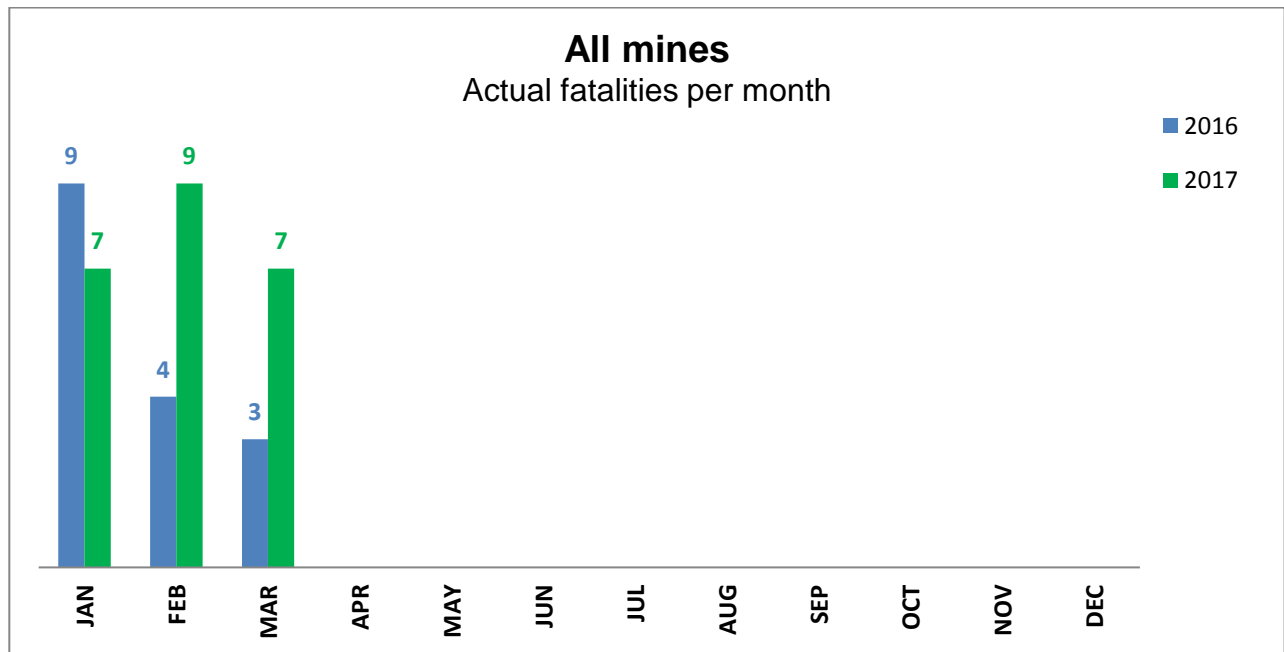




1. OVERALL FATALITIES PER MONTH

During the month of March 2017, **seven (7)** fatalities were reported whilst during the same period in 2016 a total of **three (3)** mine workers were fatally injured. This translates to an increase in fatalities of 133% year on year.



2. STATISTICS OF FATALITIES BY REGION

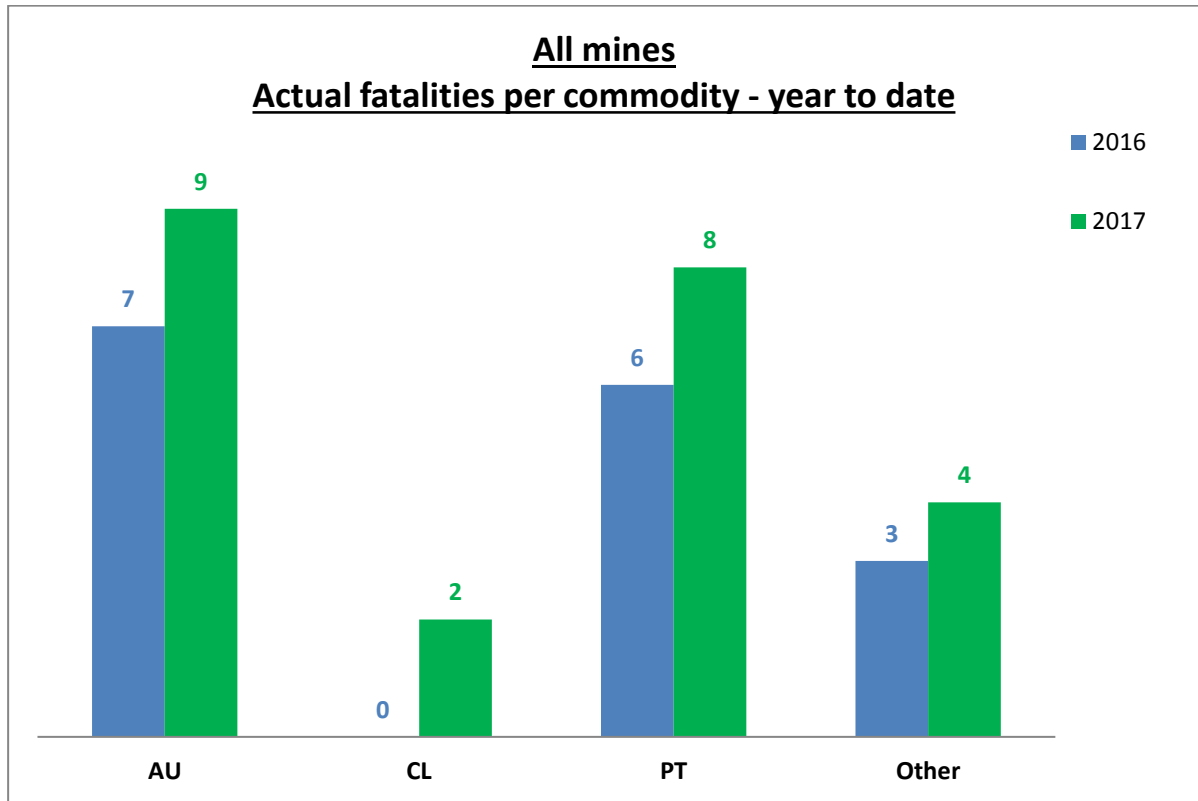
The table below illustrates the progressive performance of each region with regard to fatalities. During the month of March 2017, **four (4)** of the **ten (10)** regions managed to mine without a fatality. The Northern Cape, Eastern Cape, Kwa-Zulu Natal and North West (Klerksdorp) regions last reported a fatality on 09/11/2016, 11/10/2015, 05/02/2015 and 25/07/2016 respectively.

