copy of investigation will be forwarded to MOL.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104419 EX 07-Mar-07 Garson Mine: Underground

Incident:

Employee found an un-detonated cap in his workplace. The location was identified as to where it was found and an inspection of the workplace was performed again to ensure no other form of explosives were in the area. The workplace was inspected for any other explosives and none were found. The cap was returned to the magazine and the MOL informed of the incident by telephone. The incident is under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182028 EX 07-Mar-07 Garson Mine: Underground

Incident:

Working in area - 1 undetonated electric MS cap found on drift floor. Cap removed and placed in proper storage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108138 EX 16-Mar-07 Kidd Creek: Lower Mine

Incident:

2 sticks of powder were found in the bottom of a bailer bag that had been placed in the 46 shaft station garbage. The powder was returned to an underground powder magazine. Investigation ongoing.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1109324	EX	03-Apr-07	Kidd Creek: Lower Mine

Incident:

Flatbed truck was hauling totes of stock powder up main ramp system when the load shifted causing spillage of stick powder on the roadway. All explosives were removed from the ramp/level system and placed in explosive magazines.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1088776	EX	02-May-07	Copper Cliff South Mine

Incident:

8 electric explosive detonators were discovered while performing work at 8109 rock pass chute. No injuries or damage. During removal of an old chute cylinder at base of 8109 rock pass, 8 electric detonator caps were discovered tucked up in the back behind the screen. The supervisor of the area was notified and the caps were returned to the proper explosive magazine.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1110555	EX	11-May-07	Garson Mine: Underground

Incident:

The tram crew were in the process of moving an explosive emulsion tank from a flat truck to a trackless equipment when it tipped on its side and the top broke open allowing emulsion to the ground. The flat bed steel truck with welded corner tabs on it which is specifically designed to hold the tankers. No injury but damage to the tank and product inside. The supervisor was alerted immediately by one of the blasters who was in the area and went to assess, assist and investigate with the OHSE rep. The MOL was notified along with worker rep. The spill was contained and cleaned up completely within 90 minutes of the occurrence.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202029 **EX** **20-May-07** **Copper Cliff Nickel Refinery: IPC**

Incident:

An electric detonator was found laying on the road in the Copper Cliff Nickel Refinery yard. No injury or damage. Under investigation. Detonator was transported to Copper Cliff South Mine for storage pending result of investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135642 **EX** **21-May-07** **Kidd Creek: Deep 7000**

Incident:

After mucker dumped his second bucket, he was stopped by the rockbreaker operator. The rockbreaker operator tried to sweep a cardboard box off the grizzly with the rockbreaker boom and saw three light flashes. Some nonel caps initiated when the box was being removed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202063 **EX** **12-Jun-07** **Creighton Mine: Underground**

Incident:

Bulk explosives were improperly stored in 2400 level access, an unlicensed area without the carrier being cleaned out first. Truck #2942 involved. More details to follow. Update: #2942 emulsion explosive loading truck was left unattended at the North Mine - south of mine access point on 2400L. The unit was being moved between the two plants and was left unattended at the transfer gate separating the two mines. The truck was not properly guardrailed off and the strobe light was not activated. Supervision was notified by the worker representative and arrangements were made to move the truck to the proper storage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202063 EX 12-Jun-07 Creighton Mine: Underground

Incident:

Some icon detonators were placed in the powder mag on 7150 level. There was no equipment involved. No injuries, no damage. Work with supplier to help identify new explosive products sent to the mines. Educate employees on the identification, literature, and symbols on new explosive products.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202082 EX 18-Jun-07 Copper Cliff South Mine

Incident:

Several empty emulsion explosive containers were brought up from underground at approximately 6:00 a.m. The empty tanks were guarded for approximately 4 hours while being store in the surface yard. The tanks were picked up the supplier at approximately 10:00 a.m. The emulsion tanks were not confirmed as being washed clean.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202100 EX 26-Jun-07 Copper Cliff South Mine

Incident:

Caller reported case of pentax 30 boosters and 15 fuses were found in top sill at 1650 level. Stope was at 1000. Cases were ot stored in a fuse magazine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1205245 EX 29-Jun-07

Incident:

While cleaning the transformer, 2 Highvec (contractor) electricians discovered 2 x 3 meter (length) nonel caps stored on the floor inside the transformer compartment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1205244 EX 30-June-07

Incident:

Four boxes of unused/damaged stick powder, bune, cordex and shork cord with two caps (live) were found stored in powder mag.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202127 EX 23-Jul-07 Creighton Mine: Underground

Incident:

At approximately 08:35 this morning, a roll of B-line was discovered in the 6680 lunchroom area. The roll was returned to the magazine.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202134 EX 24-Jul-07 Totten Mine

Incident:

Ran into old detonators they have on side but planning on disposing of them.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202142 EX 30-Jul-07 Garson Mine: Underground

Incident:

B-line explosive detonator cord discovered while cleaning floor of stope. No injuries or damage. While cleaning the floor of 1674 stope on 4370 level with a 3 yrd. scooptram, the operator noticed a 2 foot piece of B-line detonator explosive cord hanging from his bucket.

Cause:

None given.

Preventative Action:

None given.

Event ID: 11785991 EX 02-Aug-07 Fowler Construction Co.

Incident:

Caller reports the Castonguay company is blasting. Flyrock occurred. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202150 EX 03-Aug-07 Stobie Mine: Underground

Incident:

Found an electrical cap in the screen. there was nobody in the area as the heading was on hold. No injuries or damage. It is suspected that the cap was inadvertently left behind when a development blast in the Alimak raise was cancelled earlier in the week.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1208470 EX 07-Aug-07

Incident:

Mishandling of explosives.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202160 EX 20-Aug-07 Levack Mine

Incident:

No injuries to workers or damage. The mine was preparing for central blasting at the end of the shift. Contractors were asked to clear the tag-in board. the supervisor in charge of blasting checked the board to confirm that the area was clear of personnel. The supervisor initiated the blast but failed to notice that four Cementation men and the Dynatec cagetender were still underground. They noticed the five tags still on the board after blasting.

Cause:

Improper clearing of board.

Preventative Action:

Full investigation has taken place and blasting procedure has been revised.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1203218 EX 11-Sep-07 Thayer Lindsley Mine: Underground

Incident:

Blasting cap found in LHD833. Mechanic was prepping to cut a chain hanging through the floor of a scoop. No injuries. No damage. Cap removed and all crews will be notified through shift line up meetings.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203220 EX 11-Sep-07 Garson Mine: Underground

Incident:

Partsman was opening boxes that were delivered to the garage. Two boxes of powder cracker cartridges was brought to the garage with two pallets and other consummable material for the shop. The package was mixed by mistake with other supplies and sent to the garage. The product was removed from the garage and sent to a proper storage. The worker rep., foreman and general foreman for the area were notified. A procedure will be developed to handle this product at Garson Mine.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203804 EX 14-Sep-07 Lafarge - Boyce Quarry

Incident:

Caller reported that worker set explosive for blast and blast was too strong, resulting in the large pieces of fly rock. Fly rock caused property damage to surrounding properties. Caller reported that worker set explosive for blast and blast was too strong, resulting in large pieces of fly rock. Fly rock caused property damage to surrounding properties.

Cause:

Caller reported that worker set explosive for blast and blast was too strong, resulting in large pieces of fly rock.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204756 EX 21-Sep-07 Copper Cliff North Mine

Incident:

2 partially used rolls of B-line detonator cords found in an old gear storage on 4000 level during a tour and inspection of the 4000 level south exploration drift, discovered amongst some other supplies in an old gear storage. The explosives were immediately returned to the proper magazine and the incident is under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204764 EX 28-Sep-07 Creighton Mine: Underground

Incident:

Worker found a stick powder on a piece of underground equipment. The stick powder was returned to proper storage by a competent person. Investigation is ongoing as to how it got there as well as how it got left there.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135734 EX 05-Nov-07 Outokumpu Mines Ltd.

Incident:

There was a blast at the 4700 level. A crew that was blasting oversized muck initiated the blast before all the workers on the level had exited.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135735 **EX** **05-Nov-07** **Kidd Creek: Deep 7000**

Incident:

A blasting cap was found in a powder magazine at the 8300 level.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148926 **EX** **21-Nov-07** **Levack Mine**

Incident:

Mine stench as production blast knocked out electrical system underground. Very high CO levels from blast. Mine Rescue activated to restore ventilation and clear mine of contaminants.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104003 **EX** **21-Nov-07** **Island Gold Project**

Incident:

Conducted central blasting at 5:30 p.m. When night shift went in at 7:00 p.m. they found a loaded drop raise that hadn't gone off the 5:30 blast. It went off when they unplugged it. No one in the immediate vicinity at the time. No injuries.

Cause:

Loaded drop raise that hadn't gone off the 5:30 blast.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191640 EX 25-Nov-07 Coleman Mine: Underground

Incident:

While transporting explosives to storage, a 450 kg. tote of Amex fell off the back of a boom truck when it turned a corner. The spilled material was completely cleaned up within 10 minutes of the occurrence.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1194831 EX 26-Nov-07 Lac Des Iles Mine: Open Pit

Incident:

Surface drill was re-drilling a hole in the bench when it was discovered that the hole contained explosives. No explosion. No injuries, no damage. Break down in communication in the loading cycle - re-drilling was done in a hole that was loaded and primed. Procedures were not followed and will be addressed. Investigation ongoing.

Cause:

Break down in communication in the loading cycle - re-drilling was done in a hole that was loaded and primed

Preventative Action:

None given.

Event ID: 1139831 EX 09-Dec-07 Williams Mine: Open Pit

Incident:

While mucking in this area, a booster was spotted by the loader operator in mucking face, then booster rolled on to the mucking floor. Booster did not detonate.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139839 EX 17-Dec-07 Williams Mine: Underground

Incident:

1 yd. operator (Manroc) was in the process of delivering one pallet (40 bags) up ramp to the workplace, when one bag fell off. A company supervisor following up ramp a few minutes later, discovered the damaged bag. The 25 kg. of Amex was cleaned up immediately.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191674 EX 18-Dec-07 Creighton Mine: Underground

Incident:

The reconditioning shop received an Anfo leader from Creighton Mine. Upon routine inspection of the interior of the tank, a small amount of Amex (4 cups) was present. Under investigation. Corrective measures taken: the Amex was properly disposed of.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148952 EX 18-Dec-07 Copper Cliff North Mine

Incident:

An anfo loader was shipped from Creighton Mine to Copper Cliff North reconditioning shop for repairs. The loader was not cleaned out properly and there was approximately 4 coffee cups of Amex powder left in it.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191676 EX 28-Dec-07 Garson Mine: Underground

Incident:

Partial case of powder left in a heading during a blast. Partial case of water gel stick powder, some stick were damaged by fly rock. Several sticks were found in water in front of muck pile. Water was pumped and area inspected for powder. Powder was cleaned up at once. Mucker was advised of the situation prior to starting to muck pile. Water was pumped and area inspected for powder. Powder was cleaned up at once. Mucker was advised of the situation prior to starting to muck. This incident will be discussed with all workers at the safety meetings.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148958 EX 30-Dec-07 Copper Cliff South Mine

Incident:

Track level @ 862 chute gangway. Returned back to proper powder storage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

FG – FLAMMABLE GAS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105812 **FG** **03-Jan-07** **Copper Cliff South Mine**

Incident:

Flammable gas encountered during development drilling on 4530 level. No injuries or damage. A jumbo driller noticed water gushing out of a drill hole and an odour associated with flammable gas. The area was barricaded and the ventilation technician was immediately notified. Drift barricaded, compressed air blowing at collar of drill hole.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102776 **FG** **04-Jan-07** **Kidd Creek: #1 Mine**

Incident:

Fall of ground discovered in 2022 XC. Possibly caused by LHB in 2323-M stope. No persons working in that area for past 3 weeks.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110196 **FG** **09-Jan-07** **Musselwhite Mine: Underground**

Incident:

Methane gas was encountered in diamond drill hole. Work has been suspended until methane has dissipated. Area is being ventilated. Methane detected with a hand held gas detector (solarius).

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110266 FG 09-Jan-07 Campbell Complex: Underground

Incident:

At a depth of 145 feet, methane gas was encountered which caused the workers to discontinue drilling. Signage was posted. The area was re-tested for methane gas at 12:37 hrs. on 10-Jan-07 and the all-clear to return to drilling was given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105825 FG 15-Jan-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling. The driller followed the standard procedure for a flammable gas. Drilling was stopped, the area was barricaded off and compressed air was left blowing at the hole collar as per standard protocol. The hole will be grouted upon completion.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108287 FG 18-Jan-07 Copper Cliff South Mine

Incident:

No injuries or damage. A diamond driller noticed a smell associated with flammable gas while drilling on hole #120035. The drill is located in the 4530 level fresh air access. Gas was intersected at 65 to 68 feet. Driller followed standard procedure. Notified the ventilation technician. Proper signs posted on barricade, and compressed air blowing at the hole collar. The hole had stopped making gas by the start of the next shift and will be grouted when complete.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110464 FG 19-Jan-07 Campbell Complex: Underground

Incident:

Methane gas encountered at 1310 feet of DDH 36-236 on 3609 drift at 14:45 hrs. The reading at the source was off the scale. Work ceased. Water flow was present at the hole. Signs were posted. Follow-up testing was done at 2000 hrs. All readings were zero. Work resumed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108831 FG 24-Jan-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on diamond drill hole 120086 (-69.5 deg.) at a depth of 955 feet. The operator followed the standard procedure. Area was guardrailed off. Compressed air was left blowing at hole collar, ventilation and supervision were notified.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110572 FG 25-Jan-07 Campbell Complex: Underground

Incident:

Methane gas encountered at 1519 E drift, DDH 25-996 at the 198 foot depth. Work ceased. Area re-tested several times, 13:30 hrs., 14:30 hrs. and 22:30 hrs. All clear given at 22:30 hrs. and work resumed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110465 FG 26-Jan-07 Campbell Complex: Underground

Incident:

Methane gas encountered in 2519 drift, DDH 25-996 at the 255 feet. Work ceased and signs were posted. Follow-up done by Morrisette supervisor at 13:40 hrs. Readings were zero. Work resumed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110398 FG 07-Feb-07 Campbell Complex: Underground

Incident:

Methane gas was encountered on 4143 W drift collar. Work ceased at this location and supervisor was notified. Vent tubing was moved up to allow air to sweep the face better.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110197 FG 08-Feb-07 Musselwhite Mine: Underground

Incident:

Diamond drill hole was freshly grouted but not plugged at the collar. The cement was observed bubbling and at the source there was methane gas detected. Later on that day, at 1:35 p.m., after venting the diamond drill hole area, no significant values of methane was detected, but the cement was still observed bubbling slightly. Later that day, approval to install a safety plug at collar of diamond drill hole was ordered.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110363 FG 08-Feb-07 Campbell Complex: Underground

Incident:

Methane gas encountered at the 2756-E #2 sub. worker reported reading of .2 by L/hole drill site. Work at the location was stopped. New tester was brought to site. Both testers read "0." Area was re-tested on 25-Feb-2007 at 22:25 hrs. No CH4 was found in area. Okay to continue work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110372 FG 09-Feb-07 Campbell Complex: Underground

Incident:

At a depth of 1750 ft, methane was encountered which caused the workers to discontinue drilling. Methane was tested at collar of drill, two feet away and at the barricade. Signage was posted. Methane gas procedures were followed. Monitoring continued and compressed air was kept flowing on collar. At 07:30 hrs. on 10-Feb-2007, the all-clear to return to drilling was given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109933 FG 14-Feb-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on DD hole 120098. Standard protocol was followed for an underground flammable gas occurrence.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109940 **FG** **21-Feb-07** **Copper Cliff South Mine**

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on D.D. hole 121009. Driller followed standard procedure. At 03:45, the flammable gas had stopped. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 11109940 **FG** **23-Feb-07** **Campbell Complex: Underground**

Incident:

Methane gas encountered on the 2351 east drift at DDH 23-639 at a depth of 303 feet. Work ceased. Signs posted. Re-tested four times and area cleared at 2000 hrs. Work resumed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110736 **FG** **25-Feb-07** **Campbell Complex: Underground**

Incident:

Methane gas encountered at 39-002 drift, DDH 39-677 at a depth of 595 feet. Work ceased. Re-tested at 2120 hrs. Readings clear. Work resumed at this location.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109050 FG 28-Feb-07 Campbell Complex: Underground

Incident:

Workers operating an underground diamond drill hit methane gas while drilling. Workers tested gas levels at source 2 feet away and at barricade. Ventilation provided. Methane procedures were followed. A short time later, drilling resumed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109051 FG 04-Mar-07 Campbell Complex: Underground

Incident:

Underground diamond drill workers were putting the diamond drill rods back into the drilled hole (depth 830 ft.) when workers encountered gas coming from the drilled hole. Measurements were taken at the collar and at different locations in the work area. Because of the high concentration of methane, compressed air was left blowing at collar and the drift was barricaded off and ventilation provided. On March 5th, methane gas levels were clear and work resumed. Methane procedure was followed according to reports provided to MOL.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109331 FG 06-Mar-07 Campbell Complex: Underground

Incident:

At a depth of 1040 ft., methane gas was encountered which caused the workers to discontinue drilling. Compressed air was provided inside diamond drill rods. Methane was tested at collar of drill 2 feet away and in surrounding areas of drill and at barricade erected.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109332 FG 08-Mar-07 Campbell Complex: Underground

Incident:

Methane gas was encountered and tests/concentration of gas levels caused work to cease. No water indicated. Barricade and signage posted. Area has a history of high methane. Area is being ventilated and signs posted.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139081 FG 08-Mar-07 Campbell Complex: Underground

Incident:

A diamond drill crew was installing overhot at the diamond drill hole which was at 1340 feet when methane came out of the hole. Tests were done. Area was allowed to ventilate for approximately 15 minutes and no methane values were detected. The okay was given to return to work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139080 FG 15-Mar-07 Campbell Complex: Underground

Incident:

Underground drift crew encountered methane gas and water while drilling a drift round. Supervisor was notified and signs were posted. A barricade was erected and hourly tests were done of the methane levels at the source, two feet away, in the ambient air and at the barricade. The area was ventilated and the all-clear to go back to work was made on March 17th.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139073 FG 20-Mar-07 Campbell Complex: Underground

Incident:

Methane gas encountered at a development heading 2530 south drift. Work ceased. Area re-tested on March 21st at 09:15 hrs. All clear. Work resumed at that location.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139078 FG 20-Mar-07 Musselwhite Mine: Underground

Incident:

Underground diamond drill crew encountered methane gas (hand held methane detector used) while drilling with an air-powered diamond drill. The workers contacted supervisor and a gas test was done. The results were not ambient and were restricted to the collar of the hole. Drilling was stopped until the gases were ventilated. Note: this happened on March 19th. Methane was also encountered on the same hole on March 20th and 21st. Same action taken as on the 19th of March.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139097 FG 22-Mar-07 Campbell Complex: Underground

Incident:

A diamond drill crew encountered methane gas while drilling at a depth of 1010 feet. There was no water encountered. The drill was shut down. Electric fan running in drift. Signs were posted and a barricade installed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139098 FG 25-Mar-07 Campbell Complex: Underground

Incident:

A jumbo operator encountered methane while drilling off a drift round. At the source of the hole, readings were 12.2 percent, 2 away from hole, 6.8 percent. There was no water encountered. The drift was shut down, signs were posted and a barricade erected. Readings at 11:00 p.m. at the source 10 percent, 2 feet away, .06; in the ambient air, .2. Very good ventilation was provided at drift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139079 FG 26-Mar-07 Campbell Complex: Underground

Incident:

Diamond drill encountered methane gas at approximately 156 feet. There was water flow coming from the hole and measurements at the collar were 5.0 and two feet away. 1.35 percent methane. Signs were posted and the area was ventilated. Crews returned to work a short time later.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139082 FG 27-Mar-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered methane gas at approximately 470 feet. Work ceased. Compressed air was added at the collar. Measurements were 5.0 at the collar, 0.1 two feet away from the collar and with an ambient measurement of .05. Signs were posted, the area was re-tested again at 09:00 hrs., 09:30 hrs., 10:00 hrs. and at 10:30 hrs. Crews were allowed to return to work at 10:30 hrs.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139083 FG 27-Mar-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered methane gas at 388 feet. Work was stopped. There was water flow coming from the hole and the measurement at the collar was 2.5 and was .30 two feet away. Signs were posted and ventilation was added at the collar. Area was re-tested after two hours. The area was ventilated. The okay to return to work was given at 10:00 hrs. on 27-Mar-2007. However, at 10:25 hrs., methane gas was again detected. Work ceased. There was water flow coming from the hole and the measurement at the collar was 0.7 and 0.1 two feet away. Signs were posted. The area was re-tested. Methane gas encountered again at 1200 hrs. Work was again stopped. There was water flow coming from the collar and the readings were 2.5 at the collar and 0.30 two feet away. Signs were posted. The area was ventilated with a fan and vent tubing. The area was re-tested.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182044 FG 27-Mar-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on D.D. hole 121026 (-22.0 deg.) at a depth of 355 feet. Corrective measures taken: the diamond driller followed standard procedures for an underground flammable gas occurrence, the area was guardrailed off and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139088 FG 30-Mar-07 Campbell Complex: Underground

Incident:

Encountered methane gas at DDH 36-251 on 3699 drift at a depth of 1210 feet. Work was stopped. Reading at source was 5% and 2.112 two feet away. Signs were posted and the area was closed off. Area was re-tested at 7:30 a.m. Readings were zero. Okay given to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139089 FG 30-Mar-07 Campbell Complex: Underground

Incident:

Methane gas encountered on the 3699 drift, DDH 36-251 at a depth of 1350 feet. Work was stopped. Reading was off the meter and at two feet away was 1.75. Signs were posted. Air was left blowing at the collar. Area re-tested at 21:15 hrs. All clear given. Work resumed. Air mover kept on collar while drilling.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139092 FG 03-Apr-07 Campbell Complex: Underground

Incident:

Methane gas was encountered in the 33-295 drift, #3 draw point. Work was stopped. signs were posted. Readings were 7.5 at the source, and barricades were sent up. Area was re-tested at 08:30 hrs. Readings were zero. Okay given to return to work. Area will be monitored with a continuous methane monitor.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139099 FG 05-Apr-07 Campbell Complex: Underground

Incident:

Diamond drill crew hit methane gas and water was observed coming from the diamond drill hole. Methane readings were taken of area and signs and barricades were posted. On night shift, no methane was detected and the okay to resume work was given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139106 FG 10-Apr-07 Campbell Complex: Underground

Incident:

Workers measured methane readings at collar of hole. 5.00. There was no water observed. Signs and barricades were posted and the drill was shut down. Area to be re-tested on day shift. Compressed air was left blowing through the diamond drill rods. Day shift measurement no methane detected. Okay to return to work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139103 FG 12-Apr-07 Campbell Complex: Underground

Incident:

Methane encountered at DDH #33-275 at a depth of 650 feet. Work was stopped. Signs were posted. Area was barricaded off. At the source, reading was 5%; at two feet away, it was 3.7% and ambient reading was .5%. Area was re-tested at 12:50 p.m., readings were zero. All-clear was given to return to work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139168 FG 19-Apr-07 Campbell Complex: Underground

Incident:

While drilling a diamond drill hole, workers encountered high levels of methane at approximately 590 foot mark. Barricades were erected and signs were posted. No water flow observed. Workers tested at hole, two feet away and in the ambient air. The all clear was given at 13:30. Air ventilation was provided to air movers.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139169 FG 20-Apr-07 Campbell Complex: Underground

Incident:

At approximately 165 foot mark, diamond drillers encountered high readings of methane. A barricade was erected. No water flow was observed. Signs posted. Air mover provided ventilation to diamond drill cut out. The following shift was to test methane readings. On the day shift at 6:54 a.m., methane readings zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139146 FG 25-Apr-07 Campbell Complex: Underground

Incident:

Methane gas encountered while drilling. It is reported at source 9.9%; two feet away at 5.4% and in the ambient air 3%. Work was stopped. Barricade was erected. Water was observed flowing from hole. Ventilation was flow through. Testing continued until 1:00 p.m. All clear given and work resumed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110366 FG 29-Apr-07 Musselwhite Mine: Underground

Incident:

Methane gas was detected out of a diamond drill hole NB 07-DEL-081. Readings at the hole collar were .5, ambient was .5 ppm. The drilling was suspended. Testing was done again at 2:00 a.m. At the collar it was .7 ppm, and 0 ambient. Methane levels were monitored every 1/2 hour and drilling began at 08:45 a.m. on April 30th, when the readings were 0 at the collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191593 FG 02-May-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas while drilling on D.D. hole 121060 (-38 Deg.) at a depth of 422 feet. Driller followed standard procedure for an underground flammable gas occurrence. Drilling was stopped, the area was barricaded off, supervision notified and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191694 FG 04-May-07 Copper Cliff North Mine

