GOVERNMENT NOTICES

DEPARTMENT OF MINERAL RESOURCES

No. R. 89 **11 February 2011**

MINE HEALTH AND SAFETY ACT, 1996 (ACT NO 29 OF 1996)

REGULATIONS RELATING TO MACHINERY AND EQUIPMENT

I **S SHABANGU** Minister of Mineral Resources under section 98 (1) of the Mine Health and Safety Act, 1996 (Act No. 29 of 1996), after consultation with the Council, hereby amends the Regulations in terms of the Mine Health and Safety Act, as set out in the Schedule.

S SHABANGU

MINISTER OF MINERAL RESOURCES

Mine Health and Safety Act, 1996
Proposed Regulations for health incident report.

11.8 REPORTABLE OCCUPATIONAL DISEASES

11.8.1)

The employer must report to the office of the Principal Inspector in the manner prescribed in this section any of the following occupational diseases that are as a result of working in the mining enviroment. These diseases are also compensable through ODMWA (occupational disease in mines and works Act) or COIDA (compensation for occupational injuries and disease Act).

a) Any occupational lung disease that is reportable and compensable in terms of ODMWA or COIDA. This will cover:
   1. Cardio respiratory tuberculosis and silicotuberculosis
   2. All pneumoconiosis(silicosis and coal worker's pneumoconiosis)
   3. Asbestos related lung disease with proven exposure to asbestos in the working environment.
   4. Carcinoma (cancer) of the lung with proven exposure to environmental hazards at the mine.
   5. Chronic obstructive airways disease

b) Noise induced hearing loss that is reportable (PLH shift of 5% or more).

c) Any other occupational disease as covered by the COID Act or ODMWA and other illnesses that may impact on the health and safety of employees, required by the Medical Inspector from time to time through an instruction by the Chief Inspector Of Mines.

11.8.2)

OCCUPATIONAL DISEASES ARE REPORTABLE CONSIDERING THE FOLLOWING:

a) **SILICOSIS/ COALWORKER'S PNEUMOCONIOSIS (CWP)**

A radiological diagnosis of silicosis/ cwp is made considering:

- History of significant exposure to airborne silica/coal dust(especially pertaining to the gold/coal mines) and
- A chest X-Ray consistent with silicosis/ cwp (without other clinical explanation like milliary TB)
- Or lung tissue pathology consistent with silica/cwp exposure if histology has been done.

b) **CARDIORESPIRATORY TB (TUBERCULOSIS)**

Any tuberculosis affecting the lungs and or the heart muscles whereby:

- The employee was affected with the disease while performing risk work in the mines
- The employee contracted the disease within 12 months after leaving employment.

c) **OTHER OCCUPATIONAL LUNG DISEASES**

1. Any other occupational lung disease with significant correlation with the risk in that particular mine, which are also compensable under ODMWA or COIDA.

d) **NOISE INDUCED HEARING LOSS**

An impairment of hearing as a result of exposure to excessive noise in industry considering:

- Percentage loss of hearing(PLH) shift of >/=5% from baseline
- Or PLH of more than 5% where baseline is unknown or regarded as zero

11.8.3)

1) An occupational disease incident referred to in paragraph (a), (b) or (c) of regulation 11.8.1 must be reported to the PI within 30 days from the time of diagnosis and entered on DMR 90 form (Annexure 2)

2) All DMR90 forms must be submitted once every two months for all persons diagnosed with a reportable occupational diseases which were diagnosed in that period.

DMR 90

DEPARTMENT: MINERAL RESOURCES

HEALTH INCIDENT INPUT FORM

A. DETAILS OF EMPLOYER

Current Employer: _____ SAMRASS Code: _____

Mine code: _____ _____

_____

_____ _____ _____

Employer's address: _____ _____ _____

_____

B. PERSONAL DETAILS OF AFFECTED EMPLOYEE

SA ID Number/ passport No: _____ _____

Industry No: _____ PF Number: _____

TEBA No: _____ COY No: _____

Surname: _____ First Names: _____

Date of Birth: _____ / _____ / _____ Date of Death: _____ / _____ / _____

(dd / mm / yyyy) (If applicable) (dd / mm / yyyy)

Gender: male ☐ Female ☐

Working place: .....

Occupation.....