	WC	NC	FS	EC	KZN	MPU	LP	GP	NW-KD	NW-RB	TOT
Jan	2	0	1	0	0	1	0	1	0	2	7
Feb	0	0	3	0	0	1	1	2	0	2	9
Mar	0	0	1	0	0	2	2	0	0	2	7
Total	2	0	5	0	0	4	3	3	0	6	23

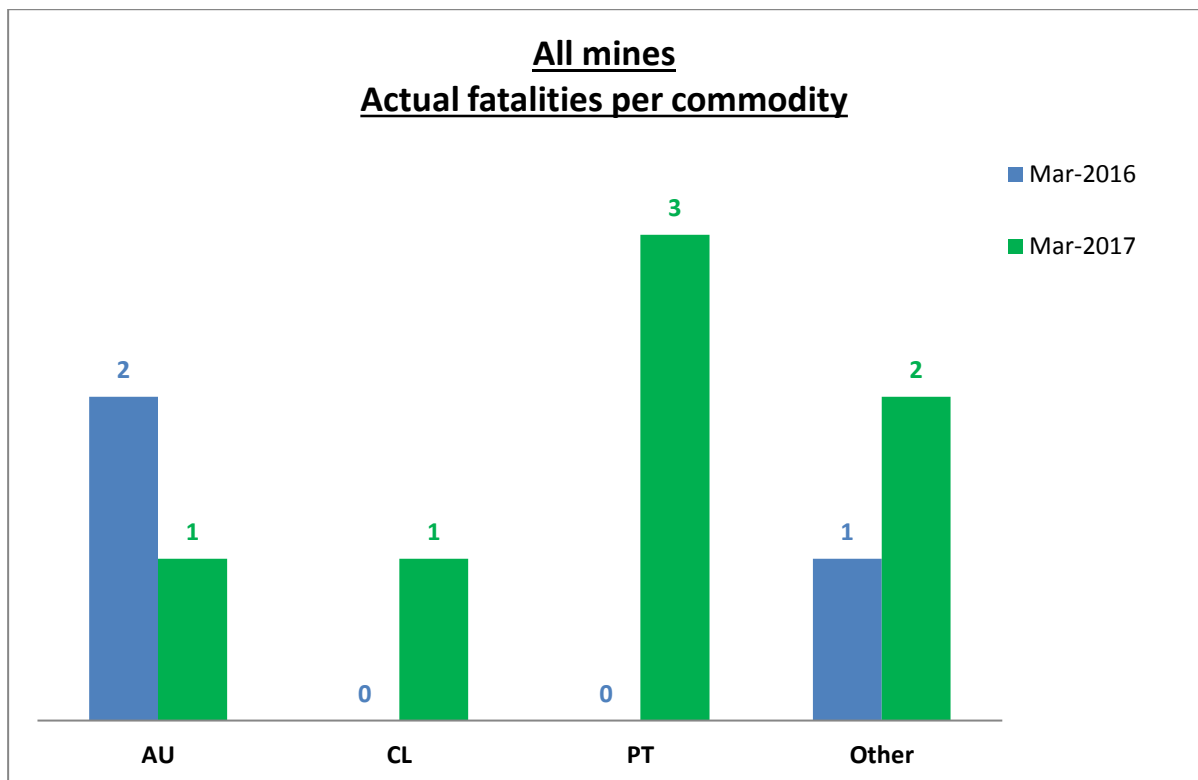
3. ANALYSIS OF FATALITIES BY COMMODITY

For the purpose of the analysis, commodities are grouped into gold (AU), platinum (PT), coal (CL) and other mines (i.e. chrome, manganese, diamonds, stone, sand, brickworks, etc.).

- 3.1 The comparison of fatalities year to date for March 2016 and 2017 are reflected on the graph below and shows an increase in fatalities in the gold, coal, platinum and other mines sectors of 29%, 200% 33% and 33% respectively.