Incident:

Diamond driller on 4000L reported the presence of gas at the collar of hole #1183160. Driller notified the supervisor on shift and implemented the standard practices for methane occurrence. The station was closed for afternoon shift May 04, 07. The area was guardrailed off and the auxiliary ventilation system turned on.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139126 FG 09-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered on 2519 E drift. Reading of .5 at the source, .1 two feet away, zero ambience. Water flow from the hole. Work stopped. Signs posted. Area barricaded off. Re-check at 09:30 hrs. All readings zero. All clear given to return to work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109897 FG 12-May07 Falconbridge Ltd: Kidd Mine

Incident:

An operator in the Leach Plant detected the smell of natural gas. He proceeded to check the area with gas monitor. LEL was 6%. Plant was evacuated and ERT called. Main gas valve was isolated and locked out. Plant was vented. Tested for LEL plant all okay.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202008 FG 13-May-07 Copper Cliff South Mine

Incident:

Diamond driller noticed water bubbling out of a drill hole at 813 diamond drill station in 2200 haulage drift. The driller notified the ventilation technician, and then followed the standard procedure for flammable gas. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139127 FG 16-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered from an old diamond drill hole. Readings of 4.2 at the source; .2 two feet away; zero ambience. Work stopped. Re-tested at 11:55 p.m. Zero readings found - all clear given. Work resumed. Compressed air lieft blowing at the collar of the hole as a precaution.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202026 FG 16-May-07 Garson Mine: Underground

Incident:

An Inco diamond drill encountered some methane while drilling on 5050 level into #11 remuck bay. Inco diamond drill equipped with a continuous gas monitor reading. No injury or damage. When first encounter reading at the hole was 114% LEL and 0% LEL in the atmosphere. It cleared on Tuesday morning but after drilling for a short period of time, the drill kicked out again on high reading. Thw workplace was barricaded off. Are is being ventilated to clear the area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139128 FG 17-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered at 33-251 drift. Readings of 4.3 at the source; 1.8 ambience. Work stopped. Readings were taken again four times. Area was finally cleared at 8:25 p.m. Work resumed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139137 FG 26-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered while deepening a diamond drill hole. work was halted as tests were above methane limits. A barricade was erected, signage was posted, water was flowing from hole. Measurements continued through shift - readings remained high. Area was ventilated with electric fan. The following shift readings were stil high (May 27th). After testing on Monday, May 28th, drilling resumed as readings were zero.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139138 FG 27-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered while deepening a diamond drill hole. After testing, the drilling was halted. Concentration of methane were high. Water was flowing from the diamond drill hole. Barricades were erected. Signs were posted. An air mover was installed. Later in the shift, the okay to re-start drilling was given as concentration readings were zero.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202036 FG 28-May-07 Garson Mine: Underground

Incident:

Hole was cleared at 8:25 a.m. and then once rods were pulled, concentrations increased to above 5% methane at the collar of the hole. Inco drill equipment with a continuous monitoring gas detector. No injruy nor damage. At 9:25 a.m. at the collar of the hole, the readings wer 5.00% methane but in the atmosphere it remained at 0.00%. The area was ventilated, barricaded, and signs posted. Monitoring will be conducted by diamond driller throughout the shift.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139144 FG 31-May-07 Campbell Complex: Underground

Incident:

Methane gas encountered while drilling at the 458 foot depth. Readings at drill collar over range. Drilling stopped and barricades erected. Signs posted. No water flow. Ventilation was provided by an air mover. Approximately an hour later, readings nil at source. Okay to return to work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139145 FG 04-Jun-07 Campbell Complex: Underground

Incident:

Methane gas encountered while drilling. Drilling was ceased. Barricades were erected. Signs posted. Water was observed coming from diamond drill hole. Ventilation was provided by air mover. Approximately 1 hour later, all clear was given to go back to work.

Cause:

None given.

Preventative Action:

None given. None given.

Event ID: 1202055 FG 04-Jun-07 Garson Mine: Underground

Incident:

Flammable gas is present in a workplace in an underground mine. An Inco diamond drill encountered methane on 4700 level into the #1 east shear. Diamond drill equipped with a continuous gas detector. No injury nor damage. Methane was intersected at 255 feet and was reading 5% LEL at the collar of the hole with 0% LEL in the atmosphere. The area was guarded and the methane procedure was followed. The area will be continually monitored until clear.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139163 FG 05-Jun-07 Campbell Complex: Underground

Incident:

A diamond drill crew encountered methane while drilling at the 265 foot depth. Readings were taken at the collar, two feet away and in the ambient air. Water flow was observed from hole. A barricade was erected and signs posted. Ventilation was provided by an electric fan and air was blown through diamond drill rods. At approximately 2055, methane tests were zero. Work resumed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139164 FG 05-Jun-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered methane gas while drilling at approximately 416 ft mark. Water was observed coming out of hole. Methane values at collar were 4.1%. Ventilation provided by an air mover. Barricades and signs posted. Testing completed at 2:30 p.m. All clear to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139171 FG 07-Jun-07 Campbell Complex: Underground

Incident:

Diamond drillers encountered high levels of methane at approximately 460 foot mark. A barricade was erected and water was observed coming out of hole. Signs were posted. An air mover was used to ventilate drill station. At 11:55 hrs., methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139172 FG 10-Jun-07 Campbell Complex: Underground

Incident:

Diamond drill workers encountered high methane readings and water flow from the hole at approximately the 106 foot mark. Barricades were erected. Signs were posted. The area was ventilated by flow-through ventilation. On June 11th at 12:30 a.m., methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139170 FG 12-Jun-07 Campbell Complex: Underground

Incident:

A diamond drill crew high readings at approximately 405 foot mark. There was water flow observed coming from the hole. A barricade was erected. Signs were posted. Ventilation was provided by an air mover. At 11:09 hrs., the okay to resume work was given.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139166 FG 19-Jun-07 Campbell Complex: Surface

Incident:

A surface diamond drill operated by Boart Longyear workers encountered gas at approximately 1080 feet while drilling from surface in the tailings pond area. Night shift crew tested at the source until 5:00 a.m. High methane reading. At 10:40 a.m., tests showed zero methane. All clear to resume work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1139165	FG	20-Jun-07	Campbell Complex: Underground

Incident:

Diamond drill workers encountered high readings of methane while drilling at approximately 437 ft. mark. Readings were taken at hole collar, two feet away, in the ambient air and the erected barricade. Methane was detected at all locations. No water from hole. Ventilation was provided by vent fan and air was provided diamond drill rods. Methane readings were taken until the end of day shift. On June 21st, night shift okay to resume drilling.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1139161	FG	21-Jun-07	Musselwhite Mine: Underground

Incident:

At 8:30 p.m., methane was detected at the drill hole collar. At the source, the reading was off the scale; at 2 feet, the reading was 0.05%. Following methane gas procedures, drilling was immediately suspended and the underground supervisor was notified. At 11:50 p.m., methane at the collar was tested by the shipper and was 27%; 0.05% at 2 feet from the collar. Methane levels were monitored every half hour and drilling was suspended. the methane hazardous evaluation form was signed by the product co-ordinator and the underground superintendent signed the SOP before grouting started on night shift of June.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1202089	FG	21-Jun-07	Copper Cliff North Mine

Incident:

Flammable gases, with the compressed air on, the diamond driller had an initial reading of 8.9% methane at the hole collar. The diamond driller followed standard procedure for an underground flammable gas occurrence. Drilling was stopped, the area was barricaded off, supervision was notified, and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1139185	FG	21-Jun-07	Campbell Complex: Underground

Incident:

Diamond drillers encountered high methane readings at the 460 foot depth. Water was observed coming from the diamond drill hole. Barricades were erected and signs were posted. Compressed air was used to ventilate diamond drill hole. Area was ventilated using an air fan. After one hour, methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1162155	FG	21-Jun-07	Musselwhite Mine: Underground

Incident:

At 08:30 a.m., methane was detected at the drill hole collar. At the source, the reading was off the scale. 2 feet from the hole reading was .05 percent. Following methane gas procedure drilling was immediately suspended. At 11:50 p.m., methane at the collar was tested and itw as 27 percent. At 2 feet from the collar .05 percent still. Methane levels were monitored every half hour. Methane levels at the collar continued to be monitored on dayshift until 11:30 a.m. when the levels at the collar were zero percent. The hole was grouted at the start of nightshit June 21st, 2007.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1162154	FG	23-Jun-07	Musselwhite Mine: Underground

Incident:

At 4:58 a.m, methane was detected at the drill hole collar. At the source, reading was 1.8 percent and 2 feet away it was 0. Following methane gas procedure, drilling was allowed to continue after flushing the hole with air between shifts as requested by the underground supervisor. The hole was tested before the start of day shift at 08:30 a.m. on June 23rd, 2007, monitored every hour, zero percent at the source and 2feet from the collar. The hole was grouted the night shift of June 24th, 2007.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139167 FG 23-Jun-07 Campbell Complex: Underground

Incident:

Diamond drill workers encountered high readings of methane at approximately 510 feet. A barricade was erected. No water was observed from hole. Signs were posted. Ventilation was flow-through. Workers set-up air mover to increase ventilation in area and compressed air was provided through diamond drill rods. At 13:06 hrs., the okay to resume work was given as methane readings were zero.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202104 FG 27-Jun-07 Copper Cliff South Mine

Incident:

Diamond driller noticed an odour associated with flammable gas. The diamond driller followed standard procedure for an underground flammable gas occurrence. Drilling was stopped, the area was barricaded off. Supervision was noticed and compressed air was left blowing at the hole collar. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1162153 FG 27-Jun-07 Musselwhite Mine: Underground

Incident:

At 10:00 p.m., methane was detected from a drill hole collar - reading was off the scale. 2 foot reading from the hole was 0 percent, following methane gas procedure drilling was allowed to continue after flushing the hole with air between shifts as requested by the underground supervisor. The hold was tested before the start of day shift June 28th, 2007, monitoring every hour. At 09:45 a.m., all readings were zero.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1139188	FG	29-Jun-07	Campbell Complex: Underground

Incident:

Diamond drill crew encountered high methane readings at the 1080 foot mark and work was halted. Barricades were erected and signs were posted. No water was observed coming out of hole. Ventilation was provided by electric fan and compressed air was provided into diamond drill rods. At 23:00 hrs., methane tests were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1139189	FG	29-Jun-07	Campbell Complex: Underground

Incident:

Diamond drill crew encountered high methane readings at the 267 foot mark of the hole. Barricades were erected and signs posted. Ventilation was provided by electric fan and compressed air was provided down diamond drill rods. At 2:00 p.m., okay to resume work as methane readings were zero.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1139190	FG	06-Jul-07	Campbell Complex: Underground

Incident:

Diamond drill crew encountered methane at 1135 foot depth. No water was observed coming from hole. Barricades were erected and signs posted. Ventilation was provided by electric fan. The okay to resume drilling given at 11:30 hrs.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1139191	FG	08-Jul-07	Campbell Complex: Underground

Incident:

Diamond drill crew encountered high methane readings at the 180 foot depth. Work was halted. Barricades were installed and signs were posted. No water was observed coming from hole. Ventilation provided by electric fan. Air mover blowing at DDH collar. At 02:35 hrs., methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191973	FG	13-Jul-07	Campbell Complex: Underground

Incident:

Methane gas encountered while drilling. Work halted. Barricade erected and signs were posted. No water was observed coming from drill hole. Air hose put directly into diamond drill hole to ventilate (compressed air). At 09:40 hrs., methane readings were nil.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191974	FG	14-Jul-07	Campbell Complex: Underground

Incident:

Methane gas encountered at the 240 foot depth. Work was halted. Barricades were erected and signs posted. Water was observed from diamond drill hole. Ventilation provided by electric fan. At 14:35 hrs., methane readings nil. Work okay to resume.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1193293 FG 14-Jul-07 Campbell Complex: Underground

Incident:

Methane gas encountered at 249 foot depth. Work was halted. Barricade was installed. Signs were posted. No water was observed. At 11:45 hrs., negligible methane readings. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1193294 FG 15-Jul-07 Campbell Complex: Underground

Incident:

Methane gas encountered at 300 foot depth. Work was halted. Barricades were erected. Signs were posted. No water observed coming from hole. Ventilation was provided by an air fan into diamond drill cut-out. At 21:40 hrs., methane readings nil. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139186 FG 19-Jul-07 Campbell Complex: Underground

Incident:

An underground development crew encountered methane gas while drilling a drift round. There was no water observed coming from the hole. High readings were detected at collar of hole. At 1:45, methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1139187	FG	19-Jul-07	Campbell Complex: Underground

Incident:

Diamond drill crew encountered high methane readings at the 105 foot level and work was stopped. Water was observed coming from hole. Barricade and signs posted. Air was provided to flush diamond drill hole. At 12:35 hrs., methane readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1202129	FG (F)	21-Jul-07	Norman Mining Project

Incident:

Installing brattice in shaft. Hose broke at fitting on gauge. Spark caught it on fire. Acetelyne torch's hose caught fire. Brattice installation suspended until investigation complete and findings incorporated. Incident still under investigation. All torck sets being checked to ensure they are not the same.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1202131	FG	23-Jul-07	Copper Cliff South Mine

Incident:

While drilling with a diamond drill on hole 1210840, (-61.50) at a depth of 1362', the diamond driller noticed an odour associated with flammable gas. The diamond driller followed standard procedures. Drilling was stopped, the area was barricaded off. Supervision was notified, and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139192 FG 23-Jul-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered high levels of methane gas at the 1160 foot depth. Water was observed coming from the diamond drill hole. Barricade was erected and signs posted. Area was ventilated via fan. At 11:00 hrs., the okay to resume work was given as methane readings were zero.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139203 FG 10-Aug-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered methane gas at 39-002 drift at diamond drill hole #39-286. At the source, reading was 5%, two feet away, reading was 5% and the ambience was 5%. Signs were posted and barricades erected. No water present. Area was re-evaluated at 11:30 hrs., readings were all zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202181 FG 15-Aug-07 Garson Mine: Underground

Incident:

Methane was intersected on Wednesday, August 15, 2007 on day shift. During diamond drilling on #1 ramp, 5050 level. Area was guardrailed and the standard procedure for a methane gas occurrence was followed. The area was monitored until clear.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139207 FG 16-Aug-07 Campbell Complex: Underground

Incident:

Methane gas encountered by diamond drill crew at 2530 south drift, DDH 25-1129. Readings were .97 at the source; .1 two feet away and ambience was zero. Signs were posted. No water flow observed. Re-tested at 09:45 hrs., all readings were zero. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202204 FG 22-Aug-07 Copper Cliff South Mine

Incident:

While drilling with 704 diamond drill, the operator noticed an odour associated with flammable gas. Description of equipment and test was taken at the collar of the hole at the time of the discovery and showed 10% CH₄. But nothing in the general atmosphere. Again August 24th at 8:25 the test at the collar of the hole showed 8.7% but nil in the general atmosphere. Driller followed standard procedure. Drilling was stopped, the area was barricaded off, supervisor notified, and compressed air left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203196 FG 29-Aug-07 Garson Mine: Underground

Incident:

Inco diamond drill equipped with a continuous gas monitor. At the time of occurrence, sampling was done in the atmosphere with reading of 0% methane. At the collar of the hole, the reading was 5.00% methane. Area was guardrailed off until the methane concentration at the hole was clear. The area and hole was clear at 11:00 p.m. and diamond drilling resumed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1203204	FG	04-Sep-07	Copper Cliff South Mine

Incident:

While drilling with 704 diamond drill, the operator noticed an odour associated with flammable gas. Testing was done at the time of the occurrence. Findings were 10% at the collar of the hole and 6% into the atmosphere a few feet away from the collar of the hole. Later at 00:30 hr. September 06, 2007, the reading at the collar of the hole and into the atmosphere were zero. Driller followed standard procedure. Drilling was stopped. The area was barricaded off, supervisor was notified, and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1189346	FG	04-Sep-07	Campbell Complex: Underground

Incident:

Methane gas encountered by diamond drill crew at approximately 260 foot depth. No water was encountered. Barricade and signs posted. Work was halted because of high methane readings. Ventilation was provided by electric fans. Okay to resume work at 13:15 hrs. as readings were negligible.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1203207	FG	07-Sep-07	Copper Cliff South Mine

Incident:

While drilling with 704 diamond drill, the driller noticed an odour associated with flammable gas. Test taken at the time of occurrence; 2.1% at the collar of the hole and 0.2% into the atmosphere. Later during the same shift at 10:30 a.m., readings were negative at the collar of the hole and into the atmosphere. Driller followed standard procedure for an underground flammable gas occurrence. Drilling was stopped, the area was barricaded off, supervision was notified, and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139223 FG 17-Sep-07 Musselwhite Mine: Underground

Incident:

Methane gas was detected at the drill hole collar. At the source, the reading was off the scale; at 2 feet away, 6%; ambient air was -5. Work stopped and underground supervisor notified. Area was re-tested again at 12:06 hrs., methane at the collar was zero; p two feet away was zero and ambient was zero. Drilling was resumed and area was monitored every fifteen minutes.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191971 FG 19-Sep-07 Campbell Complex: Underground

Incident:

Methane gas encountered at the 275 foot depth and work was halted. Barricades were erected and signs were posted. Water was not observed coming from the hole. Crew was using a solarus tester. Ventilation was provided by an electric fan. at 03:00 hrs., the water was observed flowing from hole. At 11:00 hrs., methane readings were negligible and the hole was making small amounts of water. Okay to resume drilling.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191972 FG 20-Sep-07 Campbell Complex: Underground

Incident:

Methane gas encountered at the 170 foot depth. Work was halted and barricades were erected. Signs were posted. No water observed coming from hole. Ventilation was provided by an air fan. At 12:30 hrs., methane readings were negligible and okay to resume work was given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1180282 FG 21-Sep-07 Musselwhite Mine: Underground

Incident:

Methane gas encountered at 657 metre exploration drift, DDH #07-PQE-086. Drilling was stopped. Readings were at the source - 36%; two feet away - 14%; ambient air was zero. Re-tested at 15:15 hrs. - at collar - 1.7%, two feet away and ambient were zero. Requested that hole be monitored every 1/2 hour. Drilling commenced at 11:30 hrs. on Sept. 22nd.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189344 FG 24-Sep-07 Campbell Complex: Underground

Incident:

Methane gas was encountered at approximately 380 ft. depth of DDH. The drill was shut down as gas readings were over the limit. A barricade was installed with signs posted. No water was encountered.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189345 FG 28-Sep-07 Campbell Complex: Underground

Incident:

Methane gas was encountered while drilling. Barricades were erected and signs posted. The ventilation was provided by electric fans. No water was observed coming from hole. Gas testing was done by a hand held solarus. At 15:00 hrs., readings were still off the scale. At 20:30 hrs., readings were negligible.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1189343 FG 08-Oct-07 Campbell Complex: Underground

Incident:

Methane gas was encountered at approximately 82 feet depth of DDH. There was no reported water flow from hole. The area was ventilated by flow-through ventilation. The drill was shut down, barricades installed and signs posted. Night shift tested and readings were negligible. Testing was done by a solaris hand held tester.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204781 FG 10-Oct-07 Garson Mine: Underground

Incident:

Diamond drill hit methane gas on 5050 level while drilling on hole #216-500. Inco diamond drill equipped with a gas monitor. Test was done into the atmosphere with 0% methane, at the collar they had 5% methane concentration. The methane procedure was followed and the drill was shut down. The area will continue to be monitored until cleared.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189348 FG 12-Oct-07 Campbell Complex: Underground

Incident:

Methane gas encountered at approximately 780 foot depth. Work was stopped. Barricades erected and signs were posted. No gas was observed coming from diamond drill hole. Methane levels were tested using a solaris hand held tester. At 23:15 hrs., okay to resume work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1189347 FG 13-Oct-07 Campbell Complex: Underground

Incident:

Methane gas encountered at approximately 92 foot depth. Work was stopped. Barricades were erected and signs posted. No water observed flowing from hole. Ventilation was flow-through. Methane readings taken with a hand held solarus tester and at 12:35 hrs., readings were negligible.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189349 FG 20-Oct-07 Campbell Complex: Underground

Incident:

Methane gas was encountered by drift crew. Work stopped. Barricades erected and signs were posted. No water was observed coming from hole. Ventilation provided by electric fans. On October 21st, all clear, okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191970 FG 20-Oct-07 Campbell Complex: Underground

Incident:

Methane gas encountered at the 530 foot depth. Work was halted. Water was observed coming from hole. Barricades were erected and signs were posted. Compressed air was provided to diamond drill rods in hole and ventilation was provided by electric fan. At 12:20 hrs., the all clear was given.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1148905 FG 24-Oct-07 Garson Mine: Underground

Incident:

Methane was noted from two old diamond drill holes by the diamond driller in the remuck bay off #1 ramp. Reading of the tests taken in the atmosphere were 0.00% methane at the time of discovery. The reading at the collar of the holes were 2.05% and 2.45% methane. Procedures were followed and monitoring will continue.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189350 FG 24-Oct-07 Campbell Complex: Underground

Incident:

Methane gas was encountered at approximately 60 foot depth and air was provided through diamond drill rods. Stop work and barricades erected, signs posted. Water was observed coming from hole. At 01:16 hrs. on 25-Oct-2007, okay to resume work as readings were negligible.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148906 FG 24-Oct-07 Garson Mine: Underground

Incident:

Technica was reconditioning the east exploration drift on 5000 level on day shift Wednesday, October 24th, 2007 at 3:00 p.m. when they noticed water bubbling out of an old diamond drill hole. Procedures were followed and monitoring was done by the diamond driller who was in the area. Monitoring will continue until cleared. The methane procedure was reviewed with the contractor.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1189351 FG 25-Oct-07 Red Lake Complex: Underground

Incident:

Methane gas encountered at the 1162 metre depth. Drilling was stopped. Barricades were erected and signs posted. Oct Oct. 26th at 08:00 hrs., the okay to return to work was given. Ventilation was provided by electric fan.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191969 FG 25-Oct-07 Campbell Complex: Underground

Incident:

Methane gas was encountered at the 1251 foot depth. The diamond drill was stopped because of high methane readings. Water was observed coming from hole. Barricades and signs erected. Methane gas tested with a solarus hand held tester. The following shift (night shift) at 23:00 hrs. re-tested. Readings were negligible. Work okay to resume. Ventilation provided by electric fans.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1190043 FG 27-Oct-07 Red Lake Complex: Underground

Incident:

Methane gas encountered at approximately 1180 metre depth. Work was halted because of high methane readings. Barricades were erected, signs posted. No indication of water flow. Ventilation provided by 24 inch vent tube. At 14:30 hrs., okay to work given. Readings were zero.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1191621	FG	06-Nov-07	Garson Mine: Underground

Incident:

Methane was intersected on day shift by a diamond drill on 5000 level. Inco diamond drill equipped with a continuous reading gas monitor. The drill was drilling on hole #1216520 at -51 deg. to a depth of 1020 feet. Tests into the atmosphere were taken with a result of 0.00% methane. At the collar of the hole, the readings were: 3:00 p.m. - 1.00% methane, 4:00 p.m. - 2.25%, and 5:00 p.m. - 2.35% methane. Methane procedures were followed and the foreman was notified. The nightshift took readings at the beginning of the shift and deemed the air clear and work continued.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191622	FG	08-Nov-07	Copper Cliff North Mine

Incident:

Diamond driller on 4000L reported the presence of methane gas at the entrance of the 4000 level south exploration drift. Driller followed proper procedures when he encountered methane, the area was guard railed off and the auxiliary ventilation system was turned on. Ventilation personnel checked the entrance to the 4000L south exploration drift to monitor results.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1193992	FG	18-Nov-07	Musselwhite Mine: Underground

Incident:

Methane gas encountered at the 657 metre exploration drift, cut-out 12225 N. at the source, the reading was 1.1%; at two feet away, .4% and ambient readings was .2%. The hole was flushed with air and water and monitored every 1/2 hour. At 13:00 hrs. all readings were zero. Work resumed. Methane was continually monitored every half hour.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191636 FG 21-Nov-07 Copper Cliff South Mine

Incident:

Diamond driller reported readings associated with flammable gas on diamond drill hole 123043 (-46 deg.) at a depth of 383 feet. The operator followed the standard procedure for a flammable gas occurrence. The area was barricaded off and a compressed airline was left blowing at the hole collar. Supervision and the ventilation department were notified.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1200858 FG 29-Nov-07 Campbell Complex: Underground

Incident:

Diamond drill crew encountered high methane readings at approximately 20 feet. Ventilation was provided by electric fan. Signs and barricades were erected - no water observed coming from hole. Hole was ventilated using compressed air. At approximately 1:10 p.m., methane readings negligible. Okay to resume work. Tester used was a hand held Solaris.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120485 FG 29-Nov-07 Holloway - Holt Mine #3 Hoist

Incident:

Methane gas encountered at diamond drill program at Holt Mine #3 shaft. An SOP is in place for encountering methane.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1200822 FG 01-Dec-07 Campbell Complex: Underground

Incident:

A diamond drill crew encountered methane gas the 600 foot depth. Work was stopped. Barricades were erected and signs posted. No water observed coming from hole. Day shift drilling was ceased and area was left to be re-tested on night shift. At approximately 21:00 hrs., the all clear to resume work was given. Methane readings were taken using a hand held solaris.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1201052 FG 10-Dec-07 Campbell Complex: Underground

Incident:

Methane gas was encountered by diamond drill crew at approximately 440 foot depth. Drilling was halted. Barricades were erected and signs posted. No water observed coming from hole. The area was ventilated using an electric fan and methane tested using a hand held solaris tester. At approximately 12:25 hrs., methane readings negligible. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191666 FG 12-Dec-07 Copper Cliff South Mine

Incident:

While drilling with 693 diamond drill on hole #123067, (-42.00) at a depth of 413, the diamond driller intersected water and also noticed an odour associated with flammable gas. The diamond driller followed standard procedures for an underground flammable gas occurrence. Drilling was stopped, the area was barricaded off, supervision was notified, and compressed air was left blowing at the hole collar.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1183762 FG 12-Dec-07 Musselwhite Mine: Underground

Incident:

At 12:10 p.m. a grout plug installed in 07-PQE-105 hole was blown out of hole. While drilling was commencing on 07-PQE-119 (82 degrees) no methane was intersected during drilling of 07-PQE-105 and the hole was cemented and plugged on Nov. 8/07. Currently the hole is still being monitored. Following the plug ejection, the hole has been producing methane and is currently being monitored.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120488 FG 14-Dec-07 Holloway - Holt Mine #3

Incident:

Night shift diamond drill crew reported encountering methane (CH₄) while drilling. 0.125% at source.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1200859 FG 15-Dec-07 Campbell Complex:

Incident:

Diamond drillers encountered high methane readings at approximately 220 foot depth and drilling stopped. Crews erected barricades and signs were posted - no water observed coming from hole. the area was ventilated using an electric fan. air was left blowing at collar of diamond drill hole. Methane readings taken with a hand held solarius unit. At approximately 2:30 p.m., methane readings negligible. Okay to resume work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

HS – HOISTING

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1103520 **HS** **20-Jan-07** **Norman Mining Project**

Incident:

The cage arm on No. 1 side of shaft was found bent at start of day shift.