C. DETAILS OF DISEASE (GENERAL)

Date Examined: (or Diagnosed) _____ / _____ / _____ (dd / mm / yyyy) Type of work associated with disease: _____

Disease Group: NIHL ☐ PNEU ☐ CRTB ☐ COAD ☐ HEAT ☐ OTHER ☐

Disease: 1. _____ (e.g. Silicosis) ICD 10 Code: _____

2. _____ (If applicable) ICD 10Code: _____

Is the disease to be submitted for compensation? YES ☐ NO ☐

E. DETAILS OF SUBMISSION FOR COMPENSATION													
Date Submitted (dd / mm / yyyy													
Disease Caused Death: YES			NO										
Employment Status Changed: YES			NO		Date:		/		/				
					(dd / mm / yyyy)								
Which Compensation House/Bodies? (e.g. Compensation Commissioner, MBOD OR RMA)													

F. DESCRIBE THE WORK THAT LED TO THE DISEASE (if thought to be caused by exposure to an agent, e.g. a specific chemical, mention the agent)

G. EMPLOYMENT HISTORY RECORD

COMPANY NO.	NAME OF MINE/WORKS	TYPE OF MINE (e.g. Gold, Coal, Platinum)	OCCUPATION (e.g. Miner/ Stoper)	OCCUPATIONAL HAZARDS EXPOSED TO (e.g. Dust, Noise)	DATE STARTED	DATE ENDED
					MM YYYY	MM YYYY
					MM YYYY	MM YYYY
					MM YYYY	MM YYYY

H. GENERAL DETAILS

Person submitting:

Surname: _____ Name: _____

Date: | D | D | M | M | Y | Y | Y | Y | Telephone No.: _____

Diagnosing doctor:

Surname: _____ Name: _____

Occupational medicine inspector:

Surname: _____ Name: _____

Occupational hygiene inspector:

Surname: _____ Name: _____

Signature of submitting person: ----------

Date: ----------

PLEASE RETURN THE COMPLETED FORM TO:

The Medical Inspector: Occupational Health Directorate, DMR, Trevenna campus, Private Bag X59, Arcadia, 0007
Tel: (012) 444-3614,
C/o Regional inspectors of medicine
NOTE: Please refer to the attached User Guideline when completing this form.

USER GUIDELINE ON HEALTH INCIDENT REPORT FORM

A. DETAILS OF CURRENT EMPLOYER

- **All relevant information pertaining to part A should be filled.**

B. PERSONAL DETAILS AFFECTED EMPLOYEE

- **ALL** available information on personal details as per section B of the DMR 90 Form to be filled

C. DETAILS OF DISEASE (GENERAL)

- *Date Diagnosed*: The date when the disease was diagnosed or confirmed.
- *Disease Group*: Indicate the appropriate disease group with an "X".
- *Disease*: Indicate which disease/s the employee is suffering from.
- *Separate forms are required if more than one disease is diagnosed per case*
- *Disease Group and specific Disease Code* : Fill in the ICD 10 codes from table below:

ICD 10 code list for occupational diseases

Disease Group	Disease Code	Specific Disease	Disease Group	Disease Code	Specific Disease
H 83.3 Noise Induced Hearing Loss	H83.2	Noise Induced Hearing Loss	**Other Occupational Diseases**	J 44	Chronic obstructive airways disease
Exposure to electric current radiation and extreme temperature and pressure	W94	Baro trauma in miners Only for deep see mining	Respiratory conditions due to chemicals, gases fumes and vapours	J 68	RADS J68.9
Pneumoconiosis	J 65.0	Silicosis with Tuberculosis		J 45	Occupational Asthma
	J 62.0	Silicosis		J 70	Occupational lung diseases
	J 60.0	Coal Workers Pneumoconiosis	Hard metal pneumoconiosis	J 63	i.e. aluminosis
	J 61.0	Asbestosis		J 80	Adult respiratory distress syndrome
	C 45	Malignant Mesothelioma		J67.9	Extrinsic Allergic