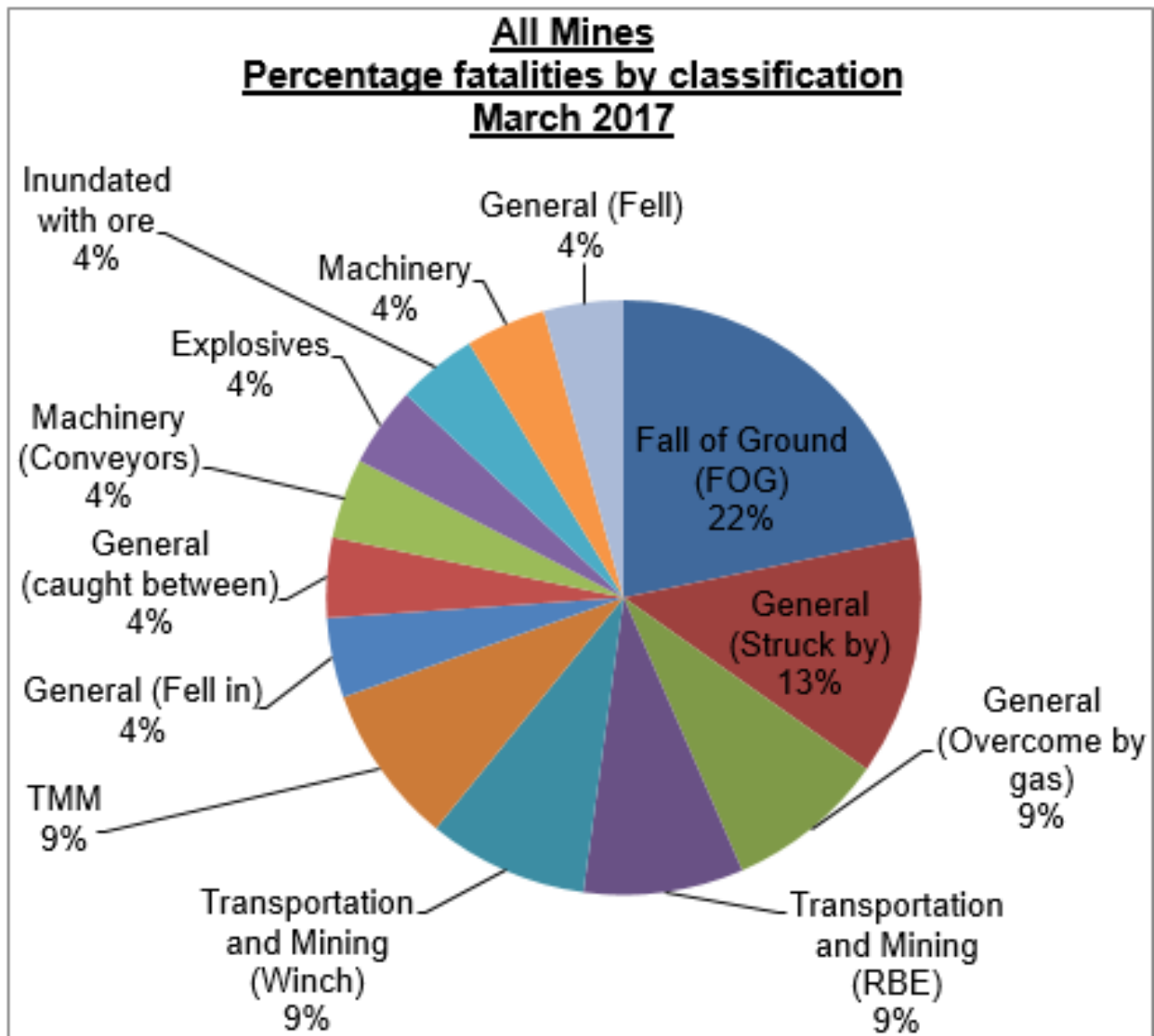


3.1 In March 2017, the gold, coal, platinum and other mines sectors reported **one (1)**, **one (1)**, **three** and **two (2)** fatalities respectively.





4. ANALYSIS OF FATALITIES BY CLASSIFICATION



4.1 FOG (Fall of Ground) (22%)

There were **five (5)** fatalities reported in this category this year. **Two (2)** were reported in March 2017, both at platinum mines. In the first accident, the now deceased an employee was fatally injured in a fall of ground accident. Details were not yet available. In the second accident, the now deceased a Miner was fatally injured and a Rock Drill Operator survived with critical injuries from the FOG accident during early entry examination.

4.2 General (Struck by) (13%)

There were **three (3)** fatalities reported in this category this year, all in the gold mines. None were reported in March 2017.



4.3 General (Overcome by gas) (9%)

There were **two (2)** fatalities reported in this category this year, both at a refinery. None were reported in March 2017.

4.4 Transportation and Mining (RBE (Rail Bound Equipment)) (9%)

There were **two (2)** fatalities reported in this category this year at a gold mine and a platinum mine each. None were reported in March 2017.

4.5 Transportation and Mining (Winch) (9%)

There were **two (2)** fatalities reported in this category this year at a gold mine and a platinum mine each. None were reported in March 2017.

4.6 Trackless Mobile Machinery (TMM) (9%)

There were **two (2)** fatalities reported in this category this year and **one (1)** was reported in March 2017 at a chrome mine. The now deceased a Security Officer was fatally injured as a result of being run over by a haul truck whilst standing between the trailers.

4.7 General (Fell in) (4%)

There was **one (1)** fatality reported in this category this year at a gold mine. None were reported in March 2017.

4.8 General (Caught between) (4%)

There was **one (1)** fatality reported in this category this year in March 2017 at a coal mine. The now deceased an Artisan Aide was fatally injured when he was caught between the belt drive that they were pulling with a Load Haul Dumper and another belt drive structure that was in the adjacent split. The belt drive that was being pulled got stuck against another structure. The now deceased was trying to free it when he ended up being caught between the two structures.

4.9 Machinery (Conveyors) (4%)

There was **one (1)** fatality reported in this category this year at a colliery. None were reported in March 2017.

4.10 Explosives (4%)

There was **one (1)** fatality reported in this category this year. None were reported in March 2017.



4.11 Inundated with ore (4%)

There was **one (1)** fatality reported in this category this year. One (1) was reported in March 2017. The now deceased a Loco Driver was injured when he had entered a 'cas&jack' box from the top to bar down a rock that was obstructing the ore. It released and he was caught inside the box. He was covered with ore and was removed from the front. He was brought to surface, still had a pulse and taken to hospital where he later passed away.

4.12 Machinery (4%)

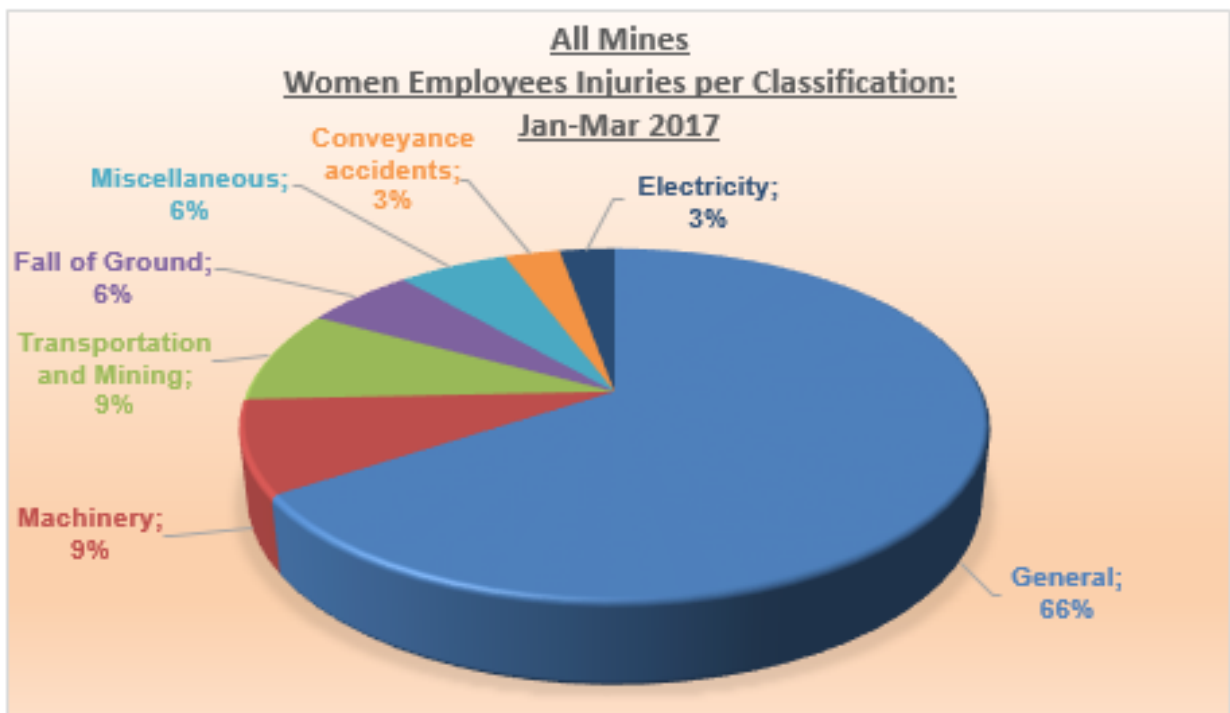
There was **one (1)** fatality reported in this category this year in March 2017, at a diamond mine. The now deceased a Boilermaker Assistant was fatally injured when he was dragged along in a revolving mud pan.