Cause:

None given.

Preventative Action:

Check straps on vent ducting on No. 1 side.

Event ID: 1104186 **HS** **03-Feb-07** **Nickel Rim South Mine**

Incident:

The #1 cross head momentarily caught on the Galloway tower resulting in damage to the hoist rope three to four feet above the cross head. The Galloway was not sufficiently level, resulting in the cross head to contact the Galloway tower. Injuries and damage: twenty (2) feet of the hoist rope was removed and re-socketed.

Cause:

None given.

Preventative Action:

Twenty (2) feet of rope was cut and the socket attachment re-installed. Hoist and shaft inspection performed. Galloway levelled. Tower frame tapered. Cross head angle tapered.

Event ID: 1103844 **HS** **04-Feb-07** **Kidd Creek: Deep 7000**

Incident:

1.5 tonnes of ore went down shaft. A defective control relay allowed the skip to be loaded when it was too low in the shaft. Due to rope stretch, the skip sank in the shaft as it was loaded until the lip of the loading pocket dumped ore onto the skip canopy and eventually down the shaft.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104188 **HS** **06-Feb-07** **Norman Mine Project**

Incident:

Lowered cage into water. Full investigation is ongoing.

Cause:

None given.

Preventative Action:

Follow procedures.

Event ID: 1105485 **HS** **09-Feb-07** **Hoyle Pond: Surface Skip**

Incident:

Caller reported a near miss incident. Skip tender was working with hoist when skip dogged out. Safety feature okay but problem is sudden accelerated cable and the crosbie clamps moved. Skip tender shut it down. Mechanical boss said to go ahead but cage tender refused to move the cage. Superintendent was notified and had crosbie clamps re-torqued.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1160043 **HS** **13-Feb-07**

Incident:

Minor damage to skip guides presumably caused by a small rock temporarily jammed in the top of the skip bail while skipping.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109937 HS 18-Feb-07 Creighton Mine: Underground

Incident:

Hoist drum the kellems grip holding the rope came loose on the last turn of the winder bull wheel and the skip rope landed on the ground. No injuries, no damage. Under joint investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104681 HS 28-Feb-07 Fraser Mine Production Hoist

Incident:

Canopy came out of position while conveyance was coming to surface. The sides of the canopy then started rubbing on the shaft guides at this location. Shaft crew had completed chaging out shaft guides and were coming to surface. At approximately the 80 meter mark from surface, they heard a banging hoise and stopped the conveyance. A crew from surface walked down the manway and found that the protective canopy and slowly hoisted the conveyance to surface. No injury. Damage to canopy, and one shaft guide.

Cause:

None given.

Preventative Action:

Canopy was removed. Conveyance and shaft rope were inspected. Damaged shaft guide was changed out. Shaft inspection was also done.

Event ID: 1182023 HS 05-Mar-07 Copper Cliff North Mine

Incident:

The cage hoist tripped while travelling at normal speed. No injuries or damage. Pressure drop in the hoist braking system. Two pressure regulator valves were suspected to be faulty and subsequently replaced. The appropriate tests were done to confirm normal operation following the repairs.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1107984 HS 19-Mar-07 Nickel Rim South Mine

Incident:

A shotcrete accelerator tote (cube) container (1000L) was being slung to send to the 1520 elevation level. As the container was lowered below the collar, the container slipped from the slinging arrangement striking the steel divider. The container (plastic with aluminum frame) split, resulting in the contents spilling in the shaft. Shaft inspections were performed and no damage to equipment resulted. The slinging apparatus did not fail. The tote slipped from the slinging gear. No injuries or damage. Engineered slinging box is now used to set the toe into for slinging.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182041 HS 28-Mar-07 Copper Cliff North Mine

Incident:

Cage hoist brakes applied inadvertently. No injuries or damage. On several instances over the past week, the North Mine cage hoist brakes have inadvertently applied in a controlled manner but unexpectedly and before the conveyance had reached its desired destination. Under investigation by Inco's hoist specialist.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139109 HS 18-Apr-07 Red Lake Complex Mine

Incident:

A maintenance crew were testing the regulated braking system during scheduled hoist inspections. The regular overspeed trip-out was tested along with the full E-stop. There all tested okay. A test was done on the clutch interlock at about 1000 to 1100 FPM and it showed they had good regulated braking. They did a second test at 1201 FPM and the conveyance went into a full E-stop. The second test was performed because the crew had not recorded the actual FPM on the first test. There were no injuries as there were no workers in conveyances while maintenance crew were testing. The hoisting rope was kinked and the dogs were engaged in the shaft. The number 4 compartment skip / counterweight is where occurrence happened. A rope cut was done and as well as a drop test and a shaft inspection.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139111 HS 19-Apr-07 Red Lake Complex Mine

Incident:

After slinging material in the #3 compartment, the hoistman was in the process lowering the cage after the crosshead had been removed. The cage tender signalled the hoistman to lower the cage and while the cage was being lowered, it became lodged on the top of the shaft swing guide that had not been fully closed to its proper position. This in turn caused the cage to stop and rest on the swing guide also caused approximately 17 feet of slack rope. There were no injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139113 HS 23-Apr-07 Red Lake Complex Mine: Underground

Incident:

The underground winze hoist (#2 hoist) reported intermittent power spikes while operating hoist at high speeds. A preliminary electrical investigation did not identify any problems. A shaft inspection did not identify any problems. As a safety precaution, a decision was made not to hoist men on #2 hoist. As a result, men were brought up to #1 shaft via underground main ramp. There were no injuries or damage reported.

Cause:

Continuous investigation identified an encoder coupling attached to the #2 hoist drive shaft that was slipping.

Preventative Action:

The set screw on the encoder coupling was re-tightened and the hoist was returned to normal operations.

Event ID: 1135630 HS 30-Apr-07 Kidd Creek: Upper Mine

Incident:

Skip did not get its position to load on 2800. The hoist attendant then rescaled the north skip when at about the 5000 ft. level, the north pocket door on 2800 opened up and unloaded its contents into the shaft and onto the top of the conveyance.

Cause:

None given.

Preventative Action:

None given.

Event ID: 11354639 HS 30-Apr-07 Kidd Creek: Upper Mine

Incident:

While skipping from 2800, the north empty skip went passed 200 with a full pocket and stopped around 4750. It tripped on long wait. Employee brought skip back up and put it back in auto. It did the same thing again, so employee brought the skip back up and proceeded to scale the north skip. When employee finished scaling the north skip, he heard a banging noise and stopped all conveyances.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109208 HS 16-May-07 Campbell Complex: Reid Shaft

Incident:

Problem with power supply from hydro. Due to a failed capacitor in Red Lake, power surges through the Red Lake, Balmertown and Cochenour areas, hoists kicked out. Seven men on the Campbell cage mid shaft around 900 level. Cage came to controlled stop and everyone okay. Reid cage on way to surface when hydro shut the power off. Came to controlled stop and everyone okay. They are going on back-up power because of surging and concerned about blowing something. At 4:37 a.m., hydro shut down the main power. At this time, 2 men were in the Reid cage coming to surface. Cage came to controlled stop and no one was hurt. Hydro blew a transformer and switched to the back-up one. 5:30 a.m. still problems re-setting the #3 Campbell hoist and eventually found a bad contact on motor #2 over current.

Cause:

Power surge by Ontario Hydro.

Preventative Action:

The action taken by company to prevent a re-occurrence: Hydro had fixed transformer.

Event ID: 1109012 HS 17-May-07 Red Lake Complex Mine: Underground

Incident:

UHM failure at #2 hoist. No injuries. There was damage to the power supply in the UHM (ultimate hoist monitor). Power supply on the UHM shorted out and failed causing the UHM (ultimate hoist monitor) to shut down and put the hoist into regulated emergency braking. Throughout the evening of May 16-17 there were a number of brown-outs due to fluctuations in the line voltage caused by the hydro sub-station in Red Lake. After the power was restored to normal operating conditions at 5:55 a.m., all hoists on the property were checked and tested before release to normal operation. The #2 hoist was running at normal man speed of 1500 FPM. The hoist tripped at around 30 level with men in the cage. The conveyance came to a regulated emergency stop. Communication with the workers was maintained every 1/2 hours. Before the conveyance was moved, it was visually inspected to determine that it was safe to hoist the men to the next level. This is per Goldcorp. procedure.

Cause:

None given.

Preventative Action:

The power supply was replaced and fine tuned through dial-up connection from Montreal.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120438 HS 08-Jun-07 Kidd Creek: Upper Mine

Incident:

20 tonnes of muck was dumped from the 49LP down the #2 shaft. No injuries and minimal shaft damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202077 HS 09-Jun-07 Nickel Rim South Mine

Incident:

The material slinging cross head was attached to the main shaft #2 sinking rope in preparation to send underground. The concoming shift was not in place so the conveyance was released. The hoistman was using the idle time to perform the hoist daily checks. As he attempted to test the #2 upper track limits, the material slinging shaft inspections were performed from the maryanne and from the #2 and #1 bucket. The shaft blasting line was cut and repairs conducted. Investigation in progress.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135671 HS 14-Jun-07 Kidd Mine: #4 Shaft Skip Hoist

Incident:

Muck spilled down the shaft while skipping from the 68 loading pocket. There were no injuries and only minor damage to one bell cord which was repaired immediately.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1202075	HS	15-Jun-07	Nickel Rim South Mine

Incident:

The skips were installed and on the first initial trip down in the shaft, a shaft / skip clearance inspection from the #1 (north) skip was in process, the hoist converter tripped. The emergency reaction of the converter trip resulted in the skip contacting the Galloway chairs (distance of approximately 25 ft) on the 1660 level. This was first trip inspection. Minor first aid injuries were received by the two employees performing the inspection from the skip. Damaged rope guide shoes on skip. Inspections and temporary repairs were made to bring the skip to surface for repairs. Under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1206030	HS	08-Jul-07	Sifto Canada Inc.

Incident:

Basket caught on timber and bent while being hoisted - no injuries. There is some repair work being done in the shaft while they were raising a man in the basket. The signal was given to stop the hoist, however, the signal was misunderstood and the hoist was not stopped. The basket then caught on a timber and bent the basket. There were no injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1092043	HS	16-Jul-07	Dome Mine: Underground Cage

Incident:

Cage had been loaded with a truck of scrap at the crusher level and then raised to 2700 with the supervisor. The supervisor loaded the stopers onto the cage and sent the cage to surface and the waiting cage tender. A mechanic on 2500 level reported. Cage tender contacted the supervisor and notified him that only one stoper had reached surface.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202120 HS 16-Jul-07 Copper Cliff South Mine

Incident:

While greasing the clutch on the cage hoist, the cage tripped o converter fault. While doing a cage shaft inspection, the shaft crew noticed fresh dog marks at 3736.7 feet elevation and the cage rope had marks that indicated possible kinks. No injury but damage to the hoist rope and marks on the guides.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1021447 HS 23-Jul-07 Williams Mine Skip Hoist

Incident:

Conveyance striking shaft safety door at collar.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202145 HS 30-Jul-07 Stobie Mine: Underground

Incident:

A 5 foot piece of angle iron was found in the shaft compartment at the 600L horizon. Angle iron protruding into shaft and making contact with conveyance at 600L. No injuries, no damage. As the cage was descending, the shaft crew noticed the conveyance had made contact with an obstruction in the shaft. The hoistman was contacted, the cage was stopped and the shaft crew returned to the 600L horizon where the contact was noticed. The cage was then inspected on 600 level with no deficiencies found.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202177 HS 12-Aug-07 Stobie Mine: Skip Hoist

Incident:

9 shaft #1 skip was overloaded resulting in jamming of the skip due to spillage of muck into the skip compartment. West sticky muck had built up inside of the skip hoist reducing the volume. No injuries or damage. As the skip left the loading pocket, loose muck fell out of the overloaded skip causing the skip to jam in the shaft approximately 10 feet above the loading position at the pocket. Upon visible investigation, the muck was approximately 1 foot above the lip of the skip and muck was observed between the skip and the compartment wall. Proper steps were taken to hoist the skip up to dump position and the skip was emptied. A shaft inspection was done. All controls were tested to ensure proper operation and the load cell was changed as a precautionary measure.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135699 HS 01-Sep-07

Incident:

The contractor was welding kicker on hoist drum when he accidentally arched the hoist rope. As a result, approximately 810 feet of hoist rope was cut off. The hoist has not been commissioned prior to incident.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1186370	HS	10-Sep-07	Goldcorp. #3 Production Hoist

Incident:

While skipping after dumping #2 skip, the conveyance failed to exit the dump. The hoistman heard a thump and observed that the skip did not pass the collar. He stopped the hoist. The skip was inspected and secured. The loose wrpas of rope were re-wound on the drum and the skip was dumped. The skip was hung up below the dump because of large waste rock. Investigation commenced by MOL.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1056876	HS	27-Sep-07	David Bell Mine: Skip/Hoist

Incident:

Skip incident at shaft collar. Damage to four guides, skip rope and the #2 shaft compartment door. workers were set-up to do an electromagnetic inspection of the #2 skip rope. The shaft door was down and the signal was given to lower skip to testing. The hoist operator raised the skip into the shaft door. The shaft door was damaged and the ends of four shaft guides were damaged by the wing plates of the shaft door. Also, the skip rope received abrasion at the skip attachment from contact wit the shaft door.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1120471	HS	05-Oct-07	Holloway - Holt Mine #3 Shaft

Incident:

Inrush of wet muck into #1 measuring box of 1145 loading pocket. The overloaded measuring box with wet muck resulted in an overloaded skip.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204773 HS 08-Oct-07 Fraser Mine Service Hoist

Incident:

Kinked rope. Worker had chaired the conveyance on 4100 level. When done unloading the load, he released the conveyance. The hoistman proceeded to lower the conveyance, causing a slack rope. The cagetender forgot to give the signal to remove the conveyance from the chair but instead gave the hoistman 5 bells to release it. The hoistman also did not catch the omission and proceeded to lower the conveyance causing the rope to kink. No injuries. Damage to hoist rope, multiple kinks. Under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204780 HS 09-Oct-07 Levack Mine

Incident:

Crew was stripping and removing old power cables from the pipe compartment in the shaft. The clamping harness was attached to the cable. The hoisting tugger was pulled up to take up the slack on the section of cable to be removed. The old power cable was secured with chain block in order to cut it free from the section hanging on the hoist tugger. The cable was ready to be lowered to the 2650 level. The crew cleared the area, and radioed up to the hoist tugger operator to start to lower the section of cable. The section was moved approximately 4 inches and the cable fell out of the clamping device. Reasons for occurrence: not sure as of yet why the cable came free from the clamping device. Must do a complete inspection of the pipe compartment and manway before investigating the cable that fell into the pipe compartment. Did a shaft inspection immediately to determine if any of the lining had been displaced. (it was fine). Investigated 1800 level and clamp that failed. Description of equipment and conditions: new hoist tugger good cable. Clamping device in good condition.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135720 HS 19-Oct-07

Incident:

The shaft crew reported that the leaf spring assembly that controls the dogs had a broken leaf. The day shift crew was sent home and no one allowed to work underground.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1210505 HS 21-Oct-07 Sifto Canada Inc.: Goderic North

Incident:

The a side of the #3 hoist was on the move and the B side was unclutched. B side tried to clutch back in and caused damage. There were no injuries and no workers involved.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148902 HS 23-Oct-07 Copper Cliff South Mine

Incident:

Faulty air solenoid valve controlling the #3 skip hopper door on 4050L loading pocket failed allowing muck to fall to spillage in the skip compartment. No injuries or damage. A visual inspection of the shaft compartment was performed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1135729	HS	02-Nov-07

Incident:

It was reported by employees at 3 different shaft stations that they heard something fall down the shaft i the skipm compartment at which time the cagetender was immediately instructed not to move the cage. The inspection doors were left open after the morning conveyance check and subsequently hit by the movement of the skip #2 compartment.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191624	HS	09-Nov-07	Craig Mine: Cage Hoist

Incident:

CCR operator was in manual and stopped the skip when he received the skip in position green light. He initiated the system into auto skip mode. The system opened the ARC gate and started the auto skipping cycle. The green position light came on even though the Craig skip was approximately 5 feet above its normal loading position. The PLC allowed the ARC gate to open, sending 20 tons of waste down to shaft bottom. A root cause failure analysis (RCFA) will be conducted.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191623	HS	12-Nov-07	Fraser Mine Production Hoist

Incident:

After dumping its load, the #2 horn side skip travelled some 2 meters down and wedged itself in the shaft below dump. the door of the skip became jammed against a shaft beam. No injuries. Conveyance in the process of being freed and damage assessment to be done afterwards. RCFA to be conducted by reliability engineer in the conjunction with mechanical electrical dept.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: **1191651** **HS** **03-Dec-07** **Copper Cliff North Mine Cage**

Incident:

The cage hoist braking system valve #23 failed resulting in an unplanned, controlled stop of the conveyance. No injuries or damage. The cage hoist braking system valve #23 failed. Valve #23 was isolated and replaced. Several test runs were performed before putting the conveyance back into service.

Cause:

None given.

Preventative Action:

None given.

Event ID: **1191654** **HS** **06-Dec-07** **Goldcorp. #3 Service Hoist**

Incident:

While completing a PM on the service hoist, the collar door safety stops (permissives) were being tested. They checked the lower safety stop and it functioned properly. They by-passed it to check the upper safety stop. The collar doors are kept closed during these checks. The service cage came up to the upper safety stop and it functioned properly but the canopy came in contact with the collar door before the conveyance came to a complete stop causing minor damage to the canopy. Investigation is on-going. The safety stops were adjusted so the conveyance will come to a full stop before the canopy can hit the collar door. The supplier was contacted to determine how to repair the canopy properly.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139832 HS 06-Dec-07 Goldcorp. #3 Service Hoist

Incident:

While completing a PM on the service hoist, the collar door safety stops (permissives) were being tested. They checked the lower safety stop and it functioned properly. They by-passed it to check the upper safety stop. The collar doors are kept closed during these checks. The service cage came up to the upper safety stop and it functioned properly but the canopy came in contact with the collar door before the conveyance came to a complete stop causing minor damage to the canopy.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139834 HS 10-Dec-07 Goldcorp. #3 Production Hoist

Incident:

Magnet fell down the skip compartments.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

IW – INRUSH OF WATER OR MATERIAL

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105813 IW 03-Jan-07 CVRD / INCO Matte Processing

Incident:

A calcine spill was found by #156 conveyor area. The conveyors were not running, however, calcine was spilling from a collection box through a gap in the #156 conveyor. No injuries, no damage. The last 2 hoppers were opened from #3 bin, which goes onto #129 conveyor and into the collection box to #156 conveyor. This caused the collection box for #156 conveyor to fill and spilled through a gap in #156 conveyor.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105822 IW 13-Jan-07 Coleman Mine: Underground

Incident:

Water entered the shaft due to the failure of a sandfill line vortex elbow. No injuries. Failure of Vortex sandfill elbow.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108830 IW 21-Jan-07 Clarabelle Mill

Incident:

Investigation by circuit operator found a run of muck on the walkway beside the feeder and on the floor beneath. No injuries or damage. 1 vibrating screen shown as running on control screen was in fact not running, which allowed primary fines water to flow onto BC-13 conveyor and subsequently into fire ore bin. This water created the wet material condition, causing the spill at #1 rod mill feeder.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1149442	IW	14-Feb-07	Lafarge Canada Cement Plant

Incident:

Loader operator working on ground when there was a material slide. Operator uninjured and managed to free himself. Loader was half barred.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1182025	IW	02-Mar-07	Copper Cliff South Mine

Incident:

An unexpected run of muck occurred in the 3930-778 orepass slide. Orepass was hung up with ore at an unknown elevation above 3930L. No injuries. Damage occurred to the 778 orepass crash gate. the gate was bent. A secondary blast was detonated in the pass to attempt to release the hang up. The hung muck did not initially release following this concussion blast. Following the blast, the pass was inspected where small amounts of muck were noticed trickling from the hang up. Shortly after this time, the main hang up in the pass released and filled the 3930 crusher slide collector with muck. The force of the running muck damaged the crash gate and completely filled the crusher slide.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1182027	IW	05-Mar-07	Clarabelle Mill

Incident:

A decision was made to run the tipple feeders empty for bin inspection. The low bin alarms were made inoperable and the feeders were bumped one at a time to empty the bin. A run of muck came out of 23-FDR-2 covering a large section of the floor. No injuries or damage. Contractor had been water blasting at top of tipple bin causing a possible accumulation of muck and water.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1021444 IW 06-Mar-07 Williams Mine: Underground

Incident:

Outflow of backfill / waste from stope into footwall drift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1021445 IW 07-Mar-07 Williams Mine: Underground

Incident:

Filled paste stopes displaced downward into unknown void - outflow of backfill / waste from stope into footwall drift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1106834 IW 09-Mar-07 Hoyle Pond Mine: Underground

Incident:

Paste wall completely failed causing paste to run into 740 UM access drift.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182037 IW 10-Mar-07 Copper Cliff South Mine

Incident:

Wet muck spilled onto the feeder platform of the 4000 level crusher. Wet muck in the 4000 level crusher feeder. No injuries or damage. Operators arriving at the 4000 level crusher discovered a run of material had occurred. Material filled the crusher feeder, spilled over the wings onto the adjacent platform, and onto part of the surround equipment. The muck was wet and constituted approximately 3 to 4 tons.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182029 IW 11-Mar-07

Incident:

Caller is reporting the roll over and spilling to "hot mat" to the interior of the Smelter building in the conveter aisle. Incident was caused by the converter not operating properly.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189732 IW 13-Mar-07 St. Mary's Cement

Incident:

Face of stockpile collapsed on a loader. Worker was taken to hospital for assessment. Injuries are not critical.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139086 IW 29-Mar-07 Red Lake Complex: Underground

Incident:

The raise bore was reaming a hole from 1600 level (18 ft. diameter) to surface and an underground worker was mucking the raise bore cuttings which came out of the 2300 level. The catch throat at the bottom of the drill string is supposed to hold the water but didn't. This allowed the water to run freely on top of the raise bore cuttings inside the raise. The underground scooptram operator started mucking out the bottom of the raise and after removing one bucket of muck approximately 30 to 40 tons of water and slime came running down into the drift. There were no injuries or equipment damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109509 IW 11-Apr-07 Dome Mines #8 Shaft

Incident:

On night shift, muck and water from orepass had spilled. 15 tons of muck and fines had spilled onto the level.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139105 IW 13-Apr-07 Campbell Complex: Underground

Incident:

An underground crusher operator was crushing ore on 2700 level when he activated (remotely) by-pass at 2600 level causing a run of muck. Approximately 50 tons of ore ran out the rockbreaker on 2700 level on to the track. It is believed that a build-up of fine wet ore was in the ore pass, which was idle for 7 shifts because the upper mine was shut down due to a cage incident.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1087694 IW 20-Apr-07 Norman Mining Project

Incident:

Contractor was mucking waste into coarse ore bin. Muck was too wet and rushed through ross feeder down to crusher approximately 20 feet below.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1087694 IW 20-Apr-07 Norman Mining Project

Incident:

Contractor was mucking waste into coarse ore bin. Muck was too wet and rushed through ross feeder down to crusher approximately 20 feet below.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1201730 IW 12-May-07

Incident:

Run of muck. An employee had started up the crusher and was crushing for about 5 to 10 minutes when uncontrollable muck came out of the ore pass. About 10 tonnes spilled out of the ore pass. Most of it was contained in the fan feeder and jaw of the crusher. Some muck did spill onto the catwalk where the operator stands.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202039 **IW** **25-May-07** **Levack Mine**

Incident:

Water was running down into the ore pass system from the 1200 level due to a blocked drain. We muck at course ore bin caused a flow of fines to leak and overflow over the control bin in the crusher room. The spill was confined to the back of the crusher room. No injuries. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1139136 **IW** **29-May-07** **Campbell Complex No. 3**

Incident:

Very heavy rainfall occurred. Manhole and drains were not able to keep up to the amount of rainfall. As a result, excess water went down the shaft compartment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202049 **IW** **31-May-07** **Coleman Mine: Surface**

Incident:

Flash flood caused water to go down the Coleman #1 shaft and the water caused the cage hoist to trip out. Northland Engineering has provided an engineered solution consisting of storm sewers and storm drains that will divert the water from these intense rain storms from the yard into the pond. They are presently designing this solution C/W necessary scope of work.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135652 **IW** **31-May-07** **Agrium Inc.: Pit**

Incident:

Approximately 25,000 BCM of clay sloughed in an inactive section of the pit. Movement of the wall in stage #2 west had been noticed during the spring and had been closed off to mining activities.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202062 **IW** **10-Jun-07** **Clarabelle Mill**

Incident:

A conveyor flag went down and someone was sent to investigate. Upon arrival at area, a run of muck was discovered. Approximately 3 cubic metres of material on belt and catwalk. There were no injuries or damage. There was a collection of wet feed build-up at the feeder while it was down.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202066 **IW** **12-Jun-07** **Copper Cliff South Mine**

Incident:

A run of wet muck was discovered at the 2350L #2 chute. The muck partially buried the feeder, feeder motor and part of the crusher station platform. Access was restricted to the area. The incident is under investigation. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139159 IW 15-Jun-07 Campbell Complex: Underground

Incident:

Had completed a non-routine hazardous task for a job in the ore pass on 2700 level. The control chains on the 2600 ore pass down were sopragged with muck behind them. An 8 foot diameter balloon was installed / inflated approximately 60 feet up from the 2700 rock breaker area where work was being carried out. The crew went down and found the balloon and wet muck on the 2700 level grizzly. MOL inspector contacted. Inspector requested a document be sent concerning stoppage of non-routine hazardous tasks inside of ore / waste passes at this mine site until a plan was submitted to an inspection an Ontario qualified Mining Engineer stamp stating that all safety precautions are in place for work of this nature that will likely ensure that workers will not be endangered doing such tasks.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1205807 IW 04-Jul-07 Williams Mine: Surface

Incident:

Feul spill (appriximately 1000 litres). No injuries. Failed 2" ball valve.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1206265 IW 10-Jul-07 David Bell Mine: Underground

Incident:

Mucking paste fill for void in A9B-H2 stope. Worker returned from last bucket to find 100 ton block on drift sill.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135679 IW 08-Aug-07 Dome Mines #8 Shaft

Incident:

Sand fill subsidence into main drift on 1500 level, from damaged bulkheads from the 1457 #4 x-cut.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202162 IW 08-Aug-07 Norman Mining Project

Incident:

Cage received damage to door. worker had taken 2 buckets of muck out and dumped them down the waste pass. Worker stopped mucking to get a weldon pump for the main drift. He and another miner were approximately 70 feet from the raise bore access drift inspection when he noticed a large volume of water coming from the raise bore access drift. He stopped the scoop and moved away from the intersection. A portion of the water leaving the raise bore drift went across the station and flowed down the shaft and a bore drift went across the station and flowed down the shaft and a yet to be determined quantity of water entered the 1750 / 2450 waste pass. At the same time that this happened, the cage, with three miners on board, had left 1750 to go down to 2450 level. They reported that about 100 feet below the 1750 level, they heard water starting to hit the top of the skip and cage. The water going down the shaft was deflected off the 2450 station canopy against the cage door as the conveyance reached 2450 level. This caused the door to open, exposing the 3 occupants to the open shaft. There had been an accumulation of water in the raise bore hole. This was due to the remaining raise bore cuttings from final reaming, prior to breakthrough on surface, plugging the bottom.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202180 **IW** **14-Aug-07** **Clarabelle Mill**

Incident:

Control room operator noticed 24-BC-101 was down and it appeared that there was wet muck on the conveyor when viewed on camera. Upon further investigation in the field, it was confirmed that wet muck had run from 24-FDR-6. Approximately one cubic metre of wet muck had spilled off the edges of the conveyor. Conveyor moves coarse ore from crusher building to coarse ore bin. Possibility of running increased pebble feed with a tipple feed may have increased the moisture content.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203208 **IW** **08-Sep-08** **CVRD / INCO Matte Processing**

Incident:

Cottrell 3A hopper door, on B floor, was open and dust was flowing out of the hopper into the work room environment. Approximately 3 cubic metres of dust had spilled. No injuries or damage. Urine samples taken of workers exposed and all of the analyses for these individuals were below the acceptable value of 50 PPM NI.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1062395 **IW** **25-Sep-07** **David Bell Mine: Underground**

Incident:

There was a run of fine wet muck from the pass into the empty chute. Fines overflowed the chute gate and spilled onto the top floor. Some of the fines spilled to the lower decks where the worker was.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1791631	IW	13-Nov-07	CVRD / INCO Matte Processing

Incident:

FBR building operator began filling FRM shipping bin 8C. Prior to switching bins, the operator took a bin measurement of bin 8C and found the bin height, measured the top of the material in the bin to the top of the bin, to be 19 feet. At the end of the shift, the operator returned to measure the bin heights of all bins in shipping and found no change in the bin height for bin 8C. The operator then began investigating the cause for no change in bin height and found piles of FRM on every floor in shipping below bin 8C. Investigation by the operator and the MPF found that the discharge piope from the bottom o fbin 8C to conveyor 153 had been cut off but had not been capped. At present, it is estimaged that 200000 lbs. of FRM drained out of bin 8C.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191638	IW	21-Nov-07	Coleman Mine: Surface

Incident:

Driver was pulling chute and when he tried closing the cute, the ARC gate would not close due to a cylinder failure, which caused the truck to be overloaded. Injuries and damage: none. The cotter pin, which holds the cylinder anchor pin in place, fell out due to the cotter pin being rusted. This resulted in the chute being unable to close causing approximately 100 tons of material to dump onto the 50 ton haulage truck.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191646	IW	25-Nov-07	Copper Cliff South Mine

Incident:

Skip was overloaded. Loading pocket. No injuries or damage. Skip was partially overloaded at 4050 loading pocket, causing approximately 1.5 cubic yards of material to fall to spillage. A faulty load cell was identified.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204805 IW 04-Dec-07 Hoyle Pond Mine: Underground

Incident:

The stope crew was pouring paste in the 820 UM PCF stope. They called for a slush and at that time heard a snapping sound. Upon investigation, they saw that their paste wall had partially failed and saw the material start to flow down the manway. Partial paste wall failure in stope causing approximately 75 tonnes of paste to run down manway onto level below.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204807 IW 06-Dec-07 Dome Mines #8 Shaft

Incident:

Operator opened ARC gate to the underground feeder and a rush of water and muck poured out over the 100 conveyor. Spillage on both sides of the 100 conveyor blocking walkway and wet slurry on lower floor.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191670 IW 13-Dec-07 Copper Cliff South Mine

Incident:

An uncontrolled run of muck discharged from 868 chute on 2050 level. No injuries. Damage occurred to the chute gangway and guardrails from the run of muck. Approximately 300 tons of wet material discharged from the chute into the haulage drift. No personnel were present. It is believed the chute lip was not properly latched the last time the chute was used. The source of the water is being investigated. A site specific procedure is currently being developed to safely handle the spilled material. The cause of the spill will be further investigated after clean up is complete.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

MM – MOLTEN MATERIALS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108829 MM 22-Jan-07 Copper Cliff Smelter

Incident:

There was a need for coolant. Workers loaded a ladle of reject anodes and the crane operator brought them to no. 14 MPV and dumped them into the molten bath. This resulted in an unexpected pop, which caused some molten metal to be exhausted out of the stack of the vessel. Some of the spray of molten copper ended up on the side window of no. 6 crane. The reject anodes were inspected prior to loading into the ladle and appeared dry. Possibly the anodes were cold when introduced into the bath.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109929 MM (F) 04-Feb-07 Copper Cliff North Mine

Incident:

While tapping #1 convertor, cardboard packaging on a pallet of ladle inner plates caught fire.

Cause:

Supplies too close to tapping area without fire blanket.

Preventative Action:

None given.

Event ID: 1109930 MM (F) 04-Feb-07 Copper Cliff Smelter

Incident:

At 7:30 a.m., a wash was done on #16MPV and at 8:30 a.m., workers skimmed 1 1/2 ladles of skim off. The temperature after the skim was 1298C. #16 MPV was reported as leaking and so the emergency stop was engaged to shut the burners off. The shell was rolled to safety. Grease hoses were ignited. Put out using a fire extinguisher.

Cause:

Leak of hot metal through #16 MPV.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109934 MM 07-Feb-07 Copper Cliff Smelter

Incident:

#3 converter was being prepared to be put back on line. The shell was fully charged. In the process of rolling the converter into stack first blow), the converter began foaming. The foaming came over the front and back of the converter causing damage to the punching machines behind the converter. The operator rolled the converter out of the stack allowing the converter to foam into the ladle in the slag bay.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109935 MM 09-Feb-07 Copper Cliff Smelter

Incident:

#3 converter tuyeres needed to be drilled as a result of the "foam over" from the events that occurred the previous night. During the course of drilling the tuyeres on #3 converter, an explosion / blow back occurred. Drilling was then stopped and a meeting was held with the crew to come up with a plan on how to drill the tuyere safely. Once a plan was agreed upon, the drilling continued, hence a second explosion / blow back occurred. The job was then stopped. Description of equipment and conditions: converter is a 45' long vessel and is refractory lined to hold molten material. The tuyere body is a device that allows air, oxygen, nitrogen to be injected into the shell and also has a punching machine mounted to it to maintain flow integrity. Two employees who reported injuries, both employees received 1st degree spot burns to their neck and developed ringing in their ears because of the incident. The tuyeres were full of frozen matte and when the drill reached the end of the tuyere pipe, the water from the drill came in contact with molten material.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109939 **MM** **21-Feb-07** **Copper Cliff Smelter**

Incident:

While cleaning the quench inlet on #1 flash furnace, 2 pops occurred because of molten metal present at the inlet. Description of equipment and conditions: build-up of material being cleaned from quench inlet. No injuries or damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182019 **MM (F)** **24-Feb-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

Tapping matte from #2 TBRC and the dead man switch on joystick for convertor control did not engage. The convertor drifted causing hot metal to overshoot ladle on transfer car causing minor fires in the Convertor Isle.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104683 **MM (F)** **28-Feb-07** **Xstrata Nickel Sudbury Smelter**

Incident:

#4 crane was dumping finish at bumper from casting ladle. The finish came in contact with wet flux or revert causing several small pops. Some material flew causing a cardboard box to ignite. A fire extinguisher was used to put out the fire.

Cause:

None given.

Preventative Action:

An elevated pad was built in the morning for the kress hauler pot. Should have used dry material from old aisle.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182024 MM (F) 03-Mar-07 Copper Cliff Nickel Refinery: NRC

Incident:

There was a minor cut out on #4 ladle at the start of granulation. To eliminate the potential of the cut-out increasing and losing control of the operation, the matte was reverted back to the TBRC as per procedure. A minimal amount of product was lost onto the east granulation platform as the ladle was moved, which ignited hydraulic oil on the platform from the hydraulic cylinder being disconnected at this point. Source of ignition: hot matte. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Cut-out of #4 ladle.

Preventative Action:

None given.

Event ID: 1182039 MM (F) 11-Mar-07 Copper Cliff Smelter

Incident:

Damage to electrical cables and panels near #6 converter. As a result of #6 converter rolling down and spilling molten matte into the main aisle, some electrical cables and panels caught fire. Method of extinguishment: fire department.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182038 MM 11-Mar-07 Copper Cliff Smelter

Incident:

While skimming #6 converter, the shell would not turn back up and subsequently rolled down. The incident resulted in several ladles of molten material emptying into the aisle. No injuries, damage to some electrical cables and electrical switches in the converter vicinity.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108782 MM 12-Mar-07 Kidd Metallurgical Division

Incident:

Operations noticed an increase in temperature of one of the cooling blocks at the blister siphon area. Molten metal leaked from the face plate of the blister siphon when the temperature rose. There were no injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182046 MM 16-Mar-07 Copper Cliff Smelter

Incident:

A ladle of matte was being taken on #8 converter as a reverse prior to skimming. When the crane operator started to pour the ladle of matte, the bath began to foam/react and started to run over the lip of the converter. the empty ladle in the slag bay was filled approximately 1/2 full and approximately 1/4 of a ladle was spilled onto the floor in the slag bay. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182053 MM 16-Mar-07 Copper Cliff Smelter

Incident:

Employee was skimming a second pot of slag when he noticed small explosions occurring at the face of the smik monkey. He immediately butted up the hole and called matte at the back of #1 furnace. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182054 **MM** **17-Mar-07** **Copper Cliff Smelter**

Incident:

While skimming the 1st pot of a new slag trip, the operator noticed small explosions in the skim chute indicating matte at the back. No injuries or damage to any equipment. Furnace levels did not indicate high matte levels.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182047 **MM** **24-Mar-07** **Copper Cliff Smelter**

Incident:

The first of 3 reported incidents occurred as a result of matte entering the skimming chute which normally handles slag. The other two incidents occurred on Sunday at 6:30 a.m., and then on Sunday at 6:45 p.m. A process upset caused matte to become entrained in the slag. As a result, while skimming slag from the #1 furnace, entrained matte entered the skimming chute causing these occurrences of small explosions. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182043 **MM** **27-Mar-07** **Copper Cliff Smelter**

Incident:

Two slag pots were skimmed off #1 furnace without any problems. When skimming the third pot, small explosions occurred in the skimming chute. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1107988 **MM (F)** **29-Mar-07** **Xstrata Nickel Sudbury Smelter**

Incident:

No. 5 converter foamed causing the need for a fire extinguisher to be used. Minor damage to gaspe puncher. Repair to tuyere line required.

Cause:

None given.

Preventative Action:

Reviewed incident with skimmers.

Event ID: 1059429 **MM (F)** **05-Apr-07** **Copper Cliff Smelter**

Incident:

While skimming #2 flash furnace, there were a few small explosions which indicated that there was matte at the back. Matte levels were too high when skimming.

Cause:

None given.

Preventative Action:

Followed "matte at the back protocol". Stopped skimming and lowered the matte level.

Event ID: 1059429 **MM (F)** **05-Apr-07** **Copper Cliff Smelter**

Incident:

The skimmer, while on his 5th pot, experienced small explosions in his chute due to matte at the back. The furnace was down at the time for shoulder cleaning. Analysis of occurrence: matte level increased during shoulder outage, possible sweating inside box, level increase due to material being dropped inside box. No injuries or damage.

Cause:

None given.

Preventative Action:

Immediately budded up the hole without incident and matte at the back protocol was followed.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1087689 MM (F) 06-Apr-07 CVRD / INCO Matte Processing

Incident:

While refining #2 anode, #2 tuyere developed a hot spot above the tuyere body. due to the hot spot on #2 anode, a small amount of copper ignited a cardboard box. The employee attempted to tap out the small flames. Heat and dust singed left eyebrow and lashes. Over the next few days, the employee experienced eye irritation. The employee made an appointment on Tues., April 17th with his optometrist. The optometrist found material in left eye.

Cause:

Refractory bricks missing above the tuyere body.

Preventative Action:

None given.

Event ID: 1084800 MM (F) 16-Apr-07 Copper Cliff Smelter

Incident:

While accessing B floor from the converter aisle, it was noticed that there was some smoke and a smell of burning wood present on B floor coming from 1 east. Upon investigation, the smoke was coming out of the east side caged off area for slag returns on #1 furnace. Once inside the caged area, it was noticed that there were tow 8 foot sections of 2 by 10 planks that were smoldering. No visible flames. They were sitting along the converter aisle wall, above the matte haul. It is possible that when picking up or putting down the matte ladle, a spark of hot metal could have made its way through the wall causing the wood to ignite. Extinguished with 1 portable ABC fire extinguisher.

Cause:

Spark from molten matte.

Preventative Action:

None given.

Event ID: 1191590 MM (F) 29-Apr-07 Copper Cliff

Incident:

Slag spilled over onto old redundant wooden railway ties located adjacent to the tracks leading to the slag dump. Method of extinguishment: water tanker truck.

Cause:

Slag splashed out of twin bowl slag car onto ties.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191692 MM 30-Apr-07 Copper Cliff Smelter

Incident:

Employee was cleaning the inlet on #2 furnace when a small stream of matte held back on the uptake transition released into the quench chamber causing a small explosion. No injuries or damage. Excessive build-up in the quench transition-inlet was completely plugged.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135629 MM (F) 30-Apr-07 Kidd Metallurgical Division

Incident:

When the copper smelter control room operator received a high temperature alarm, he found there was roasting concentrate in the lower compartment of FR 3 baghouse. The fire crew responded and washed down any of the roasting concentrate from that area. There were no injuries due to this incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202085 MM 18-Jun-07 Copper Cliff Smelter

Incident:

At approximately midnight while skimming his fifth pot, the operator experienced a loud popping sound from the chute. Matte was present in the chute. At the time of the incident, the furnace had been running on oxy-fuel burners only for some time to help bring heat to the uptake to help alleviate bell damper build-up issues. Immediately budded up the hole and followed matte at the back protocol. No injuries or damage to equipment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202086 **Mm** **19-Jun-07** **Copper Cliff Smelter**

Incident:

Employee was approximately 3/4 done filling his first slag pot of the trip when he had a minimal explosion from his chute. Level was low in furnace and scrapping was done just prior mixing the bath and therefore causing matte to come out skim hole. He then budded up and noticed that there was matte in his chute. Followed matte at the back protocol. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202094 **MM** **22-Jun-07** **Xstrata Nickel Sudbury Smelter**

Incident:

During the last ladle of the cast, a small hole burnt through refractory ladle #3. There was not very much molten material spiooled as the matte granulation operator had just finished pouring the last ladle of cast matte when the leak was noticed. This #3 ladle was taken out of service and tagged out. Investigation of this ladle failure will follow.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202091 **MM (F)** **22-Jun-07** **Copper Cliff Smelter Converter**

Incident:

While pouring slag down #2 slag return chute, a considerable amount of slag spilled over the sides of the chute at the furnace door instead of going into the furnace. The slag travelled to #6 slag bay and caught two empty pallets on fire. Investigation showed a curtain of build-up inside the furnace and several small chunks of slag at the bottom of the chute. Damage to wooden pallets only.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202121 **MM (F)** **13-Jul-07** **Copper Cliff Smelter**

Incident:

Operator was using skim gun when an hydraulic fitting let go. Oil subsequently was sprayed all over and ignited. Operator called for help and skim hole was budded up and the fire was contained. Method of extinguishment: self extinguished.

Cause:

Hydraulic fitting failed.

Preventative Action:

None given.

Event ID: 1202152 **MM (F)** **03-Aug-07** **Copper Cliff Smelter**

Incident:

Slag splashed over twin bowl slag pots resulting in a grass fire adjacent to the upper diversion rail track switch. Slag bowls had been filled above the normal standard. Method of extinguishment: Sudbury fire services pumper.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202170 **MM** **12-Aug-07** **Copper Cliff Smelter**

Incident:

Workers had finished skimming #2 anode FCE and were holding the skim in #16 MPV. The MPB operator checked #17 MPV and saw that there was some liquid in it. It was decided to move this material to #16 MPV to be mixed with the Anode skim and then re-cast it and 1/4 ladle of copper leaked out into the aisle. No injuries. Damage to ladle #301 only.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202184 MM 16-Aug-07 Xstrata Nickel Sudbury Smelter

Incident:

Ladle 991 developed a hole and the contents of molten metal leaked onto the aisle floor. Property damage to ladle.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202194 Mm 16-Aug-07 Xstrata Nickel Sudbury Smelter

Incident:

Slag combined with matte from the converter was skimmed into a ladle. Without a protective layer of slag, the matte burnt through the bottom of the ladle while it was sitting on the floor of the converter aisle under No. 5, allowing the contents of the ladle to drain out.

Cause:

None given.

Preventative Action:

Skimmers were instructed to check the level of slag in the shell and the condition of the ladle before skimming.

Event ID: 1202195 MM 18-Aug-07 Copper Cliff Smelter

Incident:

While skimming on #1 furnace, operator witnessed small explosion in skim chute indicating matte at the back. Operator butted up immediately and informed DCS operator. Double tapped the furnace before starting to skim again. No injuries, no damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1203199 MM 04-Sep-07 Xstrata Nickel Sudbury Smelter

Incident:

During the first ladle of cast from #5 converter, cast number 106, #1 ladle started leaking cast matte on the tiller, down into the emergency chute and into the converter aisle. The ladle was approximately 1/2 full when this occurred. The hole was burnt through about 1 from the bottom on the front of the ladle.

Cause:

None given.

Preventative Action:

Tagged out ladle and sent it out for immediate repairs. Investigating their refractory inspection process of ladles.

Event ID: 1204778 MM 10-Oct-07 Copper Cliff Smelter

Incident:

While employee was filling his tapping ladle on #1 furnace northwest hole, he had noticed a leak coming from behind his tapping block. He then called his supervisor and called for help on the gaitronics. With the aid of his fellow employees, the hole was plugged with clay and the leak was stopped. No injuries and minimal damage. The furnace was shut down immediately upon notification to DCS from supervisor and an alternate hole was open to lower the level in the furnace. Inspection of area where leak occurred and make repairs as required.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148896 MM (F) 13-Oct-07 Copper Cliff Smelter

Incident:

While sending a washout from 14 MPV to 6 converter, the crane man placed the ladle on the ground which is uneven and caused material to splash out of the ladle. Two fire extinguishers were used.

Cause:

The washout that splashed out of the ladle set a cardboard box in the gradall parking area on fire and also some rubber hoses on the gradall.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191600 MM (F) 17-Oct-07 Copper Cliff Smelter

Incident:

While skimming on #1 furnace, skimmer budded up his hole and proceeded to move to his last pot (8th). Skimmer bumped the pots on #2 furnace pots causing a small slag spill and consequently burning a couple of hose bags. Method of extinguishment: hose.

Cause:

Slag of pots from #1 furnace bumped slag pots on #2 furnace.

Preventative Action:

None given.

Event ID: 1191615 MM (F) 05-Nov-07 Copper Cliff Smelter Converter

Incident:

While travelling along the pole track aisle, a CVRD Inco employee noticed smoke originating from a cardboard box located in the converter aisle. The box was full of used spark plugs being reverted into the converter. The employee cut open the box and cut out the burnt section of the box. Another CVRD Inco employee approaching the site used a fire extinguisher to put out the fire. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Hot metal splash from a ladle fell onto the cardboard box.

