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The Industrial Injuries Advisory Council

Proceedings of the 12th Public Meeting

27 June 2013
Southampton

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Foreword

The twelfth Public Meeting of the Industrial Injuries Advisory Council (IIAC) was held in Southampton on 27th June 2013. This event built on the previous successes of the Public Meetings held around Great Britain over the past 11 years.

These meetings allow members of the Council to hear directly from interested members of the public and for the public to get a much better understanding of the Council's work. This Public Meeting proved an informative occasion for the Council with a number of topics being brought to our attention. I would like to thank all members of the public who came to the meeting for contributing to the lively discussions which made the occasion so worthwhile. As always, important issues were raised, which the Council and the Department for Work and Pensions (DWP) will consider going forward.

IIAC is a non-departmental public body that advises the Secretary of State for Work and Pensions and the Department for Social Development (DSD) in Northern Ireland on the Industrial Injuries Scheme. The DWP and DSD are responsible for the policy and administration of the Scheme. IIAC is independent of the DWP and the DSD. It is supported by a Secretariat provided by the DWP and endeavours to work cooperatively with Departmental officials in provision of its advice.

This document is a record of the Southampton public meeting and covers events and discussions up to June 2013. However, this report should not be taken as guidance on current legislation, or current policy within the DWP or DSD, as members may have expressed personal views, which have been recorded here for information.

Professor Keith Palmer
Chairman IIAC

Agenda

Registration

09:45 – 10:30	**Welcoming Remarks** Chairman of IIAC – Professor Keith Palmer
	Followed by:
	IIAC's approach to scientific decision making Chairman of IIAC – Professor Keith Palmer
	Work of Scientific Advisor – Dr Marianne Shelton
10:30 – 11:00	**Discussion and questions**
11:00 – 11:30	Break
	Presentations:
11:30 – 11:50	**Presumption** – Richard Exell
11:50 – 12:10	**Medical assessments** – Claire Sullivan
12:10 – 12:30	**Discussion and questions**
12:30 – 13:30	Lunch
	Presentations and open forum:
13:30 – 13:50	**Occupational chloracne** – Dr Ira Madan
13:50 – 14:10	**Terminal prescribed diseases** – Professor Paul Cullinan
14:10 – 14:30	**Breast cancer and shift work** – Professor Damien McElvenny
14:30 – 15:00	**Open forum** – Paul Faupel
15:00 – 15:15	**Closing remarks** – Fergus Whitty
15:15	End of public meeting

Welcoming Remarks

Professor Keith Palmer
Chair of IIAC

1. Professor Keith Palmer welcomed everyone to the Southampton Public Meeting and the IIAC members introduced themselves.

2. The Industrial Injuries Scheme provides non-contributory, no-fault compensation which principally includes Industrial Injuries Disablement Benefit (IIDB). This is paid to people who become ill as a consequence of a workplace accident or an occupational or 'prescribed' disease. These terms have specific legal meanings and have been refined by case law. A workplace or 'industrial accident' is defined as "an unlooked for occurrence" or "mishap" arising "out of and in the course of employment". A prescribed disease is one that is associated with an occupational cause and which is listed in the Scheme's regulations; IIAC uses a specific approach to check for this.

3. The Scheme compensates employed earners; the self-employed are ineligible to claim IIDB for work-related ill-health or injury. Claimants can receive benefit from ninety days after the accident or onset of the prescribed disease; shorter periods of disablement are not compensated.

4. Certain prescribed diseases are given the benefit of 'presumption' – if a claimant is diagnosed with a disease and had an appropriate exposure then it is presumed that their occupation has caused the disease; the rule is complicated, however, and the Council is currently reviewing this topic.

5. The Scheme compensates for "loss of faculty" and its resultant "disablement", as compared to an age- and gender-matched person as assessed by medical advisers engaged by the Department. Assessments of disablement are based on loss of function, rather than loss of earnings and are expressed as a percentage. Thresholds for payment are applied, such that in general, payments can be made if disablement is equal to, or greater than, 14%. The exceptions to this are pneumoconiosis and byssinosis where payment can be made if disablement is 1% or more and occupational deafness where the threshold for payment is 20% disablement. Assessments of disablement for accidents and prescribed diseases can be aggregated (i.e. the process whereby two or more concurrent assessments are added together to produce one award of benefit).

6. IIAC is a statutory body, established under the National Insurance (Industrial Injuries) Act 1946, to provide independent scientific advice to the Secretary of State for Work and Pensions and to the Department for Social Development (DSD) in Northern Ireland on matters relating to the IIDB Scheme or its administration. The members of IIAC are appointed by the Secretary of State after open competition, and consist of a Chairman, scientific and legal experts, and an equal number of representatives of employers and employees. Officials from the Health and Safety Executive (HSE) and relevant policy divisions of the DWP,

Ministry of Defence and DSD attend IIAC meetings to provide information and advice. There are four meetings of the full Council per year.

7. The majority of IIAC's time is spent providing advice to the Secretary of State on the prescription of occupational diseases. IIAC's other roles are to advise on proposals to amend regulations under the Scheme, to advise on matters referred to it by the Secretary of State, and to advise on general questions relating to the IIDB Scheme. The Council has no involvement in decision-making of individual claims.