Disease Group	Disease Code	Specific Disease	Disease Group	Disease Code	Specific Disease
					Alveolitis
Lung cancer	C34	Asbestos related lung cancer		J68.4	Bronchiolitis obliterans
Tuberculosis			Accidental injury & poisoning	X 30	Heat Exhaustion
A 15 Respiratory tuberculosis, bacteriologicaly and histologicaly confirmed	A 15.0	Tuberculosis of lung, confirmed by sputum microscopy with or without culture		T 78	Heat stroke
	A 15.1	Tuberculosis of lung, confirmed by culture only		T 58	Asphyxiation due to carbon monoxide
	A 15.2	Tuberculosis of lung, confirmed histologicaly	Toxic effects of metals T56 T57	T 56.3	Any disease due to cadmium
	A 15.3	Tuberculosis of lung, confirmed by unspecified means		T56.0	Any disease due to lead
	A 15.4	Tuberculosis of intra-thoracic lymph nodes, confirmed bacteriologically and histologically		T56.1	Any disease due to mercury
	A 15.5	Tuberculosis of larynx, trachea and bronchus, confirmed bacteriologically and histologically		T57.2	Any disease due to manganese or cyanide
	A 15.7	Primary respiratory tuberculosis, confirmed bacteriologically and histologically		T57.2	Chronic manganese poisoning
			And radiation	W 88	Any disease due to Ionising Radiation
	A 15.9	Respiratory tuberculosis unspecified, confirmed bacteriologically and histologically	Cancer	C34.0	Lung cancer
A 16 Respiratory tuberculosis, not confirmed bacteriologically and histologicaly	A 16.0	Tuberculosis of lung, bacteriologically and histologically not confirmed		J 68.5	Platinises
	A 16.1	Tuberculosis of lung, bacteriological and histological examination not done		J92.0	Pleural plaques or thickening
	A 16.2	Tuberculosis of lung, without mention of bacteriological and histological confirmation		M34.0	Scleroderma
	A 16.3	Tuberculosis of intra-thoracic lymph nodes, without mention of bacteriological and histological information		M 34.0	Progressive systemic sclerosis

Disease Group	Disease Code	Specific Disease	Disease Group	Disease Code	Specific Disease
	A 16.4	Tuberculosis of larynx, trachea and bronchus, without mention of bacteriological and histological confirmation		I 30.0	Pericardites
	A 16.5	Tuberculosis pleurisy, without mention of bacteriological and histological confirmation	Respiratory condition due to other external agents	J70.0 J70.1	Acute pulmonary manifestation due to radiation Chronic and other pulmonary manifestation due to radiation
	A 16.7	Primary respiratory tuberculosis without mention of bacteriological and histological confirmation	Does not have code added new code to J 68	J 68.5	Platinum salt sensitivity
	A 16.8	Other respiratory tuberculosis, without mention of bacteriological and histological confirmation	Upper respiratory	J 34..8	Oral/Nasal cavity erosions
	A 16.9	Respiratory tuberculosis unspecified, without mention of bacteriological and histological confirmation			
	I 39.8	Tuberculosis of Endocardium		L 25	Contact dermatitis
	I 41.0	Tuberculosis of Myocardium	Skin disease	L24	Irritant contact dermatitis
	K23.0	Tuberculosis of Oesophagus	Musculoskeletal disorders such as	M75.1	Rotator cuff
	I32.0	Tuberculosis of Pericardium	Repetitive strain injuries RSI du to occupation	M75.0	Frozen Shoulder
A19 **Miliary tuberculosis**	A 19.0	Acute miliary tuberculosis of a single specified site	Should have codes	W 43	Hand-arm vibration syndrome (dual codes
	A 19.1	Acute miliary tuberculosis of multiple sites	Depending on the location of injury	M70.0	Carpal tunnel Syndrome
	A 19.2	Acute miliary tuberculosis, unspecified	Accidental injury codes S for specific sites	S46.0	Injury to shoulder not specified
	A 19.8	Other miliary tuberculosis		S49.9	Injury to shoulder
	A 19.9	Miliary tuberculosis, unspecified			

D. DETAILS OF SUBMISSION FOR COMPENSATION

- *Date Submitted*: Date on which the compensation claim was submitted.
- *Disease Caused Death*: State whether the employee died as a result of the disease.
- *Employment Status Changed*: State if the employee's occupation has changed as a result of the disease.
- *Date*: Indicate the date from which the employee's employment status has changed.
- Compensation houses: Rand Mutual Assurance, Workmen Compensation Commissioner or Medical Bureau for Occupational Diseases

E. DESCRIBE WORK THAT LED TO THE DISEASE

- Describe the work done by the person that might have lead to the disease.
- If the disease is thought to be caused by exposure to an agent, mention the agent
- Give any other information which is relevant to the diagnosed disease.

F. EMPLOYMENT RECORD HISTORY

- *Type of Mine*: state main commodity of this mine i.e. gold, coal, platinum, diamond
- *Occupation*: Job done by affected person
- *Occupational Hazards Exposed to*: list any of the following: dust, noise, radiation or any specific chemical person was exposed in this job/occupation
- All other information required as per the table

SECTION 11.2 OCCUPATIONAL HEALTH REGULATIONS:

11.2 The annual medical report contemplated in section 16(1) must include details regarding at least the following:

(a)(i) Name of mine

(ii) Name, address and telephone number of the occupational medical practioner responsible for compiling the annual medical report.