Preventative Action:

None given.

Event ID: 1191617 MM 06-Nov-07 Copper Cliff Smelter

Incident:

While skimmer was skimming his second pot, he had a small explosion at the face and butted up immediately when he noticed matte at the back. he notified DCS over the gai-tronics and the furnace was immediately reduced to two burners and then shut down completely. Matte level model was off by eleven inches.

Cause:

None given.

Preventative Action:

Furnace rates cut and then reduced completely. Followed matte at the back protocol.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191632 **MM (F)** **17-Nov-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

#2 TBRC was tapped at 2:00 p.m. into the west granulation. At 3:25 p.m., smoke was detected near the roof of the NRC building. The control room was contacted and the fire alarm was activated. Hot matte splashed onto flammable H&V cable/panel. The fire was located at the mason's area of the aisle by operations personnel and extinguished with a water hose. Method of extinguishment: hose.

Cause:

Portable H&V unit stored in potential splash / spark zone.

Preventative Action:

None given.

Event ID: 1191660 **MM (F)** **29-Nov-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

#12 granulation ladle cut-out as it began and informed the granulation operator. The craneman racked onto the ladle and moved it to the pit to freeze up. The hot matte burned the local wiring. Sudbury fire service responded to extinguish the resulting fire.

Cause:

Failure of #12 ladle.

Preventative Action:

None given.

Event ID: 1191680 **MM** **28-Dec-07** **Copper Cliff Smelter**

Incident:

While skimming on #1 furnace, there was matte at the back which created a small explosion. It had been more than a day since workers tapped slag. This prevented them from resetting the radar, giving them a false level of matte.

Cause:

None given.

Preventative Action:

Matte at the back protocol was followed. Notified the DCS operator who cut the rates down to 60 tons and they took a few taps of matte out before resuming to skim.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120493 **MM** **30-Dec-07** **Kidd Metallurgical Site**

Incident:

Minor explosion at the CL slag flume located at the CL furnace. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

MS – MISCELLANEOUS

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109682 MS (F) 13-Jan-07 Campbell Complex: Surface

Incident:

A millwright had just finished cutting wear plates (oxy/ace0 in an open area. Smoke was noticed underneath a band saaw nearby (about 8 to 10 ft. away). Upon inspection, a small flame was observed. Worker extinguished fir using a hand held fire extinguisher. Water was added to see if anything further was hot. Suspected hot slag had rolled under the band saw and ignited. Unknown flammable. Review with maintenance personnel that time is to be taken to remove flammable material in work area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104017 MS (F) 15-Jan-07 Musselwhite Mine: Underground

Incident:

Alarm controller on conveyor #10 went on at 19:02 hours. Mine evacuated (except for 2). Two workers went to refuge station. No visual verification of fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105824 MS (F) 16-Jan-07 Copper Cliff Smelter

Incident:

Wooden wedge near southeast trunion under #14 MPV caught fire. Source of ignition: heat or molten material from #14 MPV. Method of extinguishment: water hose.

Cause:

Poor housekeeping.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109554 **MS (F)** **25-Jan-07** **Red Lake Complex: Mill**

Incident:

A worker was installing and welding an attachment for a heat gun to a metal frame when sparks from welding caught fire to a rag. Stand-by fire watch person saw fire and put out using fire hose.

Cause:

Sparks from welding.

Preventative Action:

Continue to follow fire procedure.

Event ID: 1110458 **MS** **30-Jan-07**

Incident:

During weekly shaft inspection of production conveyance shaft compartments, the hoistman felt sick. The conveyance was approaching 9065 level at the time. The conveyance was brought into the level and the other hoistman who was nearby was called by the ill person to relieve him. The worker was taken by ambulance to hospital immediately.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103776 **MS (F)** **01-Feb-07** **Taylor Project: Underground**

Incident:

Electrical fire broke out on one of the drills approximately 1000M below grade. No injuries. All workers accounted for. Mine rescue has been contacted.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1109931 MS 07-Feb-07 CVRD / INCO Matte Processing

Incident:

Mechanic went to grease the drive units for #5 and #6 bucket elevators. A piece of insulation that had fallen was suspected as containing asbestos. Area was roped off and tagged identifying the potential presence of asbestos containing material. The environmental people were contacted and a sample was sent out for analysis. The sample results indicated that the material contained asbestos - chrysotile 50% - 75%. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109932 MS (F) 07-Feb-07 Copper Cliff Smelter

Incident:

While using the Kobota plugger to straighten out the grizzly inside the quench chamber, there wasn't enough water flowing to keep the plugger cooled off causing the hydraulic hoses to fail and catch fire. Workers pulled the Kobota out of the quench right away and as soon as it was out, the fire went out. Source of fuel: hydraulic hoses and oil.

Cause:

Lack of cooling water on the plugger.

Preventative Action:

None given.

Event ID: 1109827 MS (F) 07-Feb-07 Musselwhite Mine: Mill

Incident:

A worker noticed blue flames emitting from the propane heating unit. The propane heater and power to unit was shut off immediately. Investigation ongoing.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1109938	MS (F)	19-Feb-07	Copper Cliff Transportation

Incident:

One of two lead wire for the traction motor on the diesel locomotive was burnt. Warning alarms sounded inside of locomotive 2003. The locomotive engineer could smell something burning and proceeded to investigate. Upon exiting the locomotive, he could see flames coming out from under the locomotive. Method of extinguishment: 1 portable ABC fire extinguisherUnder investigation.

Cause:

Copper lead wire and covering.

Preventative Action:

None given.

Event ID:	1182013	MS	21-Feb-07	Copper Cliff Nickel Refinery: IPC

Incident:

While attempting to remove a steam line in the reactor area pipe gallery, maintenance personnel noticed airborne material falling from nearby piping and suspected it to be asbestors. The job was postponed until the material was identified. The steam line in question was partially insulated with fibreglass insulation and part with asbestos. Testing confirmed the presence of amosite. The area was roped off from access until trained asbestos personnel were contracted to remove the asbestos. The pipe gallery will be assessed for any other asbestos.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1182018	MS	21-Feb-07	Copper Cliff Smelter

Incident:

While cleaning the quench inlet on #1 flash furnace two pops occurred because of molten metal present at the inlet. No injuries or damage to equipment. The procedure was not followed exactly because the soot blower was not able to operate. Clarity: if the quench inlet needs to be cleaned, the soot blower will be fired first as per procedure. If the soot blower is not working, this means that the procedure cannot be followed, then the furnace will be shut down.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1183591 MS 23-Feb-07

Incident:

An unbalanced load went over centre while being lifted from floor. The load cantilevered, causing the main bridge to drift approximately 4-6' and come into contact with the end stops. The load beam under the trolley fell as well as the load hook and lines.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1104521 MS 25-Feb-07 Falconbridge Ltd. Kidd Mine

Incident:

Rail crew was in the process of moving empty soda ash rail cars on track #17 when minor de-railment occurred. 2 cars de-railed, one set of trucks from each car de-railed. No damage or injuries.

Cause:

Root cause attributed to build up of snow/ice rail tracks.

Preventative Action:

None given.

Event ID: 1104325 MS (F) 05-Mar-07 Fraser Mine Nickel Zone

Incident:

Open flame on #4 trolley fraser Mine 4600 level tram. While loading the train at #6 chute 4600 level, the trolley operator noticed an open flame in the motor compartment. He extinguished the flame using a 20 lb. hand held fire extinguisher. The trolley is a 20 ton GE trolley. Two workers sent to surface and treated by first aid for throat irritation due to breathing in some of the extinguishing agent. Damage to the resistor grid cable.

Cause:

Due to vibrator, fatigue, wear and tear issues, the cable strands broke at the crimp on the connector. The cable came in contact with the frame and caused the open flame.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108662 **MS (F)** **10-Mar-07** **Kidd Metallurgical Division**

Incident:

Operations noticed burning concentrate at the tail end of NB44. The site fire department was called to extinguish in the affected areas. No injuries as a result of the incident.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182055 **MS (F)** **17-Mar-07** **Copper Cliff Smelter**

Incident:

There was a hydraulic leak inside take off hoist. Both hydraulic hoses were changed and leak stopped. Insulated cloth inside cover and base on hoist was saturated with hydraulic oil. While performing a cast, the casting operator saw flames coming from the take off hoist at bosh tank. A water hose was used to extinguish fire. The cast was stopped to assess damage to hoist. Method of extinguishment: hose.

Cause:

Hydraulic oil soaked insulation cause of incident. Once cast was started, heat radiating from anodes caused insulated cloth to ignite, burning part of the wiring for limit switches on hoist.

Preventative Action:

None given.

Event ID: 1182036 **MS (F)** **26-Mar-07** **Coleman Mine: Underground**

Incident:

Caller reports a fire at Coleman Mine. Fire still on at time of call and mine rescue was called out. No injuries known at that time.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139084 **MS (F)** **26-Mar-07** **Goldcorp Canada Ltd.**

Incident:

A surface diamond drill set-up on the frozen lake approximately 150 metres from shore of the surface mine site caught on fire. An oil burning stove used to heat the drill shack was accidentally left on. When the drill crew left the site after finishing their day shift. The drill was down for repairs and was going to idle for the next 1 to 2 days. It appears the stove overheated and/or overflowed causing flames to spread outside the enclosure and ignite the wooden wall and floor the next day. The fire was noticed by a mine employee at 6:10 p.m. on March 27th and was extinguished using a hand held extinguisher.

Cause:

Drill crew forgot to turn the oil stove off when leaving the drill at the end of their shift. This style of stove is known to overheat on rare occasions and is therefore never left unattended normally.

Preventative Action:

Lining the entire stove enclosure area with sheet metal. Relocating the shut-off valve to a more visible location and hanging a sign warning to shut off stove when leaving drill. Have supervisor or designate visit the drill daily.

Event ID: 1058097 **MS (F)** **30-Mar-07** **Copper Cliff Smelter**

Incident:

While using an oxy/acetylene torch, flames were noticed coming from between the quick connect fitting and the flashback arrestor. Immediate shut down of both bottles was initiated. The flame continued to burn due to fuel in the line until the quick connects were disconnected from the torch. Source of ignition: hot work being performed.

Cause:

The nut for the quick connect coupling came loose from the flash back arrestor during regular use throughout the day. Extinguished when bottles shut down.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1058470	MS	02-Apr-07	Copper Cliff Smelter

Incident:

Matte processing location: FBR freight elevator. A contractor entered the FBR freight elevator on the 4th floor of the FBR with a wheelbarrow loaded with refractory brick from #3 roaster offtake. The employee selected "A" floor where he would be unloading the brick to an outside pad. The elevator inadvertently stopped between BX floor (1st floor separation side) and "A" floor. The door to BX floor was closed. "A" floor was selected again and the elevator did go to "A" floor where the occupant was able to exit. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1059330	MS (F)	03-Apr-07	Stobie Mine: Surface

Incident:

A container of ashes from the strike group at the main gate was picked up and brought to the yard until it cooled down. The following day, Tuesday, April 3/07, the operator on the fork lift picked up the contained and dumped it into a yellow NIM box. After approximately 30 minutes, he noticed smoke coming from the NIM box. Method of extinguishment: buckets of slag over the container.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1084482	MS (F)	03-Apr-07	Clarabelle Mill

Incident:

Contract employees noticed smoke/flames coming from NIM bin in the yard at booster station. Both contract employees and CVRD INCO employees attempted to extinguish the fire. Fire department was contacted. They completely extinguished the fire and soaked the entire area down with water.

Cause:

It was noticed that steel drums with hot coals and partially burnt wood from the picket line was dumped into the scrap bin at booster. These hot coals set the wood, paper, insulation, etc. on fire.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1087693 **MS (F)** **11-Apr-07** **CVRD / INCO Central Lab**

Incident:

A pair of latex gloves ignited when worker dumped hot crucibles into the barrel. The flame was immediately put out using some water that was nearby.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109684 **MS (F)** **13-Apr-07** **Falconbridge Kidd Met Site**

Incident:

The site fire alert system was activated for a working fire. Kidd fire department responded with 15 firefighters. Upon arrive on scene, smoke was bellowing out of ventilation louvers. Plant was evacuated. All people accounted for. Info from plant supervisor was that cellhouse storage room had a fire in it. Two firefighters sent into building using breathing apparatus. Upon arriving to storage room, fire was out, however, there was a lot of smoke. Building was ventilated, scene banner taped off for supervisor and co-chair to do their incident report. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1097710 **MS** **19-Apr-07** **Musselwhite Mine: Underground**

Incident:

Jeep on fire. Stench gas released. Mine rescue being notified. Drill over - all went well.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1087692	MS (F)	19-Apr-07	Clarabelle Mill

Incident:

Two mechanics were changing out a reducer at #3 mill underflow box. A bolt was seized and they had to burn it out. They noticed a small flame on the outside of the fire and immediately extinguished it. They could still smell some smoke, so decided to start up the Mill discharge pump to make sure the rubber was not heating up inside the pipe. They ran the pump for about 15-20 minutes.

Cause:

Heat / flame from torch. Possible remnant paint on pipe caused incident.

Preventative Action:

None given.

Event ID:	1088207	MS	25-Apr-07	Xstrata Process Support

Incident:

While operating the roaster in the pilot plant, pressure in the off-gas system increased resulting in the cyclone #1 underflow and sampling paint can to rupture. System to be re-hazopped, off gas system disassemble.

Cause:

While operating the roaster in the pilot plant, pressure in the off-gas system increased resulting in the cyclone #1 underflow and sampling paint can to rupture.

Preventative Action:

None given.

Event ID:	1139147	MS (F)	25-Apr-07	Red Lake Complex: Surface

Incident:

A bush fire was started off the Red Lake complex mine property and spread to inside the property line. Concern of smoke from the bush fire being drawn into the down cast ventilation fan located in the area. Security reported the smoke to the environmental dept. and to the mine supt. It was between underground shifts when the fire occurred. A decision was made that if the smoke was evident underground, that the shift would not go down. Municipal fire dept. responded. Fire was extinguished. Smoke was not a factor. Nifht shift was able to go underground.

Cause:

A bush fire was started off the Red Lake complex mine property and spread to inside the property line.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139148 **MS (F)** **01-May-07** **Campbell Complex: Mill**

Incident:

Mechanics (Millwrights) were doing repairs to the mine's surface crusher when cutting frameliners off the standard crusher. While doing so, heat generated from the work ignited the rubber that covers the crusher frame saddle. A small fire started which was extinguished by a hand held ABC extinguisher. Workers were using oxy/acetylene torch. Fire permit was used, spotter was assigned and acted on incident. Rubber should have been cut away.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135628 **MS** **02-May-07** **Hoyle Pond Mine: Underground**

Incident:

Caller reported that they have stench the mine as a result of a smoking substation on the 1020 level. Everyone has been accounted for and the area will be inspected.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202006 **MS (F)** **18-May-07** **Xstrata Nickel Sudbury Smelter**

Incident:

Portable gas heater caused wood door of old elevator to catch on fire. Fire was discovered before any significant damage and was extinguished. Fire resulting from gas heater being directed toward a wood door.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202031 MS 18-May-07 Copper Cliff Transportation

Incident:

Locomotive #2001 collided with locomotive E2007. No injuries. Damage being assessed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202034 MS (F) 26-May-07 CVRD / INCO Matte Processing

Incident:

Separation plant operator could smell smoke as he was coming down the stairs towards door #175. He checked outside the door and could see smoke coming from a green shipping barrel. A small visible flame was seen at the bottom of the barrel and the fire was extinguished using a fire extinguisher. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202042 MS (F) 28-May-07 Copper Cliff Divisional Shop

Incident:

Fire. Hot work. No injuries. Burnt pedestal office chair. Initial investigation shows that hot metal from the cutting operation landed on the chair located adjacent to the work area. Extinguished with portable ABC fire extinguisher.

Cause:

Spark from cutting operation was source of ignition.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135651 **MS (F)** **29-May-07** **Kidd Creek: Railroad Mets**

Incident:

Train locomotive #053 2as travelling eastward on the ONR rail line when operators noticed smoke coming from inside locomotive engine enclosure. Rail crew put out fire. No injuries and minimal damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202047 **MS (F)** **31-May-07** **CVRD / INCO Matte Processing**

Incident:

An employee was going to use the toaster oven. Smoke was coming from the toaster oven and flames could be seen through the toaster window. The flames went out and then the door was opened to verify that the fire was out. There was nothing in the toaster. The source of the fuel was particles of waste food that had accumulated in the toaster.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202050 **MS (F)** **31-May-07** **Copper Cliff Smelter**

Incident:

A patch of grass approximately 40 feet by 100 feet was burnt. Source of ignition unknown. Source of fuel: dry gras. Method of extinguishment was fire department tanker truck. No injuries. No damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120436 **MS (F)** **04-Jun-07** **Agrium Inc.: Mill**

Incident:

A mill operator noticed a smell of burning material near dryer circuit. Search revealed a wet leather glove which had been placed near the dryer to get dried out had ignited. Fire was extinguished immediately. No injuries. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135659 **MS (F)** **05-Jun-07** **Falconbridge Kidd Met Site**

Incident:

At zinc roaster acid plant outdoors, a scaffold platform, which was staged at the acid plant pre-heater, burned. There was no equipment damage. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135661 **MS (F)** **05-Jun-07** **Falconbridge Kidd Met Site**

Incident:

There was a small flare up from the hot cut off bolt when cutting of bolt on structural steel rubber concrete pillar protectors. The worker put out a small fire with fire extinguisher. There were no injuries and no equipment damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202060 MS 07-Jun-07 Copper Cliff Smelter

Incident:

William Day Construction was digging a drainage ditch in front of the bulk scrap processing area (area 6) when they uncovered materials that appeared to be asbestos. The work was immediately stopped pending an investigation. The smelter environment group investigated and determined the material was indeed transite. Unknown that transite was buried in this area. The discovery was made when it was raining and the transite was wet. The material was removed from the ditch and stored nearby. The material will be transferred to a bin by continental insulation and brought to the asbestos waste disposal site in our tailings area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202071 MS (F) 12-Jun-07 Copper Cliff Transportation

Incident:

A fire started from slag that splashed from the bowls while being transported to the dump. A number of stored railroad ties ignited. Fire was extinguished with a hose and fire department.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202067 MS (F) 13-Jun-07 CVRD / Inco Matte Processing

Incident:

An Aluma Systems employee entering the 4th floor of the FBR saw a tarp on fire and grabbed a nearby extinguisher and put the fire out. Talevi welding is dismantling #1 roaster and a small corner of a blue tarp used to identify the work area had ignited. Sparks from hot work being done by a Talevi welding employee landed on the tarp. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202072 **MS (F)** **14-Jun-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

Contractor, Aluma Systems, were cutting a steel plate with a cut-off saw. Some paper and rags in a nearby redundant cabinet caught fire. Fire put out by 1 portable ABC fire extinguisher. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202087 **MS (F)** **20-Jun-07** **Copper Cliff Smelter**

Incident:

While working on east end of J floor, maintenance people were cutting out an old conveyer system when a small grease fire started. Workers proceeded to use fire extinguisher to put fire out. There was an unexpected amount of grease that was not noticeable until cutting started. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202108 **MS (F)** **02-Jul-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

While tapping #1 TBRC, sparks from the process landed on pallets of re=line brick causing the plastic wrap to smolder and ignite. A single fire extinguisher was used to put out the flame.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1162164 **MS (F)** **11-Jul-07** **Red Lake Mine Complex**

Incident:

Smoke reported on 43 level of Red Lake Mine. 2 men unaccounted for at 23:54 on the Campbell Mine side. No injuries had occurred at 00:05 on 12-Jul-07. Two mine rescue teams deployed, 1 searching for the 2 unaccounted for Morisette Diamond Driller. Second team advancing on the fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202166 **MS** **02-Aug-07** **Copper Cliff Smelter**

Incident:

Contractor was engaged to vacuum flue dust from the inside of the "copper cross flue" at #9 flash furnace lorry floor. A pneumatic hammer was used to break out some of the flue dust. When doing so, some white material dislodged itself from the outside walls of the flue and fell to the ground. Tests proved the white material to be asbestos. Corrective measures taken: the vacuuming job was stopped immediately and test samples taken. The area has been isolated and a plan to deal with the asbestos will be developed. All clean up and removals will be done by a certified company.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120450 **MS (F)** **07-Aug-07** **Kidd Creek: Deep 7000**

Incident:

A maximum mining employee was using cutting torches to remove vent door hinges when linatex rubber caught fire in turn catching his coverall sleeve on fire resulting in a second degree burn to the right forearm. An xstrata worker immediately extinguished the flame with a fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202157 **MS (F)** **07-Aug-07** **Clarabelle Mill**

Incident:

Fire - spontaneous combustion. 70 round straw bales were involved in the fire and a small wooded area. Workers noticed smoke from the hay bales in the R2 area in the central tailings area. Workers attempted to put out the fire with their hydroseeders and managed to contain fire until the fire department arrived and extinguished the fire completely.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202161 **MS** **08-Aug-07** **Copper Cliff Smelter**

Incident:

While doing demolition in #3 Cottrell old lunchroom, a discovery was made of a grey/white material sandwiched behind some drywall and fiberglass mesh. This material was suspected to be asbestos. Analysis was done on a sample of this material and was confirmed to be chrysotile > 75%. Work was stopped in this area and was roped off. A qualified asbestos removal company will be hired to remove the asbestos.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202163 **MS (F)** **10-Aug-07** **Stobie Mine - Surface**

Incident:

A small brush fire was reported to Stobie Plant Protection. The fire was located in the field of Stobie Mine property on the side of Highway 69 North, near the access gate to the Little Stobie Mine site. The Sudbury fire department was called to extinguish the fire.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135686 MS 14-Aug-07

Incident:

A 14" workman suction valve needed to be replaced under the thickener. Operations drained the thickener, but a small portion of water was still present in the discharge cone which feeds the pipe in which the suction valve is located. Workers were under the impression that the pipe was empty so when the valve was removed, the water ran out of the cone.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202202 MS 16-Aug-07 Clarabelle Mill

Incident:

An abandoned switchroom located at hill station (tailings area) was being stripped out to convert it to a storage area. An industrial mechanic observed material within the old switchroom that may contain asbestos. The area was secured and on Mond., Aug. 20th, an analyst was sent to get samples to send for assessment. The samples were assessed and results confirmed the presence of asbestos. Ceiling tile, corrugated roofing panesl, wall insulation. Ceiling tile contains 10 - 25%, chrysotile corrugated roofing panels contain 10 - 25% chrysotile wall insulation contains 0.5 - 5% chrysotile. Area was secured to restrict access. Certified company will be contracted for asbestos removal.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202187 MS 16-Aug-07 Copper Cliff Nickel Refinery: NRC

Incident:

Mechanics were removing torsion arms of the annulus to #1 reactor and once the second arm was removed, the annulus spun about 60 degrees. A 1" nylon sling used to rig the annulus was put under tension due to the rotation and broke. One 1" nylong sling broke. the annulus was not anchored at the optimum locations to prevent the top heavy unit from rotating.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202200 MS (F) 20-Aug-07 CVRD / Inco Matte Processing

Incident:

Talevi welding was working on the second floor welding column reinforcement. They had a man stationed on the first floor on fire watch. The sparks started a smouldering fire in the maintenance shop. In the maintenance shop, the brushes of the floor sweeper caught on fire. An Inco maintenance employee saw the fire and used an extinguisher to put the fire out. A second fire extinguisher was used to ensure that the sweeper brush was completely covered and the fire was completely out.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202198 MS (F) 20-Aug-07 CVRD / Inco Matte Processing

Incident:

Talevi Welding was performing hot work when sparks ignited a box on a shelf in maintenance shop. An employee took a water hose and extinguished the fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203198 MS (F) 30-Aug-07 Copper Cliff North Mine

Incident:

A crew were air arcing the liners in the 112 truck box when sparks flew into a wooden job box near the truck. This caused a small fire, burning cardboard boxes and filters. Method of extinguishment: 1 portable ABC fire extinguisher, hose.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1203205	MS (F)	05-Sep-07	Copper Cliff North Mine

Incident:

Stench injected. Pole and hardware burned. Small grass fire. Insulator failed resulting in tracking to ground. Fire department responded and put pole and grass fire out once the power was isolated. Pole and hardware replaced.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1203213	MS (F)	06-Sep-07	Copper Cliff North Mine

Incident:

Whole loading #2 bowie hydro seed unit with supplies, a strong smell of burnt electrical components was detected. A visual check revealed that the main wiring harness for the diesel engine had melted overnight. Smoke was coming from the engine's air filter. A mechanic was summoned and the battery was disconnected. The air filter was removed and flames were sighted. The fire was extinguished with water. Cause of incident: short in wiring.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1203216	MS (F)	09-Sep-07	Copper Cliff Smelter

Incident:

While doing rounds throughout FBR, the control room operator could smell wood burning in the north east corner of the building. The FBR control room operator contacted the matte processing foreman and both investigated. Contractors, in the process of repairing #6 cottrell fan, had been using torches to cut or weld on B floor in the north east corner of the building. Upon investigating the FBR control room operator and the matte processing foreman noticed that smoke was coming from behind a wall panel on the north wall of FBR east of #6 cottrell fan exhaust. Initially the water system was shut off to install a temporary line, therefore the contractor's fire extinguisher was used in an attempt to smother the fire. Smoke continued to bellow out from behind the wall panel. Sections of the wall panel were removed to expose the smoldering material and by this time the water system was back online. A water hose was used to wet the area and douse the smoldering material.