8. A permanent sub-committee of the Council, the Research Working Group (RWG), monitors and reviews medical and scientific literature to identify developments in the field of occupational ill-health which are then brought before the Council. This work is supported by a Scientific Adviser. The RWG meets four times a year.

9. IIAC also investigates diseases following referrals from the Secretary of State, correspondence from MPs, medical specialists, trade unions, and others, including topics brought to its attention by its own members and by other stakeholders.

10. IIAC produces several different types of publication. Command Papers are reports that are presented to Parliament by the Secretary of State for Work and Pensions, often forming the basis of legislation (the reports are produced by 'command' of Her Majesty). Position Papers are published on important subjects that IIAC has considered, but where it does not recommend prescription or where the matter has not been referred by the Secretary of State. Commissioned research reports may be published from time to time, funding permitting, and are instigated at the request of the Council. These reports are carried out by an independent third party, usually by an academic expert, following a bid via open competition, and are used to provide a research analysis of a specific area of the Council's work programme. Finally, IIAC publishes an annual report and the proceedings from its Public Meetings.

11. IIAC's current and recent work programme includes, by way of examples, reviews of vibration-related Dupuytren's contracture, comparisons between international lists of occupational diseases and the IIDB list of prescribed diseases, benefits for the terminally ill, the presumption rule and medical assessments of disablement.

IIAC's approach to scientific decision making

Professor Keith Palmer
Chair of IIAC

12. How does IIAC decide which conditions to prescribe? There is a legal framework for this and the Council is bound by the requirements set out in the Social Security Contributions and Benefits Act 1992. The disease must be a risk of the occupation and not a risk common to all persons, and attribution of the disease to the occupation in an individual case must be capable of being established or presumed with reasonable certainty.

13. Some occupational diseases are relatively simple to verify in that they have unique clinical features that can be ascertained and relatively rarely occur outside work. Examples of 'easy' cases are specific poisonings and mesothelioma; also, occupational asthma and contact dermatitis, where challenge with the suspected occupational agent confirms the diagnosis. On the other hand, where a disease is common in the general population and has no clinical features that are unique to occupational cases, it is much more difficult to establish a link between the occupation and the disease. Both back pain and stress are examples of 'tough' cases to verify and attribute as being caused by occupation. At the 'tough' end, judgements depend on assessment of the probabilities from the scientific literature rather than specific medical tests.

14. When considering a disease for prescription, IIAC has to address the question of attribution, i.e. whether there is a link between the job and the disease that can be presumed with reasonable certainty. For the purposes of the Scheme, IIAC interprets 'reasonable certainty' as meaning 'more likely than not' – the civil law standard of proof. Epidemiology is the branch of medicine that deals with the distribution and determinants of disease in human populations and IIAC applies epidemiological principles when considering prescription.

15. In epidemiological terms 'more likely than not' can be represented mathematically as an attributable fraction (i.e. the percentage of cases caused by an occupational exposure, assuming a causal relationship). 'More likely than not' means, for those with the exposure, an attributable fraction greater than 50%. Imagine we have two groups of equal size (for example 1000 in each group), an exposed group and a non-exposed group. Imagine there are 100 cases in the exposed group and 50 cases in the non-exposed group. Then it is clear that there is an exact doubling of risk in the exposed group (100 per 1000 vs. 50 per 1000). Also, the total risk in the exposed group can be split into two parts (i) the 50% that is due to the background risk common to all persons (ii) the 50% excess risk that is due to exposure. If the excess were slightly more (more than a doubling of risk) then it would also be the case that the disease was 'more likely than not due to the exposure'.

16. IIAC's task is to determine whether there is good evidence that the risk of a particular disease is more than doubled in a group with defined occupational exposure. If the answer to this question is yes, then IIAC would recommend that the disease is prescribed with the intention that the exposure is presumed to have caused the disease in an exposed worker on the basis of the defined group's probability.

17. The Council has already recommended prescription for several diseases where the process of attribution to occupation has been complex. These diseases include Vibration-induced White Finger (VWF), carpal tunnel syndrome, chronic bronchitis and emphysema and osteoarthritis (OA) of the hip in farmers.

18. In order to establish whether there is a more than doubling of risk of a disease attributable to a particular occupation, IIAC looks to scientific research and academic experts for evidence. It is important that the evidence comes from more than one independent, good quality study, and ideally several studies of different design, since this reduces the likelihood of methodological problems resulting in error or bias, and of any decisions being overturned by the results of future research. The occupational circumstances also have had to have affected UK employed earners (at least in the past, if not presently).

19. Practically speaking, it is also important that the disease and the relevant exposures can be easily verified and that the disease is a cause of significant impairment.

Osteoarthritis of the hip in farmers – an illustrative example of decision making in practice

20. Professor Palmer outlined IIAC's scientific decision making in practice, using OA of the hip in farmers as an example.

21. OA of the hip is common in the general population and has a similar clinical appearance in farmers to other people. An increased incidence of osteoarthritis in farmers was first suspected as this occupational group appeared on hip surgery waiting lists more often than expected given the relative high numbers of farmers in the population. This observation in itself was not proof that farmers were more at risk of OA of the hip, since the data could have arisen because farmers presented themselves to hospital for treatment more readily (their livelihood depends on their ability to perform physically demanding work). However, this observation was followed by additional research which concluded that the disease was more common in farmers.