4.13 General (Fell) (4%)

There was **one (1)** fatality reported in this category this year in March 2017, at a platinum mine. The now deceased a Truck Driver succumbed to his injuries in ICU on 13 March 2017. He had fallen and severely injured his skull on 27 January 2017. He had been in ICU since then until his passing.

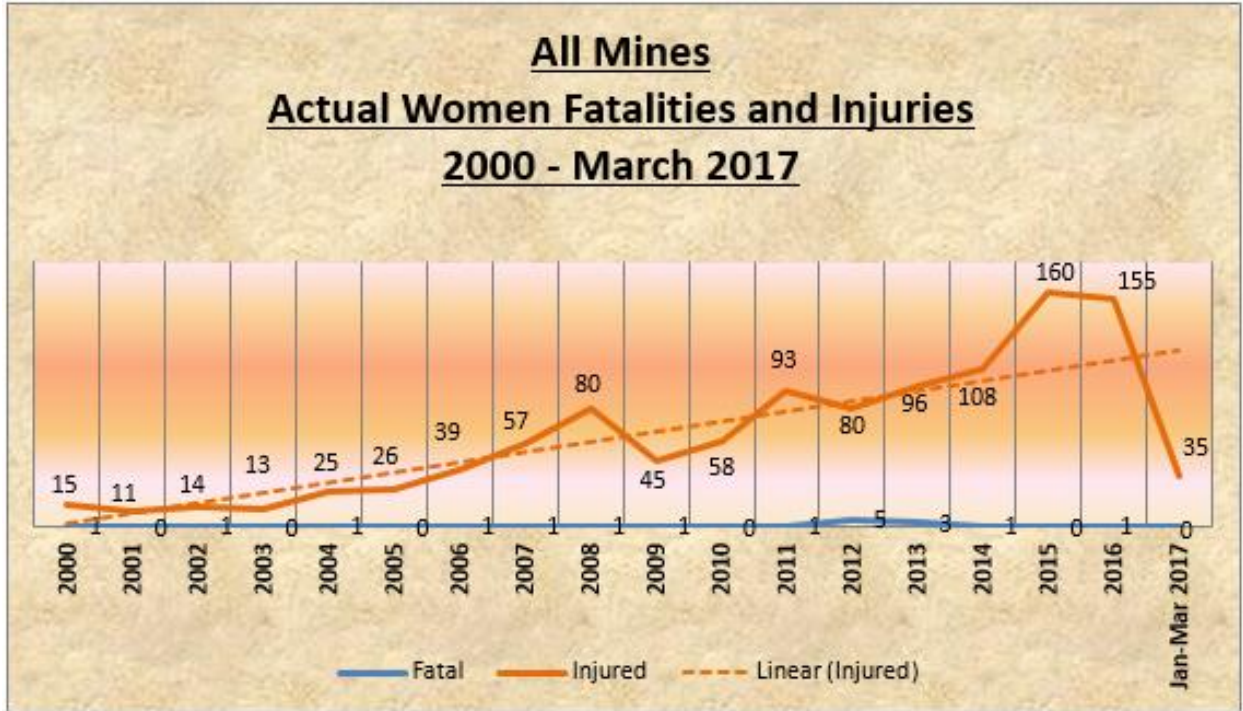
4.10 Women Employees

The number of women employees has steadily increased in the South African mining industry and the graph below shows a classification of injuries to women employees across all commodities from 2000 to March 2017:

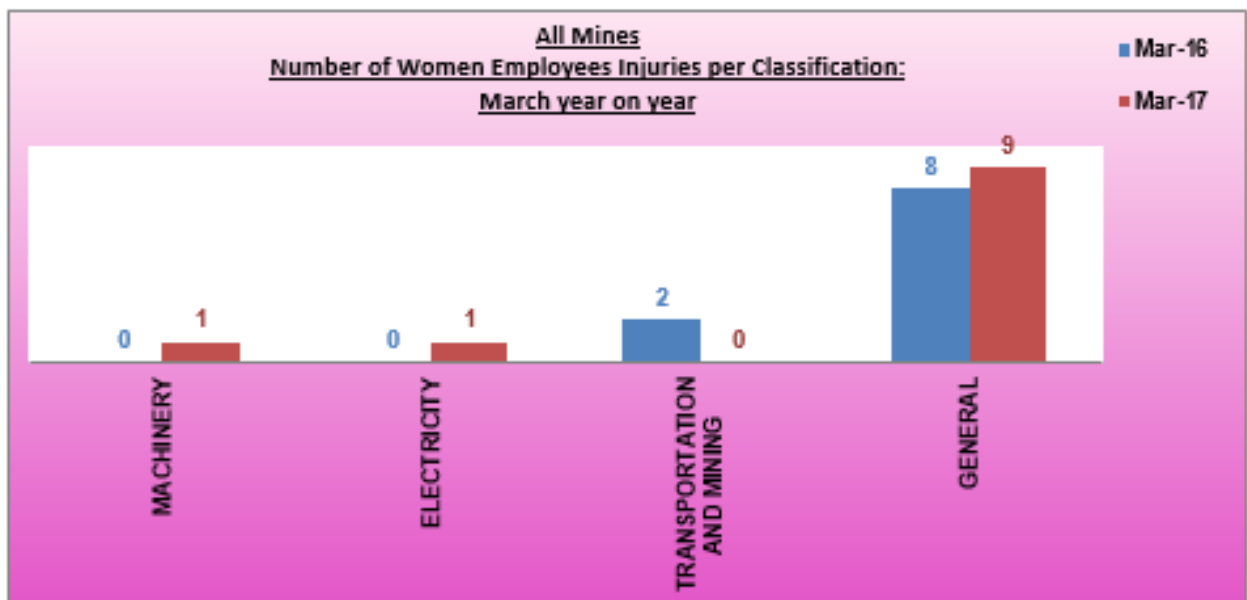




The graph below shows the number of injuries and fatalities to women employees across all commodities since 2000 to March 2017:



The graph below shows the comparison of injuries to women employees across all commodities in March 2016 and March 2017:





5. FATALITIES AND INJURIES

5.1 FATALITIES

	Jan-Mar 2016	Jan-Mar 2017
Gold Mines	7	9
Anglo Gold Ashanti	1	0
Western Deep Levels East	1	0
Sibanye Gold	4	2
Beatrix 3 MU1	0	2
Cooke 3	0	0
Ezulwini	1	0
Rand Uranium	1	0
Kloof	1	0
Beatrix West Unit 3	1	0
Gold Fields	0	2
South Deep: Twin Shaft	0	2
Harmony	2	2
Masimong	2	1
Bambanani	0	1
Other Gold Mines	0	3
Evander Gold Mine	0	1
DRD Gold: Ergo Mining	0	1
Fairview Gold Mine	0	1
Platinum Mines	6	8
Impala	5	3
20 Shaft	0	1
Marula Platinum-Clapham Shaft	0	1
1 Shaft	0	1
14 Shaft	5	0
Lonmin		2
K3 Shaft	0	1
Newman Shaft	0	1
Other Platinum Mines	1	3
Northam Platinum	0	1
Atlatsa Resources	1	1
Sibanye Platinum	0	1



	Jan-Mar 2016	Jan-Mar 2017
Coal Mines	0	2
Other Coal Mines	0	2
Bankfontein Colliery	0	1
Matla Colliery	0	1
Other mines	3	4
Mosselbaai Refinery	0	2
Kolomela	1	0
Sishen	1	0
Blaaubosch Diamond Mine	0	1
Sefateng Chrome	0	1
PPC	1	0
TOTAL	16	23

5.2 MINE INJURIES

The table below reflects the number of injury accidents that were reported for January to March 2016 and 2017 per the classification of the accident.

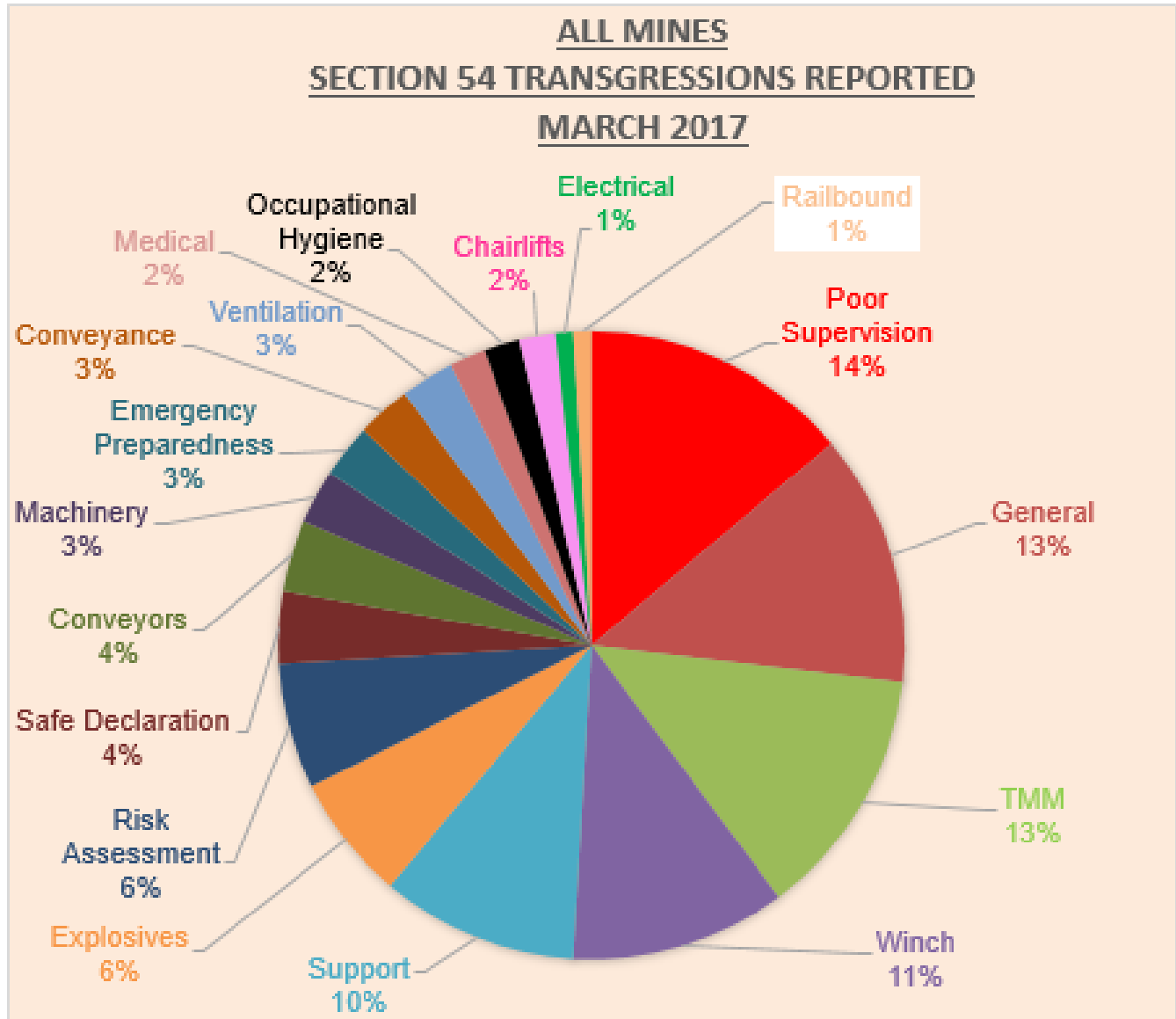
	INJURIES		
	Jan-Mar 2016	Jan-Mar 2017	%change
FALL OF GROUND	114	99	-13
Rockburst	16	14	-13
Strainburst	11	6	-45
Gravity	87	79	-9
MACHINERY	40	52	30
Conveyor belts	9	13	44
Drives, belts, chains	4	6	50
Portable power tools	24	25	4
Other	3	8	167
TRACKBOUND TRANSPORT	52	34	-35
Locomotive	18	7	-400
Locomotive drawn vehicle	12	12	0
Rerailing	3	0	-200
Coupling/uncoupling	8	4	-50
Rocker arm shovel	3	4	100
Personnel transport	3	3	0
Hand trammed	4	2	-50
Other Transport	1	2	100
WINCHES	23	30	30
Scraper Winch Installation	19	22	16
Single drum winch	0	3	300



	Jan-Mar 2016	Jan-Mar 2017	%change
Double drum winch	3	2	-33
Mono rope/rail	1	3	200
TRACKLESS MOBILE MACHINES	38	26	-32
Mechanical loaders	5	4	-20
Tractor/trailer	1	2	100
Coal mining machines	1	0	-100
Transporters	10	9	-10
Motor vehicles	5	1	-80
T&M lifting machines	8	4	-50
T&M mobile drilling machines	7	5	-29
Other TMM	1	1	0
GENERAL	356	330	-7
Fall of material/rolling rock	49	58	18
Manual handling of material	116	104	-10
Manual handling of mineral	10	17	70
Falling in/from	14	7	-50
Slipping and falling	110	86	-22
Burning and scalding	9	10	11
Splinters	9	7	-22
Dust, gas and fumes	2	12	500
Struck by ventilation door	2	3	50
Struck by any object manual handling	35	26	-26
Conveyance accidents (shaft/winze)	8	11	38
Electricity (Not causing fires)	5	2	-60
Fires	2	0	-100
Explosives	3	2	-33
Occupational Disease	1	0	-100
Heat sickness	0	1	100
Miscellaneous	21	26	24
TOTAL	662	613	-7