Cause:

Work from burning torches.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204755 **MS (F)** **20-Sep-07** **Copper Cliff Smelter**

Incident:

An iron worker was cutting checker plate on H floor adjacent to #1 flash furnace. Sparks fell through floor grating two floors below igniting plastic and a wooden pallet. The fire was immediately extinguished.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135713 **MS** **22-Sep-07** **Kidd Creek: Railroad Mets**

Incident:

A derailment occurred involving an ore train of 22 empty cars proceeding westbound to the mine site. The last two cars of the ore train derailed at the mine site load-in area. No injuries and damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1177081 **MS (F)** **22-Sep-07** **Musselwhite Mine: Mill**

Incident:

Caller received call from security that at 450 level, a toyota truck was on fire. Call came in at 1445 hrs. Caller has just mobilized mine rescue team. It's a drill. No other action required.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204763 **MS (F)** **27-Sep-07** **Xstrata Nickel Smelter**

Incident:

In preparation for a maintenance down day, a burner was installed in the furnace freeboard to control temperature. During the down day, the furnace pressure went positive, resulting in the burner flame backfiring on the burner itself, setting fire to the control cables. Fire was put out using a fire extinguisher. Minimal damage occurred.

Cause:

Internal investigation of incident initiated. Additional fans started to improve furnace suction.

Preventative Action:

None given.

Event ID: 1204766 **MS (F)** **30-Sep-07** **Copper Cliff South Mine**

Incident:

While washing the platform at 4050 feeder, a small electrical fire was noticed in a receptacle for a light. It is likely the receptacle was splashed with water. The fire was quickly put out with a fire extinguisher. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Electrical short from being splashed with water.

Preventative Action:

None given.

Event ID: 1204767 **MS (F)** **02-Oct-07** **Coleman Mine: Underground**

Incident:

Workers were preparing shotcrete machine then smelled smoke. Looked around and saw smoke under Kubota hood. Lifted forklift's hood and saw flame coming out of alternator (1"). Blew the flame out. Watered down the unit just to make sure.

Cause:

Shorted alternator.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135717 MS 05-Oct-07 Kidd Creek: Railroad Mets

Incident:

Train locomotive #052 was traveling westward on track 8 at a slow speed when a derailment occurred. A switch was left open. One wheel from the front truck of locomotive came off track. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204771 MS (F) 05-Oct-07 Copper Cliff Smelter

Incident:

Contractor reported fire at converter 1st pass outlet man door. Fire was extinguished immediately with fire extinguisher. Surrounding cladding and insulation was then removed to verify that fire was out.

Cause:

Calking rating too low.

Preventative Action:

None given.

Event ID: 1204772 MS (F) 09-Oct-07 Stobie Mine: Underground

Incident:

Caller reports there was an underground fire at the Inco Stobie Mine. The caller reports they injected stench gas and all workers left the mine without injury. The caller was evacuated to Xstrata Mine next door.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120476 **MS (F)** **11-Oct-07** **Falconbridge Ltd: Kidd Mine**

Incident:

Repairing a 6" x 12" hole on north side of B38S ppump box just above a previous patch. Shortly after maintenance personnel left the area, the patch began to smolder and ignite causing fire alarm to go off which escalated an evacuation of the concentrator. No injuries. Minor damage to rubber lining of pump box.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148899 **MS (F)** **11-Oct-07** **Stobie Mine: Surface**

Incident:

Demolition of this building required removal of old pipe lines running through the area. While cutting a pipe which was rubber lined, a fire developed inside the pipe and a flame erupted when the pipes were separated. A fire extinguisher that was on hand was used to extinguish the fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148898 **MS (F)** **13-Oct-07** **Coleman Mine: Underground**

Incident:

Supervisor discovered a storage cabinet containing toilet cleaning products on fire at the 3370 latrine area. Stench was injected, mine rescue called out. All workers were accounted for and fire was extinguished by mine rescue. Method of extinguishment: 1 portable ABC fire extinguisher, hose.

Cause:

Source of ignition: light fixture. Cause of incident: tie wraps holding light fixture failed and fixture fell onto / near boxes of kleenex.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1205112 **MS** **16-Oct-07** **Copper Cliff Smelter**

Incident:

After cleaning #3 burner on 2 flash furnace, the operator started the burner back up. There was a loud noise and dust coming from D floor. Upon initial investigation, it seems as if there has been a pressurization to the screw conveyor system on D and F floors. No injuries. Damage to conveyor troughs and covers.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1205110 **MS (F)** **16-Oct-07** **CVRD / Inco Matte Processing**

Incident:

Workers were assigned to replace a hand rail at 4 D mill. Hot work permit was in place. Welder was cutting old railing with torches when oil nearby on floor caught fire. The mechanic helping the welder had left to get a different cutting tip and upon his return, he noticed the fire and extinguished the fire immediately. Source of ignition: hot metal from burning. Source of fuel: electrical cable coating and oil. Method of extinguishment: water hose.

Cause:

Improper clean up and improper identification.

Preventative Action:

None given.

Event ID: 1095957 **MS** **17-Oct-07** **Falconbridge Ltd.: Kidd Mine**

Incident:

Sand and metal all over. No injuries. Scene has been frozen. Will not proceed until talk with inspector.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1096445 MS 18-Oct-07 St. Andrew Goldfields: Taylor Mine Site

Incident:

Caller to advise that they are having a fire drill at the Taylor mine site.

Cause:

None given

Preventative Action:

None given.

Event ID: 1120479 MS (F) 19-Oct-07

Incident:

Fire crew responded to fire call. Upon arrival two firefighters entered building and it was discovered there was no fire at that time. Prior to the fire fighter arrival, first person encountered the fire and used a 5 fire extinguisher to extinguish the fire. Initially, there was a fire on a small rubber belt conveyor that caught fire from a furnace blow back. Conveyor is approximately 18" wide by 4' long. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189341 MS (F) 23-Oct-07 Musselwhite Mine: Surface

Incident:

A welder was in the process of welding when a spark hit some floor dry that was saturated with diesel fuel and oil under the work bench. A spark ignited the floor dry. The worker used an Ansul ABC dry chemical fire extinguisher to extinguish the fire.

Cause:

Poor housekeeping. Worker did not check workplace prior to hot work which is policy.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1148904 **MS** **26-Oct-07** **Craig Mine: Underground**

Incident:

Report of smoke underground. Mien rescue has been called to the scene. This is not a drill. Reason for smoke not known. No injuries or missing persons, everyone is accounted for. The reason for the smoke is inconclusive. The team swept all levels and have stated they have no evidence of anything being burnt or on fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135726 **MS (F)** **27-Oct-07** **Kidd Creek: Lower Mine**

Incident:

There was an underground fire on the 7500 level at the north vent raise. An employee was bulding a steel wall when sparks from welding ignited burlap which in turn started the wooden regulator to start burning.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148914 **MS (F)** **02-Nov-07** **Copper Cliff Smelter**

Incident:

Operator had just finished butting up the skim hole when he noticed a little puddle of oil that was on fire. He grabbed the fire extinguisher and put the fire out. Put out with a portable ABC fire extinguisher.

Cause:

Source of ignition: a spark from the skimming. Cause of incident: the skim gun has been leaking oil for some time and oil accumulated into a small puddle.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1191609	MS (F)	02-Nov-07	Copper Cliff Nickel Refinery: NRC

Incident:

Contractor was welding and grinding in the area prior to the fire. They monitored the area for 30 minutes prior to leaving for lunch. At 12:05 p.m., the NRC control room received a phone call from an operator that there was fire at the south shack for the Fen blower. The control room then contacted the IPC control room to inform them of the fire. Simultaneously the NRC operating crew gathered fire extinguishers and began to put out the fire. A first responder was dispatched to the gate to escort the fire department that were called to the scene. The control room called a level 2 alarm announcing a fire at NRC. The fire had been completely extinguished prior to the arrival of the fire department.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191611	MS (F)	05-Nov-07	Clarabelle Mill

Incident:

It was noticed 23-BC-1 was down. The operator was sent to inspect the belt. The operator started in the pocket and then proceeded to the head end. While he was inspecting the mag belt (23-BC-3), it was noticed, by the control room operators, that there was smoke at the head end. Further investigation showed that the lower bend pulley on 23-BC01 was broken and a small spot of conveyor belt was on fire just before the take up. The fire was extinguished easily with a water hose.

Cause:

Failure of lower bend pulley.

Preventative Action:

None given.

Event ID:	1179549	MS	06-Nov-07	Island Gold Project

Incident:

Supervisors shut off fresh air fans and did not notify workers from approximately 2 to 5 end of shift. No fresh air - noticed excess fumes - complaints of headaches, light headed, etc. Supervisors did not think there would be a problem. 1 other worker called mining inspector.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1179550 **MS (F)** **07-Nov-07** **Williams Mine: Underground**

Incident:

Fire in comfort station - put out with water and extinguisher. Possible electrical cord for light started fire. Being checked and internal investigation ongoing.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135736 **MS** **08-Nov-07** **Falconbridge Material**

Incident:

Caller reported that cable of car puller snapped while pulling a rail car at off loading plant. The worker is not injured and the scene has been frozen.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1194006 **MS** **21-Nov-07** **Lac Des Iles Mine Ltd.**

Incident:

Smoke was detected underground. Everyone has been accounted for and is safe. Three miners are in a refuge station. Source of smoke is unknown. Stench gas has been injected into the mine. Update 19:14 hrs.: from original caller advising that mine rescue determined that no fire was present. No fire, no injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1194373	MS (F)	23-Nov-07	Lac Des Iles Mine: Mill

Incident:

Caller reporting a fire in conveyor. Workers were using a torch to do repairs on a roller when a small piece of rubber caught on fire. Fire was extinguished with a fire extinguisher. No injuries or damage. Internal investigation underway.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1204802	MS	23-Nov-07	Kidd Creek: Railroad Mets

Incident:

Locomotive was pushing thirteen gondola rail cars through the off-loading plant. The cars travelled too far on the east side of the plant caused the gondola car to be positioned very close to the switch point of the track. When the other locomotive drove by the switch area on a adjacent track, it noticed that the rail cars were being pushed into the switch area and stopped the loco to avoid collision. The rail cars being pushed through the off loading side swiped the loco causing damage to the locomotive and last gondola car. The incident caused no injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191649	MS (F)	29-Nov-07	Copper Cliff Smelter

Incident:

While doing normal rounds, an operator noted a fire had started in #7 pit in the old #6 furnace area. At 1:30 p.m., a level 1 was called for the furnace building area. The fire department responded, extinguishing the fire using water from a hydrant. No injuries a result o fthe fire were reported. The all clear was given at 2:48 p.m. Method of extinguishment: hose, fire department.

Cause:

Garbage containing numerous cardboard boxes.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191652 **MS** **29-Nov-07** **Copper Cliff Nickel Refinery: NRC**

Incident:

As a result of a fire that occurred at the same location, the Sudbury fire service responded to extinguish it. They discovered that there was smoldering in a wall of the granulation deck and proceeded to remove the panels from the wall to access and extinguish the source of the smoldering. The panels were identified to contain asbestos. The fire was extinguished. The fire service personnel were under SCBA throughout the process until they could access the asbestos decontamination trailer on site. Continental Insulation performed a clean-up of the area and disposed of the broken panel sections. The asbestos was in the current inventory. The asbestos was disturbed as a result of gaining access to the inside of a wall. The area was roped off until personnel trained in asbestos removal cleaned the area as per procedure.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191662 **MS (F)** **01-Dec-07** **Clarabelle Mill**

Incident:

Upon start-up of #2 rod mill, the operator noticed smoke coming from the clutch. He immediately notified the control room of the situation and #2 rod mill was shut down. Operations extinguished the fire with one fire extinguisher. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Alignment from motor to pinion was out.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1204804	MS	02-Dec-07	Kidd Creek: Railroad Mets

Incident:

Train crew were operating locomotives #T055 and #1804 loco spotting 6 empty on railcars into number one thaw shed. The first car went in as normal. Seems like the second car climbed the rail inside the shed with the first set of trucks coming off rail track. At this point, locomotives engineer realizing something was wrong so he put the train into emergency stop. A third car was half way into the shed and its first set of wheels were also off of the track and car was pulled towards and leaning against north wall of thaw shed. No injuries.

Cause:

Possible track build up of snow may have contributed to the incident.

Preventative Action:

None given.

Event ID:	1191659	MS (F)	03-Dec-07	Vale Inco Matte Processing

Incident:

An employee saw the conveyor belt on fire at the #3 roaster feed gate where the conveyor belt discharges. The fire was extinguished with a water hose. Feed gates for #3 roaster were open to preopare equipment for scaling of feed chute. The cottrell was spaded and both feed gates were open. No draft to roasters, causing heat from roaster to catch belt on fire. Source of ignition: radian heat from the roaster. Method of extinguishment: hose.

Cause:

Due to cottrell repairs, there was no available draft to remove excess heat from the roaster. The ball damper was closed. The feed belt over the feed gate chute was now exposed to the radiant of the roaster. This heat caused the belt to burn.

Preventative Action:

None given.

Event ID:	1191655	MS (F)	08-Dec-07	Xstrata Process Support

Incident:

The 2 shift mechanics were walking by #5 converter hood area at the conveyor belt level when they noticed planking on scaffolding, around the expansion joint were smoldering. The boards that were burning were put out with an ABC fire extinguisher. Removed planking around #5 converter hood area.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120489 **MS (F)** **13-Dec-07**

Incident:

Contractor was working on roof of water recycle tank and were preparing tar for roofing in a trailer on the ground beside water tank when fire started. Kidd fire crew was dispatched on arrival. Contractors already extinguished the fire with their own fire extinguishers. Area was assessed and contractor was asked for a plan before proceeding work.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191671 **MS (F)** **17-Dec-07** **Vale Inco Matte Processing**

Incident:

The fire guard, while making his rounds on the worksite, noticed a fire on the 4th floor of the KKR bins. He immediately sprayed the fire with a portable fire extinguisher containing water. This was not very effective, so a chemical ABC type extinguisher was used by the site supervisor to extinguish the fire. A large plastic garbage bag containing a 4 ft. long x 18 in. wide x 4 in. thick piece of soft foam had caught fire.

Cause:

Sparks from hot work. A fugitive spark landed on the plastic bag causing it to ignite.

Preventative Action:

None given.

Event ID: 1191675 **MS (F)** **20-Dec-07** **Creighton Mine: Underground**

Incident:

Workers were washing down the picking belt work area when they noticed flames coming from an electrical outlet located on the wall just below the floor. They immediately used a fire extinguisher on the outlet, however, this did not put out the fire. They then grabbed a broom with the handle, plugged the a cord (attached to a light) and unplugged this cord from the outlet. The fire then went out. the scene was secured, power was isolated to the outlet and shut off and tagged and the fire extinguisher replaced.

Cause:

Water shorted out the outlet.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

MV – MOTOR VEHICLES

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1105820	MV (F)	12-Jan-07	Creighton Mine: Underground

Incident:

Damage to the insulation of the starter circuit wiring. Anfo loader stalled in 001W FW drift. After repeated attempts to restart the unit, the operator noticed a small flame originating from the engine compartment. The flame was extinguished using a hand held fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1103517	MV (F)	17-Jan-07	Thayer Lindsley Mine: Underground

Incident:

Open flame on AL-010 Anfo loader. Hold down bracket had come loose and the battery had slid over and the positive anode contacted the hold bracket, heated the rod and ignited the grease on the battery. Operator was tramming AL-010 Anfo loader to 13-0-896 drift to load a drift round. As he was tramming down the ramp, he noticed a flame at the battery box. the flame was extinguished with a hand held extinguisher. The loader was emptied and brought to the shop for repair. The incident will be communicated to the crews in the morning line-up meeting.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1104120	MV (F)	17-Jan-07	Musselwhite Mine: Underground

Incident:

Front differential oil overheated and sprayed out of the breather onto the hot transmission and erupted into flames. Equipment is a 1997 Tamrock 40 D haulage truck (#406). Fire was extinguished by a hand-held fire extinguisher.

Cause:

A bearing on the front differential failed resulting in friction occurring between steel on steel which generated excessive heat and caused the drive oil to overheat and blow out breather.

Preventative Action:

Installing differential temp gauges is being looked into as well as the recommended change-out intervals for differentials to determine if this one exceeded the recommended period.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110233 **MV (F)** **25-Jan-07** **Canadian Salt Company Ltd.**

Incident:

The drill operator was driving #7 drill into a Z-panel heading when he noticed a small flame on the left jumbo arm. He stopped the drill and smothered it with a rag. No injuries. Electric oil flow solenoid damaged.

Cause:

Believed that an electrically controlled hydraulic flow solenoid malfunctioned and heated up.

Preventative Action:

None given.

Event ID: 1104677 **MV (F)** **12-Feb-07** **Thayer Lindsley Mine: Underground**

Incident:

Open flame on LHD. Main hydraulic hose blew spraying hydraulic oil onto front of hot engine. Oil ignited causing open flame. Worker was operating 830 scoop when a main hydraulic hose blew spraying hydraulic oil onto front of hot engine. Oil ignited causing open flame. Worker was able to stop the scoop and use the hand held fire extinguisher to put out the flame. Worker, area and scoop checked by supervisor. Mechanics were called to check and replace hydraulic hose.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105019 **MV (F)** **13-Feb-07** **Clavos Project: Underground**

Incident:

Scoop was backing out the stope when the operator saw a flash of fire. The oil filter "O" ring broke and sprayed a small amount of oil on the exhaust. Worker shut down scoop and fire went out. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105039 MV 13-Feb-07 Falconbridge Ltd.: Kidd Site

Incident:

Rail crew was in the process of moving an empty rejected acid car to a designated rail holding area when the end of the rail car derailed. There were no injuries and no damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105260 MF 13-Feb-07 Kidd Creek: Railroad Mets

Incident:

Rail crew were en route from minesite with 17 loaded ore cars when car #33013 derailed. Train continued to travel approximately 2.5 km. at which time the derailed car climbed over 2 rail switch points. No injuries. Damage to underside of the derailed car and switch point track area.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109936 MV 16-Feb-07 Clarabelle Mill

Incident:

While moving the skyjack SKJB-33N lift over the small rise/ramp in front of the oil room, it stopped. A Kubota 410 loader was used to assist the lift over the ramp, but as soon as the bucket touched the basket, the jib supports snapped. Upon initial investigation of the skyjack unit, the jib support arms were found to be full of material (possibly mill feed) and appeared to be corroded to jib supports on skyjack lift.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1201305 **MV (F)** **16-Feb-07**

Incident:

Worker was returning underground with load of fuel when he noticed sparks in the dash. He used fire suppression system. wires shorted. There was rubbing of wire on frame causing a short and the wire to heat and melt a section of wire casing. There was no circuit breaker for the light switch.

Cause:

None given.

Preventative Action:

All wiring checked - replaced burnt wire and installed a circuit breaker. More extensive checks for rubbing wires were being serviced.

Event ID: 1182015 **MV (F)** **20-Feb-07** **Copper Cliff Smelter**

Incident:

A private vehicle (2003 Ford pick-up truck) ignited. Method of extinguishment: fire department pumper.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182021 **MV (F)** **02-Mar-07** **Coleman Mine: Underground**

Incident:

Kiruna truck caught fire in the batteries compartment area. Operator used a 20 lb. fire extinguisher to put out. Source of ignition: batteries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1182048 MV (F) 07-Mar-07 Coleman Mine: Underground

Incident:

Exhaust on scoop ignited a muck build-up that contained oil in the exhaust compartment. Source of ignition: hot exhaust. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Oil spilled on muck near the exhaust.

Preventative Action:

None given.

Event ID: 1182050 MV (F) 07-Mar-07 Creighton Mine: Underground

Incident:

While driving up ramp from 7810 level, the operator noticed sparks coming from under the cab of the engine compartment. The operator backed the truck off the ramp at 7200 level and noticed flames coming from underneath the cab. The operator extinguished the fire with a hand held fire extinguisher and reported the incident to his supervisor and 7200 level garage mechanics. Source of ignition: heat from the Turbo charger. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Rag was left on the turbo of the engine during maintenance.

Preventative Action:

None given.

Event ID: 1056502 MV (F) 11-Mar-07 Musselwhite Mine: Underground

Incident:

Scoop fire. Mine was stenched. All miners sent to rescue areas. Mine Rescue was called.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108783 **MV (F)** **16-Mar-07** **Porcupine Joint Venture**

Incident:

Drill operator noticed a small fire on D15 drill on top of the engine. He immediately shut down the drill and extinguished the fire with a hand-held fire extinguisher. No one was injured and there was no damage to the drill.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108005 **MV (F)** **16-Mar-07** **Porcupine Joint Venture**

Incident:

Small fire occurred on D14 drill (Cubex). Fire was on tarp that houses the engine area in winter months. A hydraulic line had sprayed oil on the tarp near the exhaust stack. Dirller immediately shut down drill and extinguished fire with hand-held extinguisher. No injuries, minimal damage to tarp of the drill.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1108928 **MV (F)** **17-Mar-07** **Young Davidson Project**

Incident:

There was a fire in the headframe. Extensive fire damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1182056	MV (F)	19-Mar-07	Copper Cliff South Mine

Incident:

While attempting to jump-start #886 Kubota forklift with another piece of equipment, the operator noticed a small flame coming from the top of the dead battery. The unit was disconnected from the boosting vehicle and a fire extinguisher was used to put the flame out. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Overheated battery during boosting.

Preventative Action:

None given.

Event ID:	1107985	MV	19-Mar-07	Day Construction Ltd.

Incident:

Driver had dropped a load off at the Mill stock pile area and was returning to First Nickel mine when he went off the road. Driver was travelling approximately 55 km/hr. near the Fecunis scale when the truck started to pull to the right hand. Despite trying to counter steer to the left, the truck continued towards the ditch on the right side, broke through the guard rails and proceeded down the steep embankment and came to rest in Moose Creek. Driver was able to exit the truck and went for help. Injuries: suffered scrapes and bruises to head. Complained about upper and lower back pain and discomfort to right shoulder and left elbow and arm. No critical injuries. Incident reviewed with all supervisors, drivers. Driver trainer and supervisor to monitor road speeds, review trucking and HTA policy. In cab evaluation with all drivers with driver trainer. Incident reviewed with Xstrat management and safety personnel. Driver will be retrained on Day's truck simulator.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1109037	MV (F)	21-Mar-07	Porcupine Joint Venture

Incident:

The tarp on D-14 drill (Cubex) blew up against the muffler and caught fire. The fire was extinguished with a hand-held extinguisher. No one was injured and there was no damage to the drill.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139077 MV (F) 24-Mar-07 Musselwhite Mine: Underground

Incident:

A small fire occurred on an underground Tamrock haulage truck after mechanical repairs were done to a hydraulic hose. During the brake test, hydraulic oil was sprayed on the drive line brake disc, heated up and caught fire. The fire was extinguished using a hand-held fire extinguisher by the truck operator. Proper clean-up was not done.

Cause:

None given.

Preventative Action:

A review with crews on the importance of effectively washing equipment after a hydraulic hose has failed and has been repaired.

Event ID: 1182042 MV (F) 28-Mar-07 Creighton Mine: Underground

Incident:

Mechanic reported minor injury from inhalation of the dry chemical from the extinguisher. Operator was moving 801 Maclean bolter from 3820L to 3700L and noticed smoke coming from the engine compartment area. The fire was extinguished using a hand-held fire extinguisher.

Cause:

Cause of incident: housekeeping.

Preventative Action:

None given.

