



CMD 26-M37 - CNSC Staff Submission

Event Initial Report Workplace Injury at Denison Mines Corp.'s Wheeler River Project

Classification	Unclassified
Type of CMD	Original
CMD Number	26-M37
Reference CMD(s)	N/A
Type of Report	Event Initial Report
Public meeting date	September 02, 2026
Summary	This Event Initial Report CMD is being presented to inform the Commission of a significant injury that took place at Denison Mines Corp.'s Wheeler River.
Actions required	There are no actions requested of the Commission. This CMD is for information only.



CMD 26-M37 – Mémoire du personnel de la CCSN

Rapport initial d'événement Blessure au travail à l'établissement de Wheeler River de Denison Mines Corp.

Classification	Non Classifié
Type de CMD	Version initiale
Numéro de CMD	26-M37
CMD de référence	S.O.
Type de rapport	Rapport initial d'événement
Date de la réunion publique	02 septembre 2026
Sommaire	Le présent RIE est soumis pour informer la Commission d'une blessure grave survenue sur le site de Wheeler River de Denison Mines Corp.
Mesures requises	Aucune mesure n'est requise de la Commission. Ce CMD est fourni à titre d'information seulement.



CMD 26-M37

Workplace Injury at Denison Mines Corp.'s Wheeler River Project

Signed by:

X

Nancy Greencorn, on behalf of Karen Owen-Whitred
Director General, Directorate of Nuclear Cycle and Facilities Regulation

EVENT INITIAL REPORT (EIR)

UNCLASSIFIED

4U5CDD9ZY1UU-1326229718-258

EIR: Workplace Injury at Denison Mines Corp.'s Wheeler River Project	
Prepared by: Uranium Mines and Mills Division	
Licensee: Denison Mines Corp.	Location: Wheeler River Project
Date Event was Discovered: 2026-07-13	Have Regulatory Reporting Requirements been met? Yes ☒ No ☐ Proactive Disclosure: Licensee: Yes ☐ No ☒ CNSC: Yes ☒ No ☐
Overview	
Reporting Criteria: Serious Health Incident; significant injury to any individual as a result of a licensed activity at a nuclear facility.	
Description: The following description was provided by Denison Mines Corp. (Denison) as part of their 21-day report on the incident: On 13 July 2026 at approximately 09:00, a contractor sustained a serious injury to two fingers (index and ring fingers) on their right hand while assisting with the adjustment of a 60-foot stacker during crusher setup activities at the Wheeler River Project crusher pad. The direct contractor work group consisted of four people: (1) Crusher foreman/equipment operator, the injured person (IP); (2) Labourer; (3) Sales/technical setup representative; and (4) Helper/crusher and loader operator. At the time of the incident, the crew was engaged in the setup of a newly mobilized rock crusher. During this activity, they determined that the head end of the 60-foot stacker feed conveyor needed to be elevated to allow proper alignment with the screener hopper. To adjust the stacker height, positioning T-pins securing the telescoping frame sections had to be removed and relocated in a different set of predrilled positioning holes designed into the frame. The original plan was to use an excavator equipped with a lifting harness to support the stacker during the adjustment, however, the crew elected to use a front-end loader instead. A bucket of a front-end loader was positioned under the frame at the top end of the stacker to raise and support the structure to take the weight off the pins. The first pin was removed successfully. The second pin was found to be bound under load and could not be removed. The crew then used a hammer/sledge to strike the bottom end of the bound pin while the loader bucket was raised and lowered in small increments to relieve the weight off the pin. While these activities were still underway, the IP gripped the T handle of the bound positioning pin and began to manually pull up on and twist the pin to remove it. While the IP was pulling on the pin, it partially released, clearing the positioning hole in the underside of the frame and the action of the frame members telescoping together caused the top end of the pin, with the T handle, to pivot downwards towards the surface of the frame due to the pressure on the pin shaft. This movement towards the frame trapped the IP's right-hand fingers (index and ring fingers) between the T handle and the steel frame. The other crew members realized that the IP's fingers were pinched between the T handle of the pin and the conveyor frame and used nearby tools to pry against the frame/pin to allow the IP to remove their hand. The IP was then transported to the onsite medical clinic for initial assessment. Following medical evaluation, it was determined that the injury required transport to the nearest hospital for further treatment. Below are pictures provided by Denison as part of their investigation:	