22. In one line of inquiry, researchers used X-rays which displayed the hip joints but which had been taken for other diagnostic purposes (e.g. to look for kidney disease). The frequency of farming was considered in those with and without hip OA. Studies from the University of Southampton and research groups in Sweden showed that there was between a two-fold to 10-fold increased risk of OA of the hip in farmers. In this research the problem of 'volunteering' bias was limited since the comparisons were made among people who had not been selected on the basis of their care-seeking for hip disease.

23. The consistent demonstration of a greater than doubling of risk in multiple surveys from more than one country and across a range of study types allowed the attribution of OA of the hip in farmers to their occupation on the balance of probabilities.

24. Verification of OA of the hip is straightforward since there are well-defined diagnostic criteria. Professor Palmer showed pictures of X-rays of normal hips and an osteoarthritic hip. An osteoarthritic hip is characterised by a narrowing of the joint space between the pelvic socket (acetabulum) and the head of the femur (thigh bone), and roughened joint surfaces. Bony spikes and bone cysts may also be present. Thus the disease can be confirmed, can be disabling, and has been shown to be at least twice as common in farmers as in other comparable groups.

25. The Council then had to consider an exact definition of the occupational criteria for exposure – the definition of farming and whether particular types of farming carried special risks. No evidence was found on which to restrict prescription to a defined sub-category of farming activity; evidence was additionally found on the necessary duration of exposure.

26. OA of the hip in farmers fulfilled the criteria necessary to attribute a disease that is common in the general population to a particular occupation. Thus, IIAC recommended that OA of the hip be added to the list of prescribed diseases for those a) employed for at least 10 years in aggregate as a farm worker or farm manager and b) having osteoarthritis of the hip* or having had it prior to hip surgery (*as diagnosed by a specialist and based on a painful hip with restricted movement and on a hip joint radiograph).

27. As part of the review, OA of the hip in other occupations (such as those involved in heavy lifting) was also considered, but the strength of evidence was much lower than for farming. IIAC regularly monitors emerging scientific literature on this and other issues and reviews the terms of prescription where necessary. Future advances in research may enable the prescription for OA of the hip to be widened. The case of OA in farmers illustrates the nature and level of evidence the Council needs in prescribing for the “tough” cases as defined in paragraph 13.

Work of the Scientific Advisor
Dr Marianne Shelton

28. Dr Marianne Shelton outlined the work of the scientific advisor. The scientific advisor is a member of the IIAC Secretariat; the Secretariat are DWP staff who support the Council in its work. The scientific advisor provides a range of scientific services.

29. One of the key roles for the scientific advisor is searching for evidence to provide information to inform IIAC's reviews. This can involve undertaking literature searches of international, peer-reviewed research papers published in respected scientific journals, searching the 'grey literature' (information published generally in non-peered reviewed reports, newspapers, online, etc.). Evidence may also be collected by consulting with experts in the field or making direct calls for evidence, for example through advertising in the Society for Occupational Medicine newsletter or on the IIAC website. The Council can also make targeted calls for evidence to individuals or organisations. For example, in a recent review of noise-induced hearing loss and the use of road breakers, the Council made calls for evidence to several large construction companies and to the members of the Institution for Occupational Safety and Health.

30. Undertaking literature searches for the Council is an important part of the scientific advisor's role. This generally involves using the PubMed research database run by the National Institute of Health in the US. This is a free web-based archive of biomedical and life sciences journal literature, containing over 1.5 million reports from over 450 journals.

31. The main reason literature searches are conducted is to provide evidence of increased risks for occupational diseases and their exposures for IIAC reviews. Searches may be done at the start of a review, to scope out what evidence is available, or to answer specific questions that arise during the course of a review. As a result of the literature search, a review may be expanded if the Council identifies a need beyond the initial terms of inquiry.

32. Literature searches are also undertaken as horizon-scanning exercises to see what new research is emerging, sometimes on issues which the Council has previously considered.

33. Searches are conducted in the production of the IIAC abstract booklet which is produced every six months for Council members. Abstracts are summaries of the research reports. The abstracts booklet compiles a literature search of occupational diseases in general and those specific to IIAC's interests. This helps Council members keep up-to-date with the literature relevant to the Industrial Injuries Scheme and is a way in which IIAC can identify new evidence on topics it has undertaken to monitor in past reports, e.g. OA hip in occupations other than farming.

34. At the meeting, Dr Shelton highlighted a new area of the IIAC website, 'Calls for additional research'. This area will contain calls for research to be undertaken to answer specific questions, or to fill gaps in the evidence base, that IIAC has identified which pose a barrier to prescription. Whilst

the Council does not have its own budget to fund primary research, in the past IIAC has successfully made a request for research to be carried out to provide evidence which enabled a disease and its exposure to meet the necessary standard of proof to warrant prescription. For example, prescription for chronic obstructive pulmonary disease (formerly known as chronic bronchitis and emphysema) was hampered by a lack of evidence. IIAC highlighted the gap in the data and within a year the research was published, thus allowing the Council to recommend prescription. If IIAC highlights a particular area where a review of the literature or a data analysis would be helpful, the Secretariat can bid for funding from DWP for commissioning research from an independent expert.