Event ID: 1058083 MV (F) 28-Mar-07 Coleman Mine: Underground

Incident:

Employee was driving 1026 jeep down to 3860 to drop the washbay attendants off and upon arriving into the shop he noticed flames 6 to 8 inches by his left foot coming from the fuse panel. He immediately shut nit off and shut master switch off and proceeded to hose unit down with water hose. Once extinguished, he removed the positive cable from battery. Soucre of ignition: 12 volt DC. Source of fuel: plastic coating on wires.

Cause:

Back side of the fuse panel open to contamination causing shorts and higher resistance in the unit's wiring.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139095 MV 03-Apr-07 Musselwhite Mine: Underground

Incident:

Workers were installing ground support from a teleyne, SL6-812, 1996 scissor lift at the 745 M level access drift heading when the scissor lift frame failed on both sides. The scissor lift was operating with the jacks pulling extended when the incident occurred. The frame of the scissor lift failed in two locations. Both failure sights were located in front of the rear axles. One failure was on the right rail, the other on the left rail. The failures were approximately adjacent to each other. The incident is under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110231 MV (F) 08-Apr-07 Porcupine Joint Venture

Incident:

A fire, caused by a failed oil line that sprayed on engine, ignited on the D10 cat dozer as operator was pushing on west dump. The operator activated the fire suppression system and shut down the dozer. There were no injuries and minimal damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1084796 MV (F) 16-Apr-07 Stobie Mine: Underground

Incident:

Injury description: inhaled a small amount of fire extinguisher powder. Broke hose from underneath the engine sprayed oil onto a section of the exhaust system where the heat wrap was damaged. Source of ignition: hot exhaust. source of fuel: hydraulic oil. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1085165 **MV (F)** **17-Apr-07** **Coleman Mine: Underground**

Incident:

Employee came out from refuge and noticed smoke coming from behind the left front fender on 1024 jeep. He looked down and saw small flames. He used fire extinguisher and put out the fire. Source of ignition: electricity. source of fuel: plastic covering. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

Wires shorting.

Preventative Action:

None given.

Event ID: 108825 MV (F) **23-Apr-07** **Copper Cliff North Mine**

Incident:

A worker noticed smoke underneath the floor boards of a man carrier (gater 023), while it was parked int its spot. The worker used a hand-held fire extinguisher to put out the fire. The electrician had just parked the gator in its parking spot on 3400 level. When he got out of the unit, he noticed smoke coming from under unit and then saw a flame a few seconds later. One hand-held fire extinguisher was used to extinguish the flames. Unver investigation (suspected electrical short).

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109883 **MV (F)** **26-Apr-07** **Kidd Creek Minesite: Surface**

Incident:

While getting a bucket of sand from storage dome, loader operator smelled smoke and noticed flames coming from engine compartment of Hyundai 770 loader. Used hand-held extinguisher to put out fire. No damage to equipment.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: **1201307** **MV** **29-Apr-07**

Incident:

When travelling up ramp, rear fan pump seal blew, causing the engine to overflow with hydraulic oil and oil blew out dipstick tube into blower and onto manifold of engine. The oil smoldered on manifold but did not catch fire. Operator used fire extinguisher as a precaution.

Cause:

Pump failure (mechanical).

Preventative Action:

None given.

Event ID: **1191591** **MV (F)** **29-Apr-07** **Coleman Mine: Underground**

Incident:

Employee noticed a small flame from the cable coming out of the battery box. The employee shut off the master switch and used a 20 lb. fire extinguisher to put out the flame.

Cause:

Wiring shorted out against frame of battery box.

Preventative Action:

None given.

Event ID: **1202021** **MV (F)** **01-May-07**

Incident:

Tractor trailer was being loaded with debris from the cooling tower restoration project. The driver of the truck was outside of the truck a short distance away while material was being loaded into the box. A person passing in a 1/2 ton truck noticed smoke coming from under the hood of the truck and notified the driver. The driver immediately went to check out the source of the smoke and shut off the engine and opened the hood. Two foremen from another contracting firm assisted with fire extinguishers and put out the fire while worker was disconnecting the battery. Worker from Xstrat Nickel called in the fire department as a precautionary measure due to the truck's close proximity to building, materials and cooling tower.

Cause:

The cause of the fire is thought to be the electrical wiring around the engine compartment. There was no indication of any problem with the truck prior to the fire.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1194705 **MV** **03-May-07** **Sifto Canada Inc.**

Incident:

A loader was loading a boat when it was buried in a pile of salt. The loader operator was dug out of the pile quickly and was not injured. The loader may have been too close to the pile, therefore causing the collapse.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109896 **MV (F)** **04-May-07** **Kidd Creek: Deep 7000**

Incident:

Driveline disc brake was dragging, causing overheat condition, igniting oil caused by overheating oil seals of brake assembly. No injuries, minimal damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202017 **MV (F)** **14-May-07** **Fraser Mine Nickel Zone**

Incident:

Haulage truck operator had driven into the dump area when he noticed an open flame coming from the exhaust guard. He stopped the truck and extinguished the flame with a 20 lb. hand-held fire extinguisher. Oil was leaking from a hydraulic pump in the torque converter compartment on to the drive line. The oil was then sprayed up onto the exhaust guard. No injuries. No damage to truck. Washed engine compartment. Replace hyd. pump. Wash exhaust guard and wrapped with exhaust wrap. Will also cover transmission hood on exhaust side.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1110055 **MV** **18-May-07** **Kidd Creek: Deep 7000**

Incident:

Truck driver driving up ramp noticed smoke coming from battery compartment of 30 ton truck. Stopped and pulled out battery tray. Used fire extinguisher to put out flame. No injuries, minimal damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1110371 **MV** **23-May-07** **Porcupine Joint Venture**

Incident:

Failed oil plug caused oil to spray on Turbo causing a fire to ignite on the Cat 365 excavator. Operator immediately shut down machine upon hearing activation of fire suppression system. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135647 **MV (F)** **26-May-07** **Falconbridge Kidd Met Site**

Incident:

Cellhouse worker used a portable fire extinguisher to put out a small fire in the engine compartment of a forklift truck. There were no injuries or equipment damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202045 MV 30-May-07 Craig Mine: Underground

Incident:

Scoop tram was driving down ramp towards 43-2 sub-level when the right rear wheel fell off. The wheel rolled down ramp. Loose wheel studs contributed to the failure. 8 broken wheel studs on rear right wheel.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135654 MV (F) 02-Jun-07 Kidd Creek: Deep 7000

Incident:

A loose transmission filter sprayed oil on the hot exhaust causing a flame. Flames were noticed to be coming from the engine compartment of a Toro 501 D LHD. The fire was extinguished and there are no injuries and no damage to the unit.

Cause:

A loose transmission filter sprayed oil on the hot exhaust causing a flame.

Preventative Action:

None given.

Event ID: 1202053 MV (F) 03-Jun-07 Craig Mine: Underground

Incident:

Operator of T16 (50 tons Toro truck) was heading down ramp between 47-2 and 47-1 when he noticed he could smell smoke. He looked behind him and noticed a flame coming from the A/C unit and pulled off onto 47-1 sub leve. He immediately shut off the truck and master switch and used his hand-held fire extinguisher to extinguish the flame in the A/C unit. Field technicians are investigating.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202052 MV 04-Jun-07 Creighton Mine: Underground

Incident:

Scoop operator was dumping in 5000 remuck on 7530 when his foot slipped off the brake and the scoop rolled backwards into the trolley line.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202057 MV (F) 07-Jun-07 Coleman Mine: Underground

Incident:

Afgter leaving loc. #1 while going down the ramp, the operator had a high temp alarm for the battery compartment. He noticed smoke coming from the battery compartment and pulled into the Kiruna shop. After lifting the cab, a small flame was observed and was put out with a fire extinguisher. No injuries reported. There was an electrical short in the battery and the battery overheated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1201678 MV 12-Jun-07 Dufferin Aggregates

Incident:

A truck driver parked parallel to the overhead hydro lines, which were visible, and raised his box to dump a load of asphalt. The box contacted 27,000 KVA lines. There were no injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135669 **MV (F)** **13-Jun-07** **Kidd Creek: Deep 7000**

Incident:

Worker smelled a burning odour and saw a small flame by the starter of the Kubota tractor as he was loading gear at the 7500 shaft storage. A faulty alternator caused coil to overheat. Unit was tagged out.

Cause:

A faulty alternator caused coil to overheat.

Preventative Action:

None given.

Event ID: 1202080 **MV (F)** **17-Jun-07** **Strathcona Mine: Fraser**

Incident:

Worker drove to the 42-2 storage area to load up with screen. When he exited the unit, he smelled smoke and noticed a small flame coming from the Turbo area of the engine compartment. The flame was put out with a 20 lb. hand-held fire extinguisher. When flames were put out, a partially burnt kimtowel was found on the ground. No injuries. No damage.

Cause:

None given.

Preventative Action:

Quality of pre-ops will be reviewed with crews with emphasis on inspecting for flammable refuse on units.

Event ID: 1202079 **MV (F)** **18-Jun-07** **Copper Cliff North Mine**

Incident:

A small flame was noticed coming from under the hood area of an employee's personal vehicle shortly after the vehicle was parked in the surface employee parking lot. The flame was extinguished using a hand-held fire extinguisher. The source of the fire is unknown at this time. A short in the vehicle wiring is suspected but unconfirmed at this time. Vehicle is a Nissan Pathfinder.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1205105 **MV (F)** **21-Jun-07** **Falconbridge Ltd.: Kidd Site**

Incident:

Operator was coming up ramp with a load when he noticed smoke and sparks coming from the starter after he opened the engine cover. He used the fire extinguisher to ensure that there were no further problems.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1090812 **MV** **21-Jun-07** **Falconbridge Ltd.: Kidd Site**

Incident:

A 22 ton capacity Tandem dump truck was attempting to dump its load at the Jarosite pond area at the met site. During this operation, the cylinder bracket assembly failed causing the dump box to fall back onto the frame of the truck which in turn caused some damage to the cab of the vehicle. There were no injuries as a result of this event. The truck was operated by Passaw Limited as part of the Jarosite pond re-activation project. An internal JHSC investigation is ongoing.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1162156 **MV (F)** **22-Jun-07** **Lac Des Iles Mine Ltd.**

Incident:

Fire in underground mine on the 11 yard scooptram caused by friction in the brake. A small fire occurred and it was extinguished with a fire extinguisher. No damage, no injury.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204418 MV 04-Jul-07 Bokor Pit, James and Gail Pit

Incident:

A customer of the caller's store informed her that a dump truck flipped over across the street. This happened some time in the last 2-3 hours and there has been no ambulance. The caller does not know if there were any workers involved or any injuries. The workplace is a gravel yard and the dump truck was involved in sifting coal contaminated soil that had been brought in from a construction site.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202115 MV (F) 08-Jul-07 Craig Mine: Underground

Incident:

Open flame fire on a 50 ton truck underground which was put out using a fire extinguisher. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1091200 MV (F) 10-Jul-07 Agrium Inc.: Mill

Incident:

An operator who had been attempting to start a bobcat when he noticed a small flame near the solenoid switch. The small fire was extinguished immediately. The equipment was tagged out for inspection and servicing by a competent individual. No one was injured and very minor damage to the starter resulted.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1092436 **MV (F)** **17-Jul-07** **Kidd Creek: Deep 7000**

Incident:

While trying to start engine, cable overheated causing a small flame. Cable not secured properly and grounded against frame.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1208057 **MV** **30-Jul-07**

Incident:

Reported temporary failure of remote transmitter causing 1600, 7 yard elphinstone scoop to roll into remote safety stand. No injuries. Small scratch on steel remote safety stand. Worker was remotely mucking AL-5 drawpoint on 6 level which was on a slight incline. The operator states that the remote transmitter throttle failed causing the scoop to roll back approximately 2 to 3 feet, bumping the steel remote stand. The operator was reportedly knocked off balance and fell out of the stand on the ground. The operator reported the scoop brakes applied when the transmitter tilt switch was activated as the transmitter fell over.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1094668 **MV (F)** **04-Aug-07** **Hoyle Pond Mine: Underground**

Incident:

Mechanic was driving a 6 yard diesel scooptram from 1100 ML to the 980 ML. When he reached the 1060 ML, the mechanic noticed smoke coming from the engine compartment. He immediately pulled the scoop off the ramp at the 1060 ML and extinguished the fire with a hand-held fire extinguisher.

Cause:

Broken turbo shaft as the cause.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202151 MV 04-Aug-07 Craig Mine: Underground

Incident:

Front tire of a 10 yard scoop fell off. While tramming muck from the HH stope, the right front wheel fell off LHD1008. Tamrock 10 yrd LHD. Damaged wheel studs, no injuries. LHD fleet is being audited for wheel studs and proper torques. A root cause failure analysis (RCFA) will be conducted.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202153 MV 06-Aug-07 Copper Cliff North Mine

Incident:

Toyota jeep collided with jumbo drill due to a brake failure on the jeep. Description of equipment and conditions: CVRD/INCO #62 Toyota jeep and #621 umbo drill. No injuries. Damage to the front rad. When the operator of #62 jeep pulled into 2870 heading on 4000L and applied the brakes to stop, the brakes failed causing the jeep to collide with the rea of #621 jumbo drill which was parked in the heading. The brake pedal provided no resistance when pressed and the pedal went to the floor. A pre-operational brake test was performed on the jeep earlier in the shift with no deficiencies found. The cause of the brake failure is unknown at this time.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202169 MV (F) 11-Aug-07 Copper Cliff South Mine

Incident:

Caller reported fire at South Mine from tire on a haulage truck situated 3090 feet underground. Mine Rescue has been notified and are en route. No injuries have been reported so far. #320 haulage developed a flat tire on 3540 level. The operator proceeded to drive the truck to 3930 level garage in order to change the flat tire. As he was driving down ramp, he noticed fumes coming off the tire and pulled the truck into a cut out just above 3930 level. The tire was hot and smoking due to friction. Supervisor was contacted and when the supervisor arrived, the tire was observed to be increasingly smoking. The operator guarded the truck and the supervisor went to get water for the tire. The tire caught fire shortly after. Two fire extinguishers were used but failed to extinguish the fire. The operator and supervisor retreated up ramp. The crews were notified of fire over the radio system and stench was injected into the mine. Mine Rescue was called in and successfully extinguished the fire.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1208462 MV 15-Aug-07 Williams Mine: Underground

Incident:

Freewheeling machining. No critical injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135693 MV (F) 23-Aug-07 Hoyle Pond Mine: Underground

Incident:

As two mechanics were proceeding down the main ramp with an Isuzu utility vehicle, the driveline brake applied and caught fire. The flame was extinguished with the hand-held extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1120459 **MV (F)** **31-Aug-07** **Montcalm Project: Underground**

Incident:

Operator was driving up ramp with a loaded truck when he noticed a flame coming from the engine compartment. Operator parked the unit and extinguished the fire. Fire was caused when engine oil used to lubricate the turbo charger leaked into the exhaust side and ignited from the high exhaust temperature.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148877 **MV (F)** **05-Sep-07** **Craig Mine: Underground**

Incident:

Worker was tramming back towards Craig shaft when he noticed flame coming from the midship area. Operator shut down unit and applied the fire suppression system. Preliminary investigations point to rear brake disc dragging. No damage, no injuries. Crews sent to refuge station. Mine Rescue called to confirm fire was extinguished.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135702 **MV** **08-Sep-07** **Kidd Creek Mine Site: Surface**

Incident:

A dump truck rolled over while carrying a load to the Jarosite reclamation project area. THR truck rolled down the 8 foot embankment. The driver did not lose consciousness. He was checked over by the on-site health care.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1162171 **MV (F)** **10-Sep-07** **Lac Des Iles Mine: Open Pit**

Incident:

60 ton underground truck drove to surface with a load when a hydraulic hose broke, spraying hydraulic oil onto the exhaust system and caught fire. It was extinguished with a hand-held fire extinguisher. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203219 **MV (F)** **12-Sep-07** **Frood Mine: Underground**

Incident:

An operator was spraying shotcrete on 1000 when he noticed burned oil smell. he noticed oil spraying from transmission filter hoising to hot exhaust. He climbed into the cab to shut off engine and at that point, he saw an open flame coming from the exhaust area. Immediately he fired the fire suppression system which extinguished the fire. He retreated to fresh air with his partner.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203221 **MV (F)** **12-Sep-07** **Copper Cliff South Mine**

Incident:

Alternator wiring of #725 boom truck caught fire as a result of a damaged air filter intake pioping making contact with the positive terminal of the alternator and causing an electrical short.

Cause:

Grounding of positive alternator terminal with air intake pipe.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139222 MV (F) 16-Sep-07 Musselwhite Mine: Underground

Incident:

Exhaust system of the 3 1/2 Tamrock scooptram caught on fire. Smoke and flames were visible. The operator stopped, shut down and initiated the fire suppression system. Fire extinguished. Heat from the exhaust caused the wrapping to catch fire. Exhaust overheated and exceeded the heat range of the exhaust wrap. Investigation ongoing as to why the engine overheated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204750 MV 18-Sep-07 Coleman Mine: Underground

Incident:

Employee pressed the E-stop on his scoop and exited the scoop to close the roll up door using the light sensor. When he turned around to get back into the scoop, the scoop had rolled 40 ft. into the wall. Under investigation.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120465 MV (F) 19-Sep-07 St. Andrew Goldfields: Taylor

Incident:

While driving #500 boom truck from surface cold storage to surface shop, brake line broke causing hydraulic fluid to spray onto brakes. Operator did not notice flames underneath truck but another co-worker who was following behind noticed the flames. Co-worker stopped boom truck, took extinguisher off the boom truck and extinguished the fire. No injuries.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204754 **MV (F)** **19-Sep-07** **Stobie Mine: Underground**

Incident:

While adding oil into the engine of 106 scoop, oil splashed on exhaust causing an open flame. Operator extinguished the flame right away. Water was used to cool off the exhaust wrap and clean the spill. No stench injected. No Mine Rescue activated.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1021452 **MV** **19-Sep-07** **Island Gold Project: Surface**

Incident:

Worker, who drives a 30 tonne dump truck for Island Gold in Dubreuilville, notified OPP that another employee drove his 30 tonne dump truck right at him. Management investigated and have written up for following too close.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204753 **MV** **20-Sep-07** **Coleman Mine: Underground**

Incident:

Scoop turned into panel #3 and struck a parked jeep with the bucket of the scoop. No injuries reported. The jeep sustained considerable damage to the frame and minor damage to the body.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1204759	MV	24-Sep-07	Levack Mine

Incident:

The 3 yard was mucking from the top re-muck and the 6 yard was mucking from the bottom re-muck. The 3 yard was travelling up the ramp in reverse. He was just clearing the top of the ramp when his scoop started to sputter and it stalled. he applied the emergency stop button, tried to restart but it would only roll over and not start. The scoop started to roll down the ramp very slowly so the employee bailed out. It rolled approximately 160 feet. The 6 yard was coming up the ramp and he saw this large black shadow coming down. He put his scoop in forward and when the 3 yard got close, he went back down the ramp. He pivoted his scoop in order to stop the 3 yard and braked. The 3 yard collided into the back of th 6 yard. The operator remained in the 6 yard during this incident. Reasons for occurrence: unknown as of yet. Minor damage to radiators and some damage to back of 6 yard.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1204761	MV (F)	25-Sep-07	Creighton Mine: Surface

Incident:

Operator of Cat loader #187 noticed small flame on Turbo charger wrap. He extinguished flame with hand-held extinguisher. Source of ignition: heat from Turbo charger / engine. Source of fuel: grease on wrap.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1204765	MV	28-Sep-07	Copper Cliff North Mine

Incident:

Mine haulage truck contacted the ramp wall causing damage to the operator's cab. 30 ton haulage truck was being driven down ramp at the North Mine 175 ore body. Just above the last corner before netering 600 level, the truck cab contacted the drift wall on the left side and caused damage to the cab. The operator stopped the truck. Damage was assessed and the truck was brought to surface. The incident is under investigation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204770 MV 04-Oct-07 Craig Mine: Underground

Incident:

Operator of Maclean bolter had just completed gearing up and proceeded to his new workplace when he felt the unit was hung up. Upon investigation, he noticed the left rear wheel had broken off at the studs and was leaning over. Damaged wheel studs, no injuries. The OEM will be contacted to aid in the investigation. A root cause failure analysis (RCFA) will be conducted.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1204774 MV (F) 08-Oct-07 Fraser Mine Nickel Zone

Incident:

After dumping a load at the OK dump, the operator of #44 trolley noticed smoke entering the operator's compartment. he proceeded to check under the hood and saw a small flame coming from some wiring. He extinguished the flame using a 20 lb. hand-held fire extinguisher. Initial repairs were done to a defective grounding cable for traction motor. Further investigation also revealed damaged CAM lock connectors.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1189342 MV (F) 09-Oct-07 Red Lake Complex: Underground

Incident:

A small fire occurred on a scooptram with the engine glow plugs solenoid. The component flamed up a few inches for approximately 1 minute at the engine glow plug solenoid. At the time of the incident, the engine was at normal operating temperature and would not require the solenoid to be engaged. Flame was put out by the operator by a hand-held fire extinguisher. Investigation is ongoing.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1204776	MV (F)	09-Oct-07	Stobie Mine: Underground

Incident:

During the process of re-filling the fuel tank of a scoop on 1850 level, it caught on fire. The operator was using a Wiggins system when a leak developed on the opposite side of the scoop spraying fuel onto the hot exhaust. Operator had parked his scoop in the fuel bay and shut it off to re-fill the fuel tank. He hooked up the Wiggins system to the scoop and was filling the tank when he felt a hot flash on the opposite side of the scoop. He immediately called his supervisor which helped him control the fire and set off the fire sprinkler and fire suppression.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1204777	MV (F)	09-Oct-07	Craig Mine: Underground

Incident:

worker approached the 4300 refuge station with MC079 Minecat tractor to pick up passengers when he noticed flames coming from the steering column area. Initial observations suspect fuel from previously repaired leak saturated some wiring, causing the incident. Flames were extinguished using a 20 lb. fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191602	MV	18-Oct-07	Copper Cliff South Mine

Incident:

Scooptram lost traction on 4130 ramp. Slid down ramp and contacted ramp wall. Ramp way wet and slippery due to broken water pipe leaking on ramp. Operator of scooptram coming to a sudden stop. No damage to equipment. The unit broke traction and slid backwards down ramp for approximately 100 feet where it came to rest after contacting the ramp wall. Braking of the unit was completely ineffective due to the slippery conditions on the ramp road surface. Water leak was repaired and the ramp road surface was graded.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1148912 **MV (F)** **30-Oct-07** **Stobie Mine: Underground**

Incident:

An employee noticed a small flame coming from the midship drive line of a jumbo drill going across the level. They put the fire out right away and called the mechanic. Source of ignition: friction. Under investigation. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135728 **MV (F)** **01-Nov-07** **Hoyle Pond Mine: Underground**

Incident:

There was a small fire on scooptram. Worker was dumping a bucket of muck in the remuck when he noticed flashes on the wall. He shut down the scoop and used a hand-held fire extinguisher to put out fire on the starter wires.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1148913 **MV (F)** **01-Nov-07** **Strathcona Mine: Fraser**

Incident:

Worker was driving up the ramp when he noticed an open flame on his right side at the rear of the transmission at the back of the operator's compartment. He stopped the vehicle and extinguished the flame with a portable 20 lb. hand-held fire extinguisher. No evidence of what caused the open flame was found. Further investigation is being conducted.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1135738 **MV (F)** **05-Nov-07** **Kidd Creek: Lower Mine**

Incident:

The emergency park brake of Toyota Jeep 79 series overheated and created a small flame on some grease on the brake caliper at the 5300 level in ramp at the Xstrata Copper Kidd Mine. The fire extinguisher was used to prevent spreading of flame.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191616 **MV (F)** **06-Nov-07** **Clarabelle Mill**

Incident:

Hydroseeder, Unit #1, was in the process of being loaded at the entac tank site in the Copper Cliff Tailings. The motor was running as the tank was being filled with water and mulch. The motor had been running for 8-10 minutes when the operator smelled smoke. he climbed down off the deck of the unit to visually check the situation. Several small flames were observed on the starter unit. The operator climbed back up on the deck of the unit and shut the hydroseeder down at the operator control panel. The operator got off the machine and also shut off the master switch. He also told the driver of the hydroseeder that he had seen a fire on the starter. The operator went to his service truck and grabbed a fire extinguisher which was used to extinguish the small flames. The operator noticed that it seemed that the wiring to the starter / solenoid had burned. source of ignition: electrical. Source of fuel: plastic coating on wires. Cause of incident: unknown. Method of extinguishment: 1 portable ABC fire extinguisher.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202497 MV 12-Nov-07 Musselwhite Mine: Underground