(b) Type of mine. Commodity or commodities being mined.

(c) Total number of employees (including contract workers) who were subject to medical surveillance in terms of section 13 during the reporting period and the total number of hours worked by those employees.

(d) The number of initial, periodical and exit examinations conducted as part of the medical surveillance system.

(e) An analysis of the employee's health based on the employee's records of medical surveillance, without disclosing names of employees.

(f) Comments on the future direction of the medical surveillance system.

(g) The number of employees certified for compensation for occupational diseases.

[11.2 inserted by G.N.R. 1486 of December 1999]

OCCUPATIONAL HEALTH REGULATIONS

Section 11.2 (Annexure3) has been deleted and will be replaced by the following:

11.2
The employer must submit Annual Medical reports as contemplated in section 16.1 of the MHSA using DMR 91 Forms (annexure 4)

Draft Revised Annual Medical Report Form

DMR 91

mineral resources

Department:
Mineral Resources
REPUBLIC OF SOUTH AFRICA

DRAFT

ANNUAL MEDICAL REPORT FOR THE YEAR 200---

(Mine Health and Safety Act, Act No. 29 of 1996 Sec 2(1) and Sec 16)

1. MINE DETAILS

A. Mine Name: _____

B. Mine Code/ SAMRASS Code: _____ **Province:** _____

Physical Address of Mine:

_____

_____

_____

Type of Mine:

2.1 Description of Mine (Underground/Surface/Quarry/Brickworks): _____

_____

2.2 Commodity or Commodities being mined: _____

2. EMPLOYEE DETAILS

A. TOTAL NUMBER OF ALL EMPLOYEES----------
B. TOTAL NUMBER OF PERMANENT EMPLOYEES----------
C. TOTAL NUMBER OF CONTRACTOR EMPLOYEES----------
D. TOTAL NUMBER OF OFFICE EMPLOYEES----------
E. NUMBER OF HOURS WORKED BY EMPLOYEES SUBJECT TO MEDICAL SURVEILLANCE

3. OPERATIONAL RISKS TO HEALTH

Draft Revised Annual Medical Report Form

A. PROCESSES AT MINE- ATTACH SCHEMATIC DIAGRAM WITH BRIEF EXPLANATION

B. RISKS ASSOCIATED WITH THE PROCESSES- TABULATE

C. SIGNIFICANT RISKS RELEVANT IN THE OMP'S OPINION

4. ANALYSIS OF EMPLOYER'S HEALTH IN TERMS OF MEDICAL SURVEILLANCE

Medical Surveillance

	Company Employees
No. of Initial Medical Examinations	
No. of Periodical Medical Examinations	
No. of Exit Medical Examinations	

In terms of the above examinations, the following were found to be unfit:

INITIALS

A. No of initials found unfit----------

B. Key issues for unfitness

C. How many have lodged a section 20 appeal?

PERIODICALS

A. No of periodicals found unfit----------

Draft Revised Annual Medical Report Form

B. Key issues for unfitness

_____

_____

_____

_____

C. How many have lodged a section 20 appeal?----------

EXITS

A. Reasons include:

- Medical incapacity-(give a number)----------

- Retrenchment/retirement/resignation --(give a number)----------
- Labour relations issues --(give a number)----------

B. How many have lodged a section 20 appeal? ----------

5. OCCUPATIONAL DISEASE SUBMITTED AND CERTIFIED FOR THE REPORTING PERIOD

OCCUPATIONAL DISEASE	TOTAL NUMBER DIAGNOSED IN THE REPORTING YEAR				NUMBER SUBMITTED			NUMBER CERTIFIED		
	ICD 10 code	Company Employees	Contract Employees	Total	Company Employees	Contract Employees	Total	Company Employees	Contract Employees	Total

6. ANALYSIS- TAKING THE ABOVE INTO CONSIDERATION:

_____

_____

ALSO COMMENT ON:

Draft Revised Annual Medical Report Form

- **Measures taken to promote health**

- **Measures taken in assisting employees in matters relating to health**

8. Number of persons whose occupation has changed as a result of:

8.1 Occupational disease ☐ 8.2 Occupational accident ☐

9. Number of persons whose employment was terminated as a result of:

9.1. Occupational disease ☐ 9.2. Occupational accident ☐

ANY FURTHER COMMENTS NOT ADDRESSED ABOVE

. Particulars of Responsible Occupational Medical Practitioner:

1.1 Name: _____

1.2. Postal Address: _____

1.3. Tel. No. _____

Signature of Occupational Medical Practitioner

Date _____