35. The scientific advisor also provides scientific support for IIAC and RWG meetings (e.g. setting agendas, writing the minutes of the meetings and undertaking action points), drafting IIAC reports, dealing with correspondence, consulting with experts and commissioning data analyses or literature reviews from external researchers. In summary, the scientific advisor role helps enable the Council in its scientific workload – providing a range of focused scientific support.

Comments, questions and answers from the 'Welcoming Remarks', 'IIAC's approach to Decision Making' and 'Work of the Scientific Advisor' sessions

36. ***Mr John Thomson (NUM) – Do assessments for disablement compare a claimant with a normal person of the same age and sex, or a similar person of the same age and sex?*** Claimants are compared with a normal person from the general population of the same age and sex.

37. ***Mr Brian Oldale (NUM) –IIAC published its Command paper on lung cancer in coke oven workers in September 2011. When was this condition added to the list of prescribed diseases?*** The regulations adding lung cancer in coke oven workers to the list of prescribed diseases came into force in August 2012.

Presentations

Presentation 1 – Presumption

Mr Richard Exell

38. For the past three years the Council has been engaged in reviewing the regulations governing the circumstances under which, when claimants claim Industrial Injuries Scheme benefits for a prescribed disease, their condition can be presumed to be due to the nature of their employment (sometimes referred to as 'the causation question') (Regulation 4, Social Security (Industrial Injuries) (Prescribed Diseases) Regulation 1985).

39. The current standard rule of presumption states that claimants are given the benefit of presumption if their disease occurred whilst in the relevant job or within a month of leaving that job. Not all prescribed diseases attract the presumption rule, and some have rules specific to the disease. The rules also allow the decision-maker the opportunity to rebut the claim if there is 'proof to the contrary' that the disease was caused by non-occupational exposures. Where presumption does not apply, claimants may still be eligible for benefit, although the rule does provide easier passage for claimants through claims processing by removing the need for detailed evidence gathering when considering the causation question.

40. The rules for presumption date back to the inception of the Scheme in 1948, where the onset of the type of occupational diseases commonly occurring in those days (e.g. poisonings) tended to be rapid, and when the one month time rule would have been broadly appropriate. Some of the prescribed diseases where the 'standard' time rule applies are:

    - PD A1 Leukaemia, cancer of the bone, female breast, testis and thyroid
    - PD A6 Beat knee
    - PD A14 Osteoarthritis of the knee
    - PD C3 Poisoning by phosphorus
    - PD D3 Mesothelioma

41. For beat knee and poisoning by phosphorus the standard time rule for presumption is appropriate as these are conditions which usually occur during work. However, the time limit is inappropriate for the occupational cancers listed for PD A1, osteoarthritis of the knee or mesothelioma where the onset of the disease generally occurs many years after the first exposure. In scientific research certain solid tumours that develop within the first few years of exposure in a workplace are disregarded as being occupational in nature as the disease is unlikely to be due to the exposure. This is similar for diseases, such as osteoarthritis of the knee, where it takes many years of exposure before symptoms of the disease develop.

42. Claims ineligible for presumption can still be awarded benefit, but presumption negates the need for detailed evidence gathering by the claimant and decision maker, facilitating easier processing of the claim. The DWP is aware of the issues surrounding the time limits for presumption and certain long latency diseases, and has reassured the Council that, in practical terms, decision makers have borne this in mind when processing claims.

43. Non-standard time rules apply for presumption for:

PD	Disease	Presumed if onset….
A10	Noise induced hearing loss	> 10 yrs exposed and worked in a job within 5 years of a claim
B5	Tuberculosis	6+ weeks into a job and not > 2 years after leaving it
D2	Byssinosis	Within a job or any time after leaving it

44. Presumption does not apply for other diseases at all, such as PD A12 (carpal tunnel syndrome), PD C13 (liver cirrhosis), PDC22a (nasal cancer) and PD C27 (liver toxicity).

45. In the Council's review of the presumption rule, consideration has been given as to whether the presumption rule should apply for each prescribed disease in turn, and if the rule should apply, what the time limit should be based on current evidence. To this end, IIAC has undertaken literature searches, reviewed sample IIDB cases and consulted with numerous experts in relevant fields and DWP officials.

46. IIAC is considering making a number of recommendations to the Secretary of State regarding the presumption rule, such as increasing the time limit for a) long latency diseases, b) diseases with delayed effects and c) diseases where diagnosis may be delayed, such as cancers, osteoarthritis of the knee, hepatitis B and hydatid infections, to "in the job or any time after leaving it." The Council is also considering recommending changing the time limits for certain diseases due to biological agents ('B' diseases) to take into account incubation periods. Of 70 prescribed disease considered, IIAC are likely to recommend amendments for 29 diseases, whilst 41 may remain unchanged. The impact of these changes is likely to be small in terms of new potential claims or re-claims but will bring the regulations up to date with modern scientific knowledge.

Presentation 2 – Medical Assessments
Ms Claire Sullivan

47. The law states that the level of payment received from the Industrial Injuries Scheme depends on the severity of the disablement from the accident or prescribed disease. Medical assessments provide this information and include medical advice on diagnosis, loss of faculty and the effect on each individual. The assessment of disablement is expressed as a percentage and is used to determine the level of payment a claimant receives.

48. There is a statutory list of the disablement percentages for certain diseases and injuries. For example, claimants with mesothelioma are automatically awarded 100% disablement. The loss of all the fingers of a hand equates to 50% disablement and 14% for the loss of the index finger only. These payment points provide a framework against which diseases and injuries which are not listed on the statutory list are assessed against.