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Fig 1. Aerial reference photograph of the crusher pad showing the mobile crushing spread, 60-foot stacker, loader and adjacent equipment.

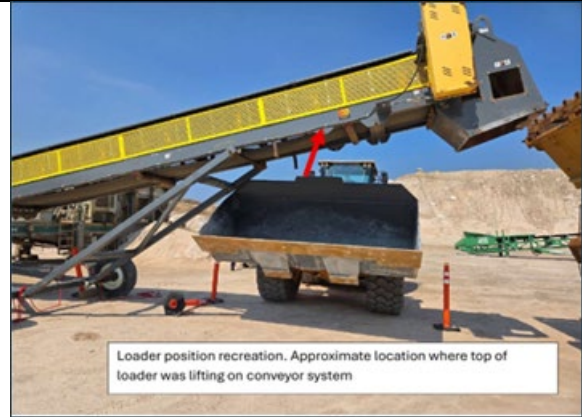


Fig 2. Post-incident view of the raised stacker head end with the loader bucket adjacent to the frame, illustrating the loader-to-stacker contact.



Fig 3. Workers' location at the time of incident



Fig 4. Recreated the IP's hand position at the pin lifting handle.



Fig 5 Close-up of the sliding support and the T pin arrangement.

Cause(s):

Causes determined by Denison included causal factors, immediate causes, and root causes.

Causal factors (CF):

CF1: The injured worker's fingers were positioned on the pin handle within the pinch point/line of fire during the removal attempt.

CF2: The retaining pin was removed while it remained bound and under load, with the stacker supported solely by a front-end loader bucket and no secondary mechanical support in place.

CF3: The crew continued work after the pin became bound without stopping to reassess hazards and controls.

Immediate Causes (ICs)

IC1: Failure to appreciate risk: the IP placed their fingers on the pin handle while a bound pin was being manipulated and while the loader bucket position was being adjusted. The pinch point and line-of-fire hazards were not fully recognized or appreciated

IC2: Unanticipated Exposure to Mechanical Hazards: the telescoping movement of the stacker frame and pin handle created a mechanical pinch/crush point which trapped the worker's fingers.

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IC3: Inadequate equipment: The stacker was being supported solely by a front-end loader bucket, with no evidence of secondary support such as cribbing, blocking, or jack stands. The support arrangement was inadequate for safely removing a load bearing positioning pin as it did not allow for continuous support of top end of stacker, or provide the ability for controlled, incremental adjustments of load heights.

Root Causes (RCs)

RC1: Inadequate employee selection: subcontractor responsible for the work did not supply experienced crew to work with sales representatives to facilitate install of the crusher.

RC2: Inadequate definition of accountability: No direct supervisory oversight assigned by the Contractor.

RC3: Inadequate System for Positive Engagement of Contractors: Responsibilities between the service provider and contractor personnel were not clearly delineated, including who was responsible for leading the task, authorizing changes to the work method, operating the loader, verifying competency, and providing supervision. This resulted in a lack of clear control and oversight during the execution of the task and when work conditions changed.

RC4: Inadequate Hazards Identification: the field level risk assessment (FLRA) and job hazard analysis (JHA) did not identify hazards associated with task at hand (e.g. stored energy, pinch points associated with frame movement, loader supported pin removal, etc); the JHA being used was intended for equipment lifts using an excavator and was not applicable to loader-supported pin removal or stacker height adjustment activities.