6. SECTION 54 TRANSGRESSIONS REPORTED DURING THE MONTH



6.1 Poor Supervision (14%)

This category of transgressions accounted for most of the section 54 transgressions observed in March 2017 and the areas covered were:

- key control procedure was not adhered to in that operators could access keys at any time without verification of the operator;
- a pegmatite vein was identified by the rock engineering department and instruction / recommendations given but the recommendations were not followed;
- employees were allowed to work without a Team Leader for more than three days;
- poor ground conditions were not escalated to the rock engineering department;
- the employer had failed to supply health and safety equipment in line with Mine Health and Safety Act Section 6(1), (2) and (3);



- the employer had failed to provide PPE (Personal Protective Equipment) in line with Mine Health and Safety Act Section 11.(2) (d)(i) and (ii);
- two instructions given by the Inspector related to explosives storage were not adhered to;
- the employer had not compiled and submitted Codes of Practice for Minimum Standards to Perform Work at a Mine and Management of Medical Incapacity due to ill health;
- the employer had not compiled and submitted Codes of Practice for Minimum Standards to Perform Work at a Mine and Management of Medical Incapacity due to ill health;
- the waiting place notice board was not updated with statutory reports;
- poor key control for machines that were on breakdown was observed;
- the Mine Health and Safety Act Section 3.1(a) appointee's area of responsibility was too large for him to handle;
- poor visitor's site induction system and improper implementation of chrome transporters safety checklist were observed;
- there was no control over the issuing and receiving of the lifting equipment - items were not signed in and out from the issuing register book; and
- water accumulations at the travelling ways were observed. Shiftboss' log books for night shift and day shift were inspected and there was no recording of the accumulation of water in travelling ways.

6.2 General (13%)

The areas covered in this category of transgressions were:

- employees could not demonstrate the correct understanding of the COP on Fatigue Management, thereby leading to its miss-application;
- employees were working without Personal Protective Equipment (PPE);
- poor face preparation was observed as the procedure was not followed;
- poor barring was observed;
- there was no life line or procedure for operators working on the crusher;
- handrails were missing and not to standard;
- excessive water was coming out of box number 2 and 3 at the crosscut;
- dangerous scaling was observed around the tip;
- slippery road conditions were observed in the decline;
- accumulation of water and mud were observed in the travelling road;
- an old adit was not fenced off to prevent any unauthorised entry or access;
- the bi-annual illumination report at the waiting place was incorrectly reporting the type of lighting installed and lux reading. There was no light installation at waiting place;
- excessive ore accumulation was observed in the gullies; and
- loose rocks were barred down at the travelling way during inspection.

6.3 TMM (Trackless Mobile Machinery) (13%)

The areas covered in this category of transgressions were:

- an employee had not followed the lock out procedure on the TMM;



- several dump trucks were found with damaged air conditioning systems, brake testing was not conducted as required, pre-use checklist was not marked on brakes items and the Operator did not have his operating licence in his possession whilst operating;
- the drill rig was found with no water available for the dust suppression system on the machine, damaged air conditioning system, such that the Operators opened their cabin whilst operating, strobe light was found not working but the rig was used;
- an Articulated Dump Truck was found working with one light in order, illumination of TMM's was not verified and the mine had a night shift;
- the pre-use checklist for the Dozer was marked showing all items were in order but the reverse hooter was found not functional;
- poor brakes maintenance was observed;
- poor key control for TMMs was observed;
- a Proximity Detection System was not detecting the machine and persons;
- a TMM Operator was found using a licence from another mine;
- a TMM Operator was not using the corrective lenses as recommended by the Occupational Medical Practitioner;
- the Proximity Detection System of a LHD was found not to detect other vehicles and persons, another LHD was found to have oil leakage and brakes had locked;
- Operators of two Excavators were operating without any authorisation or licences;
- one key of a TMM could be used to operate any other TMM of the same name; and
- employees' transport mini bus was also used to transport employees to the pit but the mini bus did not follow the brake test procedure.

6.4 Winch (11%)

The areas covered in this category of transgressions were:

- no illumination and poor housekeeping around the winches were observed;
- there was no proof of face winch declaration form provided when requested;
- there was no code of signals posted up at the winch cubby, bulb to illuminate the winch was not working and had been reported by the Winch Operator for the past five days, loose strands on the winch rope were observed and wires were used on the winch handles instead of approved clips;
- another winch was not locked out by the day and night shifts, there were loose strands on the winch rope and wires were used on the winch handles instead of approved clips;
- a winch was found not locked out, drum guards were not sufficiently bolted on the winch, loose strands were observed on the winch rope and wires were used on winch handles instead of mine approved clips;
- another winch screen or guard was holed (a hand could fit through), loose strands were observed on the winch rope, wires were used on winch handles instead of mine approved clips and drum guards were not sufficiently bolted on the winch;
- winch bell wires were not installed throughout the scraper path and four winches were found not locked;
- the winch bell wires were not installed on the other side of the scraper path, the winch bell wires were not installed in the Advanced Strike Gully (ASG), tip barricade was secured with wires, tip barricade was not covering the entire tip area, winch was not



locked, ropes were not connected to the scrapers and electrically powered, the ASG winch was not locked and the centre gully winch was not locked;

- a winch was not locked, winch barricade was not effectively installed, there was water accumulation in the winch cubby, the winch checklist had not been over-inspected by the supervisor for the previous four days and bell wires were not installed on either side of the scraper path;
- key control on winches was not adhered to during night shift operations in that a Miner had collected all shaft winch keys and the keys were returned by another employee;
- substandard rigging of winch snatch blocks was observed; and
- face winch at BA 39, panel 3 signalling device of a face winch was not extended along the full scraper path.