49. The current process first involves the injured or ill person making a written IIDB claim. Generally, a DWP lay decision-maker makes the following initial decisions:
    - Is the person an employed earner?
    - Has there been an industrial accident/disease in the UK*?
    - Does the person meet the requirements of the disease they are claiming for (for example, have they done the right job for the right length of time, worked with the right tools or met any specified conditions)?

    If the initial queries have been completed and the conditions met the decision-maker will then send the claimant for a medical assessment with a medical advisor. An exception to this is diseases that automatically attract 100% disablement, such as PD D3 (mesothelioma), where a medical assessment is not necessary as the percentage disablement is already determined by regulations.

50. During a medical assessment, the medical advisors will take a statement from the claimant and carry out a relevant examination. The advisor then writes a report for the DWP giving a medical opinion about whether the claimant has suffered loss of faculty as a result of the accident or disease. A recommended percentage disablement is suggested and advice about how long the disablement is likely to last is given.

51. IIAC has been reviewing medical assessments to check they are fair, and transparent; are up-to-date and in line with current scientific and medical knowledge; offer good value for money; are as straightforward as possible to administer, and are appropriate for a large volume, 'no-fault', state-run compensation system. IIAC will then advise the Secretary of State about

* Occupational accidents and prescribed diseases occurring outside the UK may be eligible for IIDB under certain circumstances as outlined in the 'Decision maker's guide. Volume 11: Industrial Injuries benefits: staff guide' Amendment 28 October 2011, Chapter 66: Industrial Accidents, paragraph 66071 and Chapter 67: Prescribed Diseases, paragraph 67201.

any recommended changes. It will be for the Secretary of State to decide whether to accept any recommendations made by the Council.

52. IIAC's review has not been instigated by an awareness of problems related to medical assessment, but rather that medical assessments involve difficult and complex judgements which IIAC has not reviewed since the inception of the Scheme in the 1940s. The Council is keen to review whether there are any improvements that can be recommended and whether there may be lessons the UK can learn from other countries.

53. IIAC has successfully bid for a small research fund (£25,000) from DWP to help the investigation into medical assessments. The investigators will aim to benchmark the disablements awarded for occupational diseases and injuries in the UK compared with those in other countries with no-fault state compensation schemes for accidents and diseases caused by work. An example of the type of information the research will provide is given in the table below showing the percentage disablements in the UK compared with Denmark:

Injury/disease	% disablement awards in:	
	UK	Denmark
Loss of thumb & its metacarpal bone	40%	30% (R), 25% (L)
Loss of thumb	30%	25% (R) 20% (L)
Loss of terminal phalanx of thumb	20%	12%
Loss of all 4 fingers, one hand	50%	55% (R), 50% (L)
Carpal Tunnel Syndrome	N/A	Between 5 – 25%
Vibration White Finger	N/A	Between 5 – 15%

54. At the last Public Meeting in Leeds in June 2012, an attendee had raised concerns that medical assessments were being clustered under payment points. IIAC had considered IIDB statistics on single assessments and found that there was no evidence to suggest clustering under 14% disablement. There was a significant cluster of assessments at 14-15%, but not at assessments less than 14%. Clusters were also seen at multiples of 5% reflecting the natural propensity of medical advisors to favour 'rounded up' assessments. This data did not allow investigation about clustering for claims for more than one disease or injury (i.e. aggregated claims) but as no specific bias for single claims was identified, it is unlikely than aggregated claims are likely to be clustered inappropriately.

55. The medical assessment process for IIDB is one of three currently used by DWP, all of which differ according to the benefit they are used for. The Work Capability Assessment for Employment and Support Allowance (ESA) assesses a claimant's capability for work. The assessment used for the Personal Independence Payment (PIP; which replaces Disability Living Allowance) assesses mobility and daily living needs.

Comments, questions and answers on the 'Presumption' and 'Medical Assessments' presentations

56. ***An attendee commented that some underground coal miners regularly worked extended shifts. Overtime worked is not taken into account in calculating time spent underground for eligibility for PD D12 (chronic obstructive pulmonary disease). Should the terms of prescription for PD D12 be amended to taken hours worked into account?*** The Council is limited in stipulating a time frame based on the evidence used to frame the original prescription. The research evidence the prescription was based upon is not framed in terms of hours, but days. The science underpinning why an individual develops a disease is complex and it may not be scientifically valid to extrapolate the evidence based on years worked to hours worked.

57. ***An attendee raised concerns that the Allen's and Phalen's test was ineffective for diagnosing carpal tunnel syndrome (PD A12). The terms of prescription for PD A12 (CTS) also do not define how much vibration is required.*** Defining an exact amount of vibration needed has been hampered by the lack of available research evidence. IIAC is currently considering this issue and is in correspondence with experts in the field.

58. ***Mr Chris Kitchen (National Union of Mineworkers) – If the severity of a disease is unlikely to change claimants should not have to have a review of their claim. For example, for vibration white finger where the person no longer works in the industry and the disease is not likely to get any worse or better, an indefinite award should be considered.*** Lifetime awards are appropriate for certain diseases and in some cases. However, the Department must be afforded the opportunity to review a case when necessary.