Incident:

Two workers had completed installing ground support on the 745 metre level and were travelling via the access drift to the main ramp with a scissor lift when the left front stabilizer jack fell from the unit. The workers immediately stopped the machine and reported to a supervisor. The scissor lift was manufactured and supplied by Breaker Technology Ltd. of Sudbury. The unit referred to as SSL-9 was manufactured September 22, 2006 and commissioned at Musselwhite Mine on November 6, 2006. After notification, the machine was locked out and an investigation was initiated by the employer. Investigation team found there was inadequate design of mounting plate and jack assembly which allowed bolts to slip out. Also, it was found that improper design of slots on mounting plate and jack does not allow for bolts to hold. Employer/owner to contact manufacturer to examine design and re-evaluate stress levels when jacks are raised and lowered. 2) unit was shut down until examination completed. 3) check other scissor lift units for similar mounting of jacks. 4) add to mobile equipment pre-check for all scissor lift vehicles to examine mounting assemblies and bolt attachments before use. 5) contact another manufacturer who will be supplying new scissor lifts in 2008 for scissor lift mounting assemblies. Information was provided to employer/owner/MOL inspector by Breaker Technologies Ltd. of Lively (Sudbury) concerning manufacturer's design of re-mounting jacks to scissor lift. Engineer's drawings were provided to employer/owner/MOL inspector along with instructions of new jack/stabilizer mounting to scissor lift.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135741 MV (F) 17-Nov-07 Kidd Creek: Lower Mine

Incident:

A tractor started on fire underground. The fire was extinguished quickly and there were no injuries or evacuations.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1135742	MV (F)	18-Nov-07	Hoyle Pond Mine: Underground

Incident:

There was a small fire as a contract employee was mucking with a 6 yard scooptram, when the right front hoist cylinder hose broke spraying hydraulic oil onto the hot exhaust. The small flame was extinguished with a hand-held extinguisher. There were no injuries and no damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191635	MV (F)	20-Nov-07	Copper Cliff North Mine

Incident:

Bulk anfoloader was travelling up the 2800 ramp when a fire was oticed underneath the unit. The operator shut down the unit and two fire extinguishers were used to put out the fire. Upon initial investigation, it appears a broken hydraulic hose sprayed oil onto the driveline disc brake and heat generated by the brake ignited the oil. A detailed investigation is underway. Source of ignition: friction and heat from the drivline braking system. Method of extinguishment: 2 portable ABC fire extinguishers.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191647	MV	23-Nov-07	Copper Cliff South Mine

Incident:

Collision occurred between two haulage trucks at the intersection of 3930 storage and the down ramp. No injuries. Damage to the grill. #286 haulage truck was in the process of reversing into 3930 storage and #260 was in the process of leaving the crusher dump. Operator of #260 was leaving the crusher dump and turning to head down ramp to 4130 level when glanced right to look at a third truck approaching the crusher dump on 3930 level. As he looked back to the left, he noticed the front of #280 truck and it was too late to come to a complete stop. Incident is under investigation. Several corrective actions are being considered at this time to improve the visibility and haulage in the area.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1135745	MV	24-Nov-07	Falconbridge Material

Incident:

Operator driving Tandem truck backed truck into position and began to lift box of trailer up when approximately 3/4 of the way up, box on trailer began to shift resulting in box on trailer and cab of truck to fall over on its right side. Employee was shaken up and reported to first aid.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1213346	MV	30-Nov-07	Tri City Materials

Incident:

Truck backed up to bank and bank gave way and buried truck. Driver jumped free. Trying to dig out truck before MOL comes.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191658	MV	01-Dec-07	Copper Cliff North Mine

Incident:

Collision between a Toyota jeep and Elphinstone R1700 scooptram. No injuries, damage to the grill and hood of the Toyota jeep. Jeep was travelling up ramp to 3400 level at the intersection of the level. The jeep ran into the rear of Cementation #CS8428 scoop which was leaving the level and turning the corner to go down ramp engine first.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1195041 MV (F) 03-Dec-07 Musselwhite Mine: Underground

Incident:

The operator picked up the boom truck from the 488 shop where the Turbo had just been changed and new pipe wrap was installed. He pulled off the ramp at 300 to let traffic go by. He then noticed flames flickering on the engine. he shut down and grabbed a fire extinguisher. He saw flames coming from the fire wrap and they went out by the time he reached them. The operator never used the extinguisher. He called for help and monitored the boom truck until a mechanic and the supervisor arrived.

Cause:

The exhaust pipe was slightly squished and the PTX was worn. The inside layer of the fire wrap wasn't installed properly, leaving gaps that let the outer wrap get too hot.

Preventative Action:

Training must be given to mechanics who install the fire wrap and more training on testing and diagnostics of exhaust systems. Sourcing out better exhaust wrap that will tolerate higher temperatures is also required.

Event ID: 1191735 MV 19-Dec-07 Lockerby Mine: Underground

Incident:

L.H.D. 211 forklift / scoop rolled down ramp during the process of transferring shotcrete bags. The engine was turned off and the brakes were applied forks on ground. It rolled down the ramp around 10 feet and then stopped. No injuries or damage to unit. Still under investigation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

RM – ROCK MOVEMENT

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1105815 RM 05-Jan-07 Coleman Mine: Underground

Incident:

Rockburst. No injuries or damage. While bolting the final round in 04-18 X-cut just ahead of the barrier pillar, a rockburst occurred. The event was picked up by the microseismic system as a 1.1 MN event and was followed by an additional 14 small events in the subsequent 2 hours. Approximately 10 tons of material (small pieces) was ejected from the unsupported left side of the round and displaced onto the floor. In addition to the material lying on the ground, a large chunk, roughly the size of a sheet of screen and approximately 2 ft in thickness, was also dislodged and hanging from a single installed rebar beside the bolter setup. A second smaller chunk landed on top of the bolter pendant.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1105816 RM 05-Jan-07 Copper Cliff South Mine

Incident:

7,000 tons of material comprised of mainly olivine diabase dyke fell from the back of 1090 sill drift on 3015 level over 1521 VRM into 1451 VRM. A Maclean was bolting lower wall in the 1400 x-cut in preparation for the barricade construction when occurrence started but sustained only minor damage to electrical panel.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1102775 RM 17-Jan-07 Kidd Creek: Lower Mine

Incident:

Two separate rock bursts at shift change. first MN 2.3 in north abutement, above 6000L in far field caused no noticeable damage. Second MN 1.3 on 7500L triggered 35+ tonne fall of ground and damaged support.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104183 RM 23-Jan-07 Garson Mine: Underground

Incident:

Fall of ground due to seismic event. Workers trapped behind rubble. No injuries. Employees that were working in the area were not able to leave for approximately 2 hours. Once activity ceased, areas were opened for employees to pass through. A total of 9 employees were obstructed from leaving the levels (4600/4700) because of damaged ground support, piles of material from the seismic event and evidence of additional seismic activity. No injuries nor damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103783 RM 29-Jan-07 Redstone Mine: Underground

Incident:

Stope being emptied, 100 tonnes at the hangwall failed.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1103784 RM 17-Feb-07 Kidd Creek: Deep 7000

Incident:

Stope being emptied - 300 tonnes of the hanging wall failed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108066 **RM** **17-Feb-07** **Kidd Creek: Deep 7000**

Incident:

Small seismic event caused by long hole drilling triggered fall of ground from previously mined stope back. No injury or damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109941 **RM** **21-Feb-07** **Copper Cliff North Mine**

Incident:

Damage occurred to a scoop while mucking remote in 902 block on 4200 level. Muck fell from within the confines of the block and landed on the unit. No injuries. Damage occurred to the upper deck surface of the scoop in several area. The scoop was knocked out of operation and had to be pulled from the panel.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182014 **RM** **22-Feb-07** **Coleman Mine: Underground**

Incident:

Seismic event occurred. No injuries. Damage to some previous conditioned ground support. The event occurred 9 hrs. after blasting the second (and final) round in 11-23 x-cut.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1104542 **RM** **24-Feb-07** **Victor Diamond Project**

Incident:

Slosh incident occurred at the northwest side of the Victor Mine pit. The bench face failure covers about 2,000 sq. meters with a crest backbreak of about 30 metres. No equipment damage. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109052 **RM** **05-Mar-07** **Lac Des Iles Mine Ltd.**

Incident:

Stope had a fall of ground of approximately 2000 tons that fell from the back of the stope. No workers present at the time. Major fault runs through this particular area of the stope.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191364 **RM** **15-Mar-07** **Williams Mine: Underground**

Incident:

Ground fall in footwall drift - approximately 10-15 tonnes.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1108139 RM 16-Mar-07 Redstone Mine: Underground

Incident:

Fall of ground due to blasting a slot of 8 ft. uppers. Groundfall size 225 tons. No damage.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1107986 RM 23-Mar-07 Stobie Mine: Underground

Incident:

A seismic event occurred in the vicinity of 2990 fresh air raise, on 2600 level. there was no damage to the ramp system but there was some displacement in 2990 vent raise between 2400-3000 levels. 150-200 tons of material was found at the bottom of the raise on 3000 level.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1182045 RM 25-Mar-07 Coleman Mine: Underground

Incident:

Rockburst displacing approximately 10 tons. No equipment damage. A ground movement and ground fall occurred in communications from the north wall between the previous access on the cut below and the fill wall.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1107987 RM 26-Mar-07 Stobie Mine: Underground

Incident:

A seismic event occurred in the vicinity of 2990 fresh air raise, on 2500 level. 50-100 tons of material came down the raise to 3000 level. The fresh air raise was in the process of being mucked out. The mucking of this raise was done on remote control with the remote stand set-up approximately 200 ft away from the raise itself. No one was hurt and no equipment was damaged because of this event. At no time was the operator exposed to any hazard from the raise since he did not travel beyond the remote stand.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1058436 RM 30-Mar-07 Coleman Mine: Underground

Incident:

Rockburst approximately 275 tons. No injuries. A rockburst occurred in panel T4 while bolting the first sill round of 10-22XC.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109298 RM 03-Apr-07 Kidd Creek: Lower Mine

Incident:

MN 2.2 rockburst occurred contemporaneously with 68 SL1 stope final blast on 6700L. Caused damage to drift and support systems and expelled/triggered groundfall of 500 + tonnes. Damage contained to single location/level.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1139108 RM 11-Apr-07 Musselwhite Mine: Underground

Incident:

While mucking remotely inside of a stope, a large piece of loose fell off the wall hitting the top cover around the air conditioner box. The scoop tram stalled and while the operator was calling for assistance, approximately 700 tons fell from the stope hanging wall and buried the scooptram.

Cause:

Geological structure.

Preventative Action:

None given.

Event ID: 1087690 RM 16-Apr-07 Creighton Mine: Underground

Incident:

10 tons of material was ejected from the east wall of the drift at 40 to 50 feet from the slash location. The rockburst occurred in granite at the ore granite contact of the 202 cut. Damage to the wall support.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191588 RM 27-Apr-07 Creighton Mine: Underground

Incident:

A seismic event occurred between 3550 and 3710 levels resulting displacement within stopes. These stopes have previously experienced seismic activity and unraveling from events prior to this occurrence. An ITH drill was in the process of drilling a test hole from 3500L to determine the extent of failure and unravelling of the zone above 3700L. No injuries or damage.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191589 **RM** **27-Apr-07** **Creighton Mine: Underground**

Incident:

Fall of ground. Tons displaced: 80 tons. Material fell from the east wall of the 6400 stope topsill (461 soth sill) itno the open stope.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202024 **RM** **11-May-07** **Copper Cliff North Mine**

Incident:

A fall of ground occurred on left wall side of the stope sill (350L) and fell into the existing open stope. Access was restricted prior to the fall of ground due to the open stope.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1109949 **RM** **13-May-07** **Kidd Creek: Lower Mine**

Incident:

MN 2.2 rockburst in north abutment at 4700L triggered a significant fall of ground on 4800 to 4700 Kiruna conveyor system and minor falls of small loose in multiple locations.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202011 RM 15-May-07 Coleman Mine: Underground

Incident:

20 tons displaced from the pillar nose across from the drawpoint. Material was not ejected, but left hanging from the pillar behind the screen. Discovered 30 tons ejected from the right wall. The material half-buried a small manitou forklift. Also on Tuesday morning (May 15) at 11:34 a.m., another magnitude event occurred in the panel 1 buck zone.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202025 RM 18-May-07 Copper Cliff North Mine

Incident:

500 tonne fall of ground discovered at the brow of 44-0-490 LH stope. Brow was known to be in poor condition and seismic event caused the fall of ground. No damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202035 RM 26-May-07 Stobie Mine: Underground

Incident:

Fall of ground was discovered when the workers were in the process of clearing the area after an SLC blast in the footwall DR. The ring blasted was approximately 85' away from the face. The fall of ground is a typical wedge failure caused by at least 3 intersecting joints.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202044 **RM** **27-May-07** **Coleman Mine: Underground**

Incident:

Supervisor went into T3 and discovered material displaced from the left wall shoulder in 10 slot E. an event was recorded by the microseismic system as 0.1 level magnitude. A hydraulic hose on the bottom of a drill was damaged by the event. This incident was directly related to a blast in SO7E panel.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202048 **RM** **30-May-07** **Fraser Mine Nickel Zone**

Incident:

30 tonnes displaced from wall/shoulder 2-10 M back of current face. Burst likely occurred immediately following blast. No injuries. Broken rockbolts.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203545 **RM** **31-May-07**

Incident:

While driver was drilling on round with electric hydraulic jumbo, he went to change a bit on one boom but left the other drills rotation on. When he went to walk by the boom to change the drill bit, the bit caught his oilers and started to wrap his leg into the steel. His partner was there and stopped the drill and he then cut his clothes off his leg to free it. Driller did not follow procedure for going past the front jacks when machine is drilling. He did not shut off the second drill's rotation before going to change the bit on the first drill. Verbal warning given and went over the procedure in depth with driller.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1202054	RM	13-Jun-07	Strathcona Mine: Fraser

Incident:

A 2.5 MN burst during blasting resulted in damage to the 591 T1 RT stope. Several ground falls totalling approximately 80-90 tonnes occurred from the FW rib and access corner. A significant amount of additional loose was controlled by the support.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1202068	RM	13-Jun-07	Onaping Mine

Incident:

1 tonne of material fell from the back of a stope undercut and landed on the engine compartment of a Mclean blockhole machine. The material was massive sulphides and the area was wet. Several bolts were badly corroded and failed causing the fall of ground. Bagged loose in screen that dislodged when corroded support failed. Initial development was about 20 months old.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1202078	RM	13-Jun-07	Fraser Mine Nickel Zone

Incident:

Worker had just finished installing rail, loose came off the h/w corner of the face and struck the worker on the hand. Loose was approximately 41" x 21" x 5" thick. Medical injury, laceration to the top of left hand. Due to the degree of the raise and the ground conditions. A bigger canopy that can be moved tight to the h/w from the basket has been fabricated and installed.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1202074 RM 15-Jun-07 Creighton Mine: Underground

Incident:

Major seismic event measuring 3.0 MN occurred. This event resulted in the evacuation of all underground workings below the fefuge station on 7200L. Investigation team discovered that 60 tons of material was displaced and 50 tons was contained by the support in the pillar between the ramp to 7400 and the truck loop also discovered the floor heaved about 12 to 18" at the intersection of the main ramp and truck loop. there was no damage to personnel. Minor damage to a Mclean bolter, a compressor and a cubex.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202092 RM 22-Jun-07 Craig Mine: Underground

Incident:

Rockburst caused by 2.2 MN seismic event occurred in sill above 51-2 panel 17. Approximately 190 tonnes of rock fell from the back and upper corner of the overcut. Heavily stress fractured material violently ejected by presumed fault slip seismic event. Blasthole panel was fired on Wednesday, June 20th. Two-man blasthole crew left the area because of "ground working" prior to the large seismic event/rockburst.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202110 RM 04-Jul-07 Copper Cliff South Mine

Incident:

Corroded ground support screen containing bagged loose on 1750 level failed allowing loose to fall onto jeep. Corroded/rusted screen. No injuries. Damage to the Totota jeep, windshield was cracked.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1093390 **RM** **13-Jul-07** **Kidd Creek: Deep 7000**

Incident:

MN 1.1 rockburst on th3 6300L immediately north of the No. 4 OP, which triggered a fall of ground in the No. 3 ventilation raise. Aftershocks to MN 1.0. No noticeable damage to any supported lateral development. No injuries.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135680 **RM** **26-Jul-07** **Kidd Creek: Lower Mine**

Incident:

Remote scoop operator in 61-706 stope reported three falls of ground from the immediate brow of the stope. Scoop tram was operating on remote. Operator was in safe location 20M from brow. No injuries reported.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135684 **RM** **01-Aug-07** **Hoyle Pond Mine: Underground**

Incident:

Two workers were in the process of slushing out two sub drift bounds. While one of the workers was drilling a hold in the face with a jackleg drill, for slushing purposes, the floor gave way below. One employee fell with the falling muck and came out of the 80M WOD x-cut drift (drop approximately 10 metres). The second worker managed to remain on the sub elevation.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1203212 **RM** **05-Aug-07** **Levack Mine**

Incident:

Fall of ground occurred in AB active production stope. No injuries. Groundfall of approximately 110 tons was reported in the 1800L 93000 north limb cut and fill stope. The intersection between the pillars was slashed and the groundfall occurred following the blast.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1202155 **RM** **07-Aug-07** **Stobie Mine: Underground**

Incident:

At 8:18 a.m., a large seismic event occurred in the vicinity of 2990 far and 3015 far from 2340-3000 level. After the initial event, the seismicity continued. There was displacement on several levels: 2400 level, main x-cut approximately 100 lbs. of shakedown 2600 level, far. acc, beyond vent control, 200 tons 2800 level, far. acc, beyond vent control, 150 tons 3000 level, at bottom of 3015 far 100 tons, at bottom of 2990 far 500 tons.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1135690 **RM** **21-Aug-07** **Dome Mine: Open Pit**

Incident:

During the early morning, a wedge of rock toppled from the north pit wall onto the cath benches and ramp at the Dome Mine Pit.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1203194 RM 29-Aug-07 Creighton Mine: Underground

Incident:

Strain burst sub type: rock ejected from the face. Tons displaced: 30 tons, contained: 2 tons magnitude: 1.8. The next round of 4825 access was drilled but due to loose in the face and blocky ground conditions, the jumbo operator was scaling the face before drilling the distress holes required for all development rounds at Creighton Deep.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203214 RM 08-Sep-07 Creighton Mine: Underground

Incident:

Strain burst sub-type: rock ejected from the shoulder and back. 20 tons of material fell down from the back of 0001 FW drift west and an estimated 40 tons was ejected from the upper wall and shoulder of the pillar between 0001 FW drift west and 7840 ramp. Damage to the support in place (i.e. rebars, friction sets FS 46 and shotcrete). There was no injury to personnel or damage to equipment as the burst happened during the development round.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1203217 RM 10-Sep-07 Creighton Mine: Underground

Incident:

Fall of ground estimated to 400 tons of ore was reported on September 10, 2007. The fall of ground is mostly a failure of the south hanging wall pillar of the 4654 stope and most likely occurred during or shortly after the crown blast fired on September 7, 2007.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1204775 RM 07-Oct-07 Creighton Mine: Underground

Incident:

A 3.1 MN event was recorded along the FW shear (6900 level) at 6:15 on October 7, 2007. followed by excessive seismicity along yhe FW shear on 6800, 6900 and 7000 levels. The main event was followed by the 1.5 MN. Event at 8:56 p.m. along the plug shear on 7200 level, then a shift of seismicity from the FW shear to the plum shear on 7000, 7150 and 7200 levels. Here are the findings of the underground investigation: 6600 loeve: a total of 20 lbs. of shotcrete slabs and shards fell from the back in the 1290 bottom sill. - 6800 level: floor heave in 4770 drift and 8 to 10 tons of displaced material from the floor and lower north wall. - 7000 leve: shartds in the refuge station. - 700 level: 50 lbs. of displaced material from the south wall of 4560 sump drift at the door frame, mostly shake down. - 7150 level: 3 wooded washer bolts were ejected from the back in the walkway side of the A-belt and 60' above the picking belt. Area has been reconditioned with enchanced support (ie.e cone bolts and 00=cauge straps). - 7150 level: 1.5 ton chunk discovered at the bottom of #1 FA raise. There was no injury to personnel ro damage to equipment.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120475 RM 10-Oct-07 Kidd Creek: Upper Mine

Incident:

Fall of ground resulting from ground relaxing. No injuries.

Cause:

Fall of ground resulting from ground relaxing.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1148895	RM	11-Oct-07	Copper Cliff North Mine

Incident:

Fall of ground in 9440 top sill entrance on 3880 level following a crown blast of 9440 stope. The crown of the 9440 stope (3880-4050L) in the 900 OB was blasted at approximately 7:10 p.m. A re-entry protocol was ineffect at the time of the blast. As part of the re-entry procotocl, the ground control engineer checked the microseismic system and cleared the area at approxiamtely 9:10 p.m. Close inspection of each area suggested that each was classified as a fall of ground. 3880 L-9440 top sill: approximately 100 tons (from back). 3880 L-3860 top sill: approximately 5 tons (from face). The draw point in the bottom sill (4050L).

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191601	RM	17-Oct-07	Creighton Mine: Underground

Incident:

Shake down from even seismic. Shards in the electrical shop. 1.9 MN. Event was recorded around the electrical shop area on 7000 load-out at 8:33 p.m. on October 17, 2007. It is observed that a major shear zone crossed the wall and back in the area, where material was displaced.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1148911	RM	29-Oct-07	Strathcona Mine: Fraser

Incident:

While bolting face with the jumbo in D35 acc., fault slip burst occurred followed by 1 minute later by a 2nd burst. Second burst is likely strain burst which blew out face and lower walls at face.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID: 1191625 **RM** **10-Nov-07** **Strathcona Mine: Fraser**

Incident:

A 1.3 MN seismic event occurred during a lunch break in 42-1-1620 stope, B10 heading. Approximately 7 tonnes of material was ejected from the face and the left hand side wall approximately 5 m back from face. No injuries reported.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1120482 **RM** **13-Nov-07** **Porcupine Joint Venture**

Incident:

Fall of ground from southeast wall of pit east pod, between 3304 and 3313 elevations.

Cause:

None given.

Preventative Action:

None given.

Event ID: 1191669 **RM** **20-Nov-07** **Creighton Mine: Underground**

Incident:

A 1.3 MN event was recorded on November 20, 2007, at 9:34 a.m. at the intersection of the 7072 drift and 7072-2 muck storage / supply storage. The event occurred while drilling cablebolt holes using a Mclean bolter and caused approximately 20 tons of displaced material from the back. Then contained by the #4 welded wire mesh. Geological mapping showed the displaced material was through a low angle joint dipping at 20 degrees. Mclean bolter operator sustained a minor injury (medical aid) to his shoulder due to the displaced material.

Cause:

None given.

Preventative Action:

None given.

SUMMARY OF MINING REPORTABLE INCIDENTS

January to December 2007

Event ID:	1191633	RM	21-Nov-07	Creighton Mine: Underground

Incident:

A 1.3 MN event was recorded. The event occurred while drilling cablebolt holes using a Mclean bolter and caused approximately 20 tons of displaced material from the back that dropped then contained by the #4 welded wire mesh and failure of the row of mechanical bolts. The intersection of the area where the burst occurred was in the process of being supported using cable bolts. Bolter operator sustained a minor injury (medical aid) to his shoulder due to the displaced material.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191663	RM	05-Dec-07	Creighton Mine: Underground

Incident:

Following a 2.7 magnitude event at 9:21 a.m. December 5, 2007, on 7680 level in the 461 south drift, an estimated 15 tons of material was ejected from the right wall. Another 20 tons of material was contained by the enhanced support in the back and should of the drift. Most of the material in the shoulder and upper was was displaced but contained by the support. The material on the ground was mostly from the lower wall area. Crews were directed to refuge stations immediately following the event.

Cause:

None given.

Preventative Action:

None given.

Event ID:	1191684	RM	23-Dec-07	Stobie Mine: Underground

Incident:

On December 23, 2007, at 8:17 a.m., a seismic event occurred in the vicinity of 2990 far and 3015 far from 2340-3000 level. After the initial event, the seismicity continued. The foreman on shift investigated the area and found no damage to the accesses. There was approximately 15-20 buckets of muck found at the bottom of 2990 far.

Cause:

None given.

Preventative Action:

None given.