RC5: Inadequate identification of controls: The FLRA and JHA did not adequately identify the controls required to manage the hazards associated with retaining pin removal from a loaded stacker assembly. Specifically, the risk assessments failed to identify the need for secondary mechanical support (e.g., cribbing, blocking, or jack stands), safe hand positioning outside pinch points and line of fire areas, and control of stored energy,

RC6 Inadequate Management of Change: The crew deviated from the original plan of using excavator with rigging to adjust height of the stacker and therefore the JHA for equipment lifts using an excavator was no longer applicable for loader use. Additionally, the positioning pin became bound, resulting in a change to the planned work activity. However, the crew did not stop and reassess the associated hazards, risks, and required controls before proceeding with an alternative work method.

Impact of the Event

On People:

How many workers have been (or may be) affected? 1

Was there any impact(s) to any of the Indigenous Nations? ☐ Yes ☒ No

If yes, complete Indigenous Consultation section below. If not applicable, delete the row

How many members of the public have been (or may be) affected by the event? 0

How were they affected?

The incident resulted in a serious injury causing distal phalanx (fingertips above first joint) amputations to the IP's right index and ring fingers, requiring medical treatment and hospitalization resulting in Lost Time Incident. The investigation found that the incident had the potential to cause permanent impairment or long-term disability.

On the Environment: There was no impact from this event on the environment.

Other Implications: There was no impact from this event on other implications.

Licensee Actions

Taken or in Progress:

Denison took the following immediate actions (IAs):

IA1: The worker was accompanied to the on-site health centre for assessment and treatment, and then evacuated by helicopter to an off-site hospital with the Wheeler River project's on-site nurse

IA2: Denison notified the Duty Officer line on July 13, 2026, with the preliminary report provided on July 14, 2026

IA3: The site stood down all high-risk activities while the nurse was off-site

IA4: Denison initiated an investigation and root cause analysis

IA5: A 21-day follow-up report was submitted to the CNSC on August 4, 2026

Denison has taken the following corrective actions (CAs):

CA1: Develop and implement an original equipment manufacturer/engineering approved procedure for stacker height adjustment and pin removal, to be reviewed and approved by Project Internal Project Management Team. (note: Post investigation the crusher involved in incident was removed from site. The replacement crusher is outfitted with a hydraulic actuated conveyor positioning feature, which negates the use of pins and manual height adjustment).

CA2: Implement a project critical-control verification process/form for use of loader/excavator for lifting purposes.

CA3: Roll out a site-wide awareness campaign focused on Line-of-Fire hazards and controls.

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CA7: The contractor to conduct JHA/FLRA refresher training for all field employees.

CA8: Amend project Short Term Service Provider Onboarding procedure to include a documented field verification process by an Integrated Project Management Team Subject Matter Experts with Short Term Service Provider.

Planned:

CA4: Roll out awareness training on Wood Contractor Management procedure for all Contractor staff in management and supervisory positions. Target Completion is August 30, 2026.

CA5: Audit all existing project contractors against the Wood Contractor Management standard. Target Completion is August 30, 2026.

CA6: Verify task specific training and competences for subcontractor's crusher operation. Target Completion is August 21, 2026.

CNSC Actions

Taken or in Progress:

A CNSC inspector observed the site of the incident during a planned inspection the day after the incident. The inspector's findings are in-line with the report provided by Denison.

CNSC staff reviewed the full 21-day event report submitted by Denison on August 17, 2026, and found Denison's corrective actions to be acceptable.

Planned:

Verification that the corrective actions have been adequately implemented as well as Wheeler River's safety culture will be part of upcoming planned CNSC inspections.

A summary of the event will be posted to the CNSC website.

CNSC staff will continue oversight of the facility in conjunction with Saskatchewan Labour Relations and Workplace Safety.

Additional reporting to the Commission Members anticipated:

☐ Yes

☒ No

If Yes, provide method of reporting: N/A