59. ***Mr Bob Fitzpatrick (National Union of Mineworkers) – When deciding a new assessment, decision makers and medical assessors know what other assessments a claimant already has been awarded. This is unfair and creates a biased decision.*** There can be an interaction between different prescribed diseases or accidental injuries that can affect a claimant's overall disablement. Therefore, the interplay of all current assessments must be taken into account in deciding the total assessment. The Council is currently reviewing medical assessments and will consider this issue (Action point).

60. ***Mr Brian Oldale (National Union of Mineworkers) –*** *When calculating percentage disablements decision makers round up or down according to*

the nearest multiple of 10%. This can disadvantage some claimants. Would IIAC consider rounding to the closest 5%? For example, a claimant with 14% disablement would be rounded up and paid at 20%. If, however, they then were given an 8% assessment for an additional prescribed disease, they would still only be paid at 20% as the total percentage (20%+8%) would be rounded down (CL?). IIAC is in the process of reviewing medical assessments and will take on board suggestions if they are within the scope of the review.

61. ***Mr Chris Skidmore (National Union of Mineworkers) –*** *Some claimants have found that when they have put in a claim for PD A14 (osteoarthritis of the knee) they have been re-assessed for PD A11 (vibration white finger) due to a 'change in circumstance'. In some cases this has resulted in a reduction in their assessment for PD A11 despite VWF still being present.* The Council stated that they would take this away and ask for feedback from DWP. (Action point)

Presentation 3 – Occupational chloracne

Dr Ira Madan

62. During a horizon scanning exercise the Council noted that chloracne was included on both the International Labour Organisation and the European Union's lists of occupational diseases, but not covered in the list of prescribed diseases under the IIDB Scheme. Accidental exposures would be covered by the Accident Provisions of the Scheme but IIAC has decided to review whether prescription is warranted for chronic exposures.

63. Chloracne is a systemic disease, characterised by potentially severe and disfiguring facial acne. It is caused by exposure to certain halogenated aromatic hydrocarbons called 'chloracnegens', predominantly found in occupational settings. Dioxins are the most potent form of chloracnegen. In 1976, dioxin was accidentally released into the atmosphere in Seveso, Italy, resulting in 5% of the local population developing chloracne. More recently, the Ukrainian president, Mr Viktor Yushchenko, suffered from chloracne after a suspected non-accidental poisoning by dioxin.

64. Chloracne has several distinguishing features compared with common acne (acne vulgaris):

Chloracne	Acne vulgaris
Papules (spots) found behind ears and groins; the chest and back are spared	Papules found on face, back and chest
Dry condition – papules are not red or moist	Red, raised, moist papules
Antibiotics have no effect	Treatable with antibiotics

65. Eight cases of chloracne have been reported in the UK to the Heath and Occupational Reporting (THOR) surveillance network in the last decade; one in a fire-fighter, one in a shoemaker and six in laboratory workers working with dioxins.

66. During the course of the investigation, the Council's RWG has undertaken a literature search and reviewed key papers for reports that described chloracne in workers exposed to halogenated hydrocarbons. The RWG also looked for evidence about the appropriate doses, mode of action and duration of exposure for development of chloracne from chronic, occupational exposure to chloracnegens. Some of the evidence considered related to the use of the herbicide Agent Orange used in the Vietnam War and its effects on veterans. The Council also consulted with two dermatologists who advised on the defining clinical features of the disease.

67. As previously mentioned, IIAC's job is to advise the Secretary of State for Work and Pensions about whether a disease should be added to the prescribed list. It is up to the Secretary of State to make the final decision

about whether a disease will be prescribed. The law says a disease may only be prescribed if there is:

a) a recognised risk to workers in an occupation; and
b) the link between disease and occupation can be established or reasonable presumed in the individual case.

68. Does chloracne warrant prescription? The disease can be severely disabling and can have enduring effects, sometimes several years or decades after exposure has ceased. The condition leads to disfigurement of the face which can result in psychological distress. (The systemic effects of chloracne appear not to persist for more than 90 days following exposure.)

69. The review so far indicates there may be a strong case for prescription but the Council is still finalising its report. We anticipate sending this report to Minister and publishing it next month, after which it will be available on the IIAC website.

Presentation 4 – Terminal prescribed diseases

Professor Paul Cullinan

70. Currently, claims for certain prescribed diseases with short life expectancies are automatically fast tracked by DWP:

PD D3	*Diffuse mesothelioma (caused by exposure to asbestos)*
PD D8	*Primary carcinoma of the lung with evidence of asbestosis*
PD D8A	*Primary carcinoma of the lung after heavy exposure to asbestos*
PD D9	*Unilateral or bilateral diffuse pleural thickening (after exposure to asbestos)*
PD D10	*Primary carcinoma of the lung (linked to tin mining and other specified chemicals)*
PD D11	*Primary carcinoma of the lung with silicosis*

71. Some asbestos-related malignant diseases (PD D3, PD D8 and PD D8A) also attract beneficial exceptions to the usual entitlement rules, such that the 90 day waiting period from the onset of a disease to when payment can start is waived and that 100% assessments of disablement are automatically awarded.

72. It is also important to note that where a claim form contains information that indicates a terminal illness of any kind, not necessarily that for which the claim is being made, decision makers are advised to put the claim forward for priority assessment.