6.5 Support (10%)

The areas covered in this category of transgressions were:

- support was missing on the centre line/raise line for a distance measured to be 30m deep and 3.5 m strike between two panels;
- the face was marked for drilling but temporary support was 2.5m, 1.7m and 2.1m to the abutment pillar;
- the safety nets were not installed and drilling of the in-stope bolting had commenced 6.7m from the Advanced Strike Gully side wall;
- the last line of hydra-bolts spacing on dip was measured to be 2m, 2.1m, 1.8m, 1.7m apart and the last being 3.7m from the abutment;
- the last line of elongate support on dip was measured to be 2.9m from the breaker line to the next elongate was measured to be 3.2m;
- the clusters on the gully shoulder were missing in that in some areas only one elongate was installed instead of three;
- missing support was observed in several locations;
- support was measured at 1.2m and 1.5m from the face instead of 1.0m before the blast;
- roofbolts installed in the raiseline were measured at 55° whilst the standard required 70° to 90° angle of installation, missing or blasted out pack support elements were not replaced, brows measured 0.9m were not supported 0.5m on both sides and limit support was not installed in the stopped panel;
- more than six holes were drilled under unsupported hanging wall, top corners of the sidewall were not supported and damaged Oslo straps were not replaced; and
- Rock Drill Operators were drilling without installing mechanical jacks and drilling was done under unsupported roof with the safety net installed three meters from the toe of the face.

6.6 Explosives (6%)

The areas covered in this category of transgressions were:

- four green stope fuses with detonators were found inside an old unlocked explosives box;
- an explosives car was found underground containing 12 bags of 25 kg each and the car was sent down 21 days ago;



- explosives boxes were not marked properly next to the number one and two ventilation door, Anflex explosives box was not secured at the crosscut;
- the secondary cluster of explosives boxes at the crosscut were secured with wires against mine standard of chain or clamps;
- at least 5 holes were marked closer than 15cm from sockets;
- the Miner had left explosives inside the elephant bag which was not locked and left unattended; and
- four green stope fuses with detonators were found inside an old unlocked explosives box.

6.7 Risk Assessment (6%)

The areas covered in this category of transgressions were:

- tally clerk was observed in the vicinity of moving machinery in the pit area and there was no risk assessment done for the use of tally clerk;
- risk assessment was not conducted for change of mining direction;
- the employer had failed to assess and respond to risks in line with Mine Health and Safety Act Section 11.(1) (a) and (b);
- the employer had failed to assess and respond to risks in line with Mine Health and Safety Act Section 11.(1) (a) and (b);
- employees and supervisors had failed to identify the loose rock that eventually dislodged from 4.75m above them and injuring one employee on the right elbow, right leg and knee;
- employees were not part of the start-up risk assessment and issue based risk assessment had not been conducted; and
- the Trackless Mobile Machinery issue based risk assessment was not clearly addressing the activities of chrome transporters' interaction with employees at the stock pile and loading areas.

6.8 Safe Declaration (4%)

The areas covered in this category of transgressions were:

- no proof of safe declaration were provided for two panels when requested;
- a mining block was declared safe but it was observed that the stand-off distance barrier was not extended the full length of the block whilst employees were working on the block;
- a panel had not been declared safe during entry examination; and
- incorrect and incomplete safe declaration was observed.

6.9 Conveyors (4%)

The areas covered in this category of transgressions were:

- a conveyor was being operated with a missing pulley guard, mud rush rollers were running on the mud and substandard rollers were noted on the Operator's checklist on numerous occasions;
- there was no lockout procedure in place for the conveyor belts;
- the walkway along the conveyor belt was in bad condition; and



- a conveyor belt was having a broken pigtail for the trip wire and underpass screens were not installed where employees were passing.

6.10 Machinery (3%)

The areas covered in this category of transgressions were:

- lifting equipment were not being inspected, or tagged out for quarterly inspection;
- defective safe sling was observed in the workshop; and
- load test certificates for lifting equipment were not available.

6.11 Emergency Preparedness (3%)

The areas covered in this category of transgressions were:

- the escape route plan posted on the Assembly Point/Green Area was not as per site arrangement;
- two refuge bays had no emergency numbers and refuge bay procedure board was not displayed. Escape route plan was found out dated since June 2015, there was only one ablution facility provided in refuge bays to cater both male and female employees, three Shiftboss' log books were inspected and no entry was made regarding the inspection of refuge bays in the sections; and
- emergency shower in the battery bay was not working.

6.12 Conveyance (3%)

The areas covered in this category of transgressions were:

- the man winder Humble Hook attachment had not been changed out as required on a six monthly basis as per the mine's Humble Hook Record Book;
- the rock winder Humble Hook attachment had not been changed out as required on a six monthly basis as per the mine's Humble Hook Record Book; and
- the man and rock winders humble hooks attachments were not changed out on a six monthly cycle as required by the mine standards to be annealed and read with regulation 16.18 in force as per schedule four of the Act.

6.13 Ventilation (3%)

The areas covered in this category of transgressions were:

- inadequate ventilation was observed at the last holing; and
- a fan was found circulating;
- the Advanced Strike gully had advanced 9.4 meters without ventilation, no fan was installed.



6.14 Medical (2%)

The areas covered in this category of transgressions were:

- Category 4 and 5 employees were issued with medical certificates without doing all required medical examinations; and
- there were no measures to ensure that medical surveillance provided information to determine measures to prevent, detect and treat occupational diseases.

6.15 Occupational Hygiene (2%)

The area covered in this category of transgressions were:

- temperatures were measured 33/35⁰ C and 33/37⁰ C in a working place; and
- temperatures were measured 35/38⁰ C where the crew was in the process of installing the cooling car.

6.16 Chairlifts (2%)

The area covered in this category of transgressions were:

- reverse phase relay was found to be malfunctioning; and
- broken strands wires were observed and the rope was severely damaged, there were anomalies indicated after splice and the rope had been recommended to be removed from service.

6.17 Electrical (1%)

The area covered in this category of transgressions was that the blasting box was secured with wires and electrical wires were exposed.

6.18 Railbound (1%)

The area covered in this category of transgressions was that rails were covered by mud and water, water was leaking out of three boxholes and a locomotive was tramming whilst rails were not exposed, covered by mud and water.

7. OCCUPATIONAL MEDICINE Quarter 4 of 2016/17 (January – March 2017)

7.1 Overall occupational diseases/illness per quarter

During Q4 of 2016/17 (January-March 2017), a total of **898** occupational diseases were reported from the health incident reports (HIRs), when compared to **1939** occupational diseases reported Q4 of 2015/16.



7.2 Analysis of occupational disease trends by region

There is an overall decrease of **53.6% (54%)** in the total occupational diseases/illness reported from regions Q4 of 2016/17 when compared to the total occupational diseases/illness reported during Q4 of 2015/16.

The table below illustrates the progressive performance of each region with regards to occupational diseases/illness reported on HIRs. During Q4 of 2016/17 (Jan-March 2017), Gauteng region reported most occupational diseases followed by North West Rustenburg, Free State, Mpumalanga, North West Klerksdorp, Northern Cape, Limpopo, KwaZulu-Natal and Western Cape regions respectively. During Q4 of 2015/16 (Jan-March 2016), Gauteng reported most occupational diseases, followed by Free State, North West Rustenburg, North West Klerksdorp, Northern Cape, Mpumalanga, KwaZulu-Natal, Limpopo and Western Cape regions. No occupational disease/illness was reported from the Eastern Cape region during both quarters.

7.3 Analysis of Health Incident Reports per common disease group

7.3.1 Pulmonary tuberculosis (PTB)

Pulmonary tuberculosis (PTB) cases reported during Q4 of 2016/17 show a decrease of **56%** compared to cases reported during the same Q4 of 2015/16.

7.3.2 Silicosis

Silicosis cases reported during the current Q4 of 2016/17 have decreased by **58%** compared to cases reported during Q4 of 2015/16.

7.3.3 Noise-induced hearing loss (NIHL)

Noise-induced hearing loss (NIHL) cases reported during the current Q4 of 2016/17 show a decrease of **56.11% (57%)** compared to cases reported during Q4 of 2015/16.

7.4 Conclusion

The analysis of occupational diseases reported from health incident reports during Q4 of 2016/17 show a significant decrease when compared to cases reported during the same



Occupational Health and Safety Report: March 2017

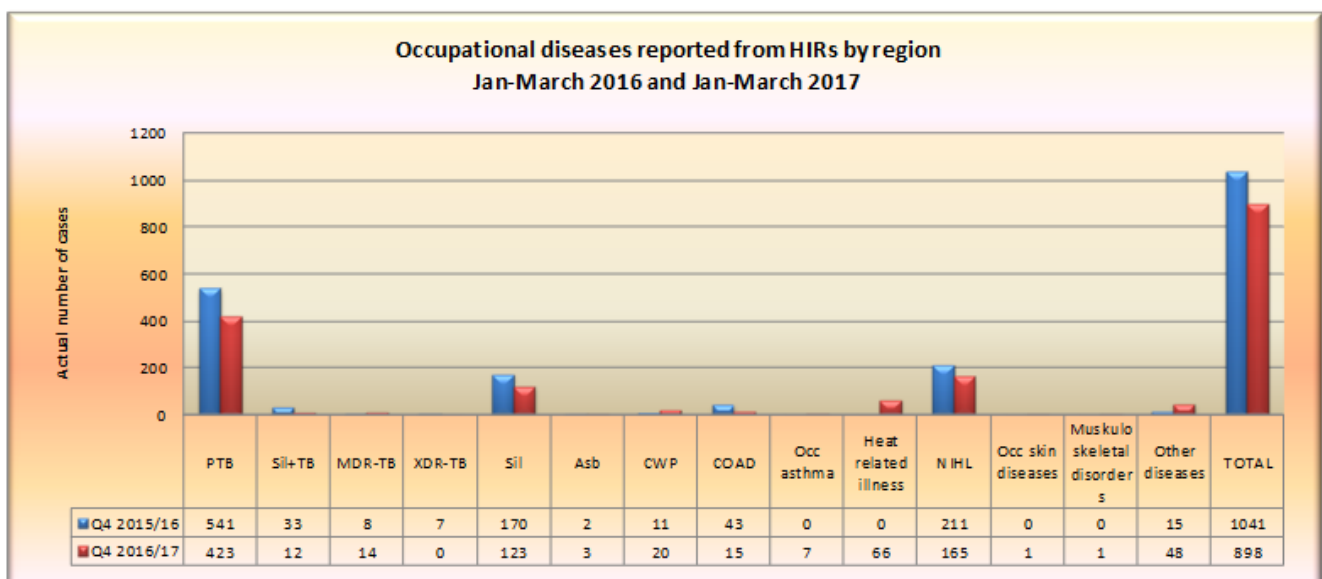
quarter of 2015/16. All occupational diseases/illness reported from health incident reports are based on the system of medical surveillance, which mines do not conduct during the period.

Table 7.2.1 Occupational diseases/illness reported on Health Incident Reports (HIRs) by region:
Q4 2015/16 (Jan-March 2016) and Q4 2016/17 (Jan-March 2017)

	Health Incident Reports by Region																						Total	Total	% CHANGE TOTAL
	EC		FS		GR		KZN		LP		Mpu		NC		NW (K)		NW (R)		WC		2016	2017			
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017			
PTB	0	0	111	101	241	111	8	2	9	6	31	19	16	23	35	11	88	150	2	0	964	423	-56		
Sil+TB	0	0	4	5	11	6	0	0	0	0	0	0	0	0	9	1	8	0	1	0	45	12	-73		
MDR-TB	0	0	2	1	2	7	0	0	0	0	0	2	2	0	0	0	2	3	0	1	22	14	-36		
XDR-TB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	7	0	-700		
Sil	0	0	90	70	34	26	4	0	0	0	0	2	0	0	34	17	8	8	0	0	293	123	-58		
Asb	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	1	0	1	0	5	3	-40		
CWP	0	0	0	0	0	6	0	0	0	1	10	13	0	0	0	0	1	0	0	0	31	20	-35		
COAD	0	0	15	0	14	6	0	0	0	1	5	4	1	1	7	0	1	3	0	0	58	15	-74		
Occ Asthma	0	0	0	2	0	1	0	0	0	2	0	2	0	0	0	0	0	0	0	0	7	7	0		
Heat Illness/Stroke	0	0	0	0	0	58	0	0	0	0	8	0	0	0	0	0	0	0	0	0	66	66	0		
NIHL	0	0	6	0	27	31	9	2	5	6	9	12	43	9	35	10	73	92	4	3	376	165	-56		
Occ Skin Dxs	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0		
Muskulo-skeletal Disorders	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	0		
Other Dxs	0	0	0	0	8	37	0	0	1	0	0	1	1	2	5	8	0	0	0	0	63	48	-24		
Total	0	0	228	180	337	289	21	4	15	17	55	64	63	37	125	47	189	256	8	4	1939	898	-54		

Verification source: Health Incident Reports submitted by 9 regions: Jan-March 2015/16 and Jan-March 2016/17

Table 7.2.2 Occupational diseases reported from the Health Incident Reports (HIRs): Quarter 4 of 2015/16 & 2016/17





8. STATUS REPORT ON THE MINE HEALTH AND SAFETY COUNCIL (MHSC) AWARD SCHEME 2017

Table 8.1 Mines that have achieved the safety awards:

No	Mine	Award	Date recorded	Last fatality
1	Impala Platinum 14 Shaft	Million (1)	24/02/2017	23/01/2016
2	Mototolo Platinum: Lebowa	Thousand (9)	07/03/2017	Never
3	Thornccliffe Mine	Thousand (10)	14/03/2017	28/11/2007