73. DWP officials highlighted that these beneficial entitlement conditions and priority processing arrangements were not the same for prescribed malignant diseases with very similar prognoses. IIAC decided to review this issue to address the potential inequity of treatment between claimants with different terminal prescribed diseases.

74. Both C22b (nickel-related lung cancer) and C24 (angiosarcoma of the liver) have one year survival rates (30% and 20% respectively) similar to the prescribed diseases which are currently fast tracked. The Council is currently considering recommending adding PD C22b and C24 to the fast tracked list.

75. IIAC is also considering adding PD C4 (arsenic-related lung cancer), PD C22b, PD D10, PD D11 and PD C24 to the list of diseases which benefit from the advantageous entitlement rules (waiving of the 90-day waiting period and the automatic right to a 100% assessment) currently applicable to the asbestos-related cancers PD D3 (mesothelioma) and PD D8/8A (asbestos-related lung cancer with/without asbestosis).

76. In addition, the Council is considering whether the exceptional entitlement awards for survivors with the diseases on these lists be routinely reviewed, with appropriate sensitivity and delicacy, after a period of three years. Although the vast majority of claimants with the diseases under consideration may unfortunately die as a consequence, there will be a few cases where a mistaken diagnosis has been made or where there has

been an unanticipated recovery, and there should be a mechanism for reviewing such cases.

77. Currently PD D9 is on the list of fast tracked diseases, despite not being terminal. IIAC is considering whether it is appropriate to remove this disease from the fast tracked list.

78. The Council is currently drafting a report on this matter and are considering whether the arguments are strong enough to recommend to the Secretary of State that the proposed changes should be made. The Council's job is to advise the Secretary of State about the Scheme; it is for the Secretary of State to decide whether to accept any recommendations the Council may make.

Comments, questions and answers

79. ***An attendee asked, what was the estimated date of operation for these changes?*** The Council's recommendations need to be finalised and the proposals will be discussed with DWP officials. The Council's report is likely to be finalised in the Autumn. If the Secretary of State accepts the recommendations, the regulations would need to be drafted and brought into force which could take a further 12 months from publication of the report.

80. ***An attendee asked, whether claimants with terminal prescribed diseases should be given lump sums instead of weekly payments?*** IIAC has considered lump sums when responding to the DWP review of reform of the IIDB Scheme and other benefits in the Green Paper 'No one written off: reforming welfare to reward responsibility' published in July 2008 (Cm. 7363). There is much to recommend lump sums to address equity of payments to those with terminal illness compared to those with less severe, long term conditions. However, this would be a major change within the IIDB Scheme and the Council do not want to delay implementation of the relatively straightforward and simple changes to fast tracking and exceptional entitlements currently being discussed to address potential inequity within the Scheme for terminally ill claimants.

Presentation 5 – Breast cancer and shift work

Professor Damien McElvenny

81. Since 1997, breast cancer has been the most common cancer in the UK, accounting for 31% of all cancers in women. It is rare in men. In 2010, just under 50,000 cases were diagnosed (150 new cases for every 100,000 women) and there were 11,500 deaths from breast cancer. In England, the five-year survival rate for breast cancer is 85%.

82. Numerous risk factors are associated with breast cancer, such as advanced age, reproductive history, family history (e.g. breast cancer in mother or sister), alcohol consumption, diet and smoking. Shift work has also been suggested as a risk factor. However, it is unclear whether people working shifts tend to be a self-selecting group which has particular behavioural characteristics (i.e. more likely to start their families later or remain childless, both of which are associated with an increased risk for breast cancer).

83. In 2008, the Danish National Board for Industrial Injuries prescribed breast cancer for those with a long history of shift working. This followed the classification of shift work as a probable cause for cancer by the International Agency for Research on Cancer (IARC). IIAC last reviewed breast cancer and shift work in 2009 and concluded there was insufficient evidence to warrant prescription. Since that time, four further studies and two reviews have been published.

84. As previously explained, when a disease has common non-occupational causes, and the occupational and non-occupational cases cannot be clinically distinguished the Council seeks robust evidence of a doubling of risk in well defined circumstances. The Council has decided to look again for robust evidence of a doubling of the risk of breast cancer in shift workers. The table below outlines the more recent evidence considered so far:

Study location	Sample	Exposure	Relative risk (%)
China	700 cases in 70,000 women	30 year shift work	1.1
Denmark	200 cases in 19,000 military female personnel	Ever vs. never worked shifts	1.4
Germany	900 cases, 900 controls	20 year night shift work	2.5 (only based on 12 cases of breast cancer)
France	12,000 cases, 13,000 controls	10 years work as a nurse (not necessarily night shift work)	1.4

85. There are a number of limitations to these studies. They have only taken account of some of the other non-occupational risk factors for breast cancer and have poorly defined information on shift work. Therefore, these studies do not allow for proper consideration of the risks. In summarising the evidence in terms of length of shift work, the raised risks of breast cancer only appear after 20 years of exposure to shift work. Studies of the impact of various shift schedules need to be conducted. There is inconsistency in the magnitude of the reported risks and in definition of shift work. The data do suggest a moderately increased risk for more than 20 years night work, but which is less than doubled. IIAC's view is that a sound case for prescription cannot currently be made but it will keep the matter under review as evidence emerges.

Comments, questions and answers

86. ***An attendee queried why shift work caused cancer –*** The evidence that relates laboratory investigations and mechanistic considerations to shiftwork-induced carcinogenesis can be divided into two basic fields: disturbance of the circadian system due to light at night with alteration of the sleep–activity pattern leading to potential melatonin suppression and circadian gene alterations; and sleep deprivation that results from the need to sleep when it is not readily possible and misaligned with the surrounding active daytime social environment.

87. ***Mr Chris Kitchen (National Union of Mineworkers) –*** *Should the HSE consider issuing guidance on prevention given the increased risk of breast cancer due to shift work?* The HSE monitors evidence relating to breast cancer and shift work but currently it is too early to say what the risks from shift work are.

Open Forum
Mr Paul Faupel

88. ***Mr Chris Skidmore (National Union of Mineworkers)*** *Have any IIAC reports not been accepted by the Secretary of State?* The Secretary of State has accepted all of IIAC's reports since Professor Keith Palmer has been Chair. Historically, recommendations to extend the Scheme to the self-employed were not accepted. The recommendations in relation to occupational deafness took several reports before PD A10 was accepted for prescription. The more radical the changes suggested, the longer it generally takes for the Secretary of State and the DWP to consider the various implications of the options put forward by IIAC and for the recommendations to be accepted.

89. ***(Durham Miners Association) –*** *How is the performance of the decision makers assessed?* Atos is the contracted firm responsible for the performance of the medical assessors and have a thorough process of audits. DWP also audits the lay decision-makers and ensures that Atos is complying with its contractual obligations with regard to the performance of their staff.

90. ***Mr Bob Fitzpatrick (National Union of Mineworkers) -*** *We have VWF sufferers where there is no evidence available to assist their claim.* DWP officials stated that decision-makers are trained to ring the claimant to seek evidence to support their claim and enable a payment to be made.

91. ***Mr Dan Shears (GMB) -*** *Diesel exhaust emissions have recently been classified as Group I carcinogens for the lung and bladder by IARC (International Agency for Research on Cancer).* IIAC will be considering this issue.

92. ***Mr Dan Shears (GMB) –*** *Both the decision maker's and the medical report should be sent to the claimant at the same time when turning down a claim. This would save time and money so that claimants can see why their claim has been disallowed.* This will be fed back to DWP (Action point).

93. ***Jackie Douglas (The Colt Foundation)*** *– What is the background of the Council members?* IIAC members have a range of experience and expertise. There are independent scientific members with expertise in various areas such as epidemiology, rheumatology, pulmonary medicine, statistics; members with legal expertise and representatives of employers and employees.

Closing remarks

Mr Fergus Whitty

94. Mr Whitty thanked all attendees for listening and engaging with the Council in such a lively and informed way. He noted that Public Meetings offer the Council a great opportunity to listen to the queries and comments from claimants' representatives. Attendees were encouraged to send the Council any evidence on new occupational diseases or exposures, or existing issues, individuals or organisations for IIAC to consider.

95. Council members extended an invitation to all attendees to attend the next Public Meeting which would be at another location (to be decided) in the UK in June 2014. The details of the meeting would appear on the IIAC website.

List of delegates

Surname	First name	Organisation
Baker	Paul	IIAC Member
Chambers	Barry	Durham Miners' Association
Charles	Mike	DWP
Chitnis	Tracey	Macmillan, CAB Havant
Coombs	Jane	Working Well Solutions
Cooper	Steve	NUM
Corkan	Keith	IIAC Member
Cullinan	Paul	IIAC Member
Cummings	Alan	Durham Miners' Association
Darnton	Andrew	Health & Safety Executive
Dignan	Ros	Macmillan, Poole CAB
Douglas	Jackie	The Colt Foundation
Exell	Richard	IIAC Member
Faupel	Paul	IIAC Member
Fitzpatrick	Bob	NUM
Fryatt	Alison	DWP
Gibson	John	NUM
Gifford	Lee	Hampshire Fire & Rescue Service
Hadfield	Dave	NUM
Hajee	Zarina	IIAC Secretariat
Hegarty	Catherine	IIAC Secretariat
Henderson	Des	NUM
Johnson	Alan	Durham Miners' Association
Khan	Sayeed	IIAC Member
Kitchen	Chris	NUM
Lamb	Keith	Durham Mechanics Trust
Linaker	Cathy	Medical Research Council
Madan	Ira	IIAC Member
McElvenny	Damien	IIAC Member
Mills	Tommy	NUM
Musgrove	Stephen	Durham Miners' Association
Nelson	Leigh	Macmillan, Poole CAB
Ntani	Georgia	Medical Research Council
Oldale	Brian	NUM
Palmer	Keith	IIAC Chairman
Pearce	Stan	Durham Miners' Association
Roach	Gareth	IIAC Secretariat
Seaton	Anthony	IIAC Member
Shears	Daniel	GMB
Shelton	Marianne	IIAC Secretariat
Skidmore	Chris	NUM
Sullivan	Claire	IIAC Member
Tan	Lina	Tesco Stores Limited
Thomson	John	NUM
Turner	Andrew	IIAC Member
Walshe	Fiona	DWP
Watkin	Terry	Durham Mechanics Trust

Whitty	Fergus	IIAC Member
Whitworth	Joe	Durham Miners' Association