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# The Industrial Injuries Advisory Council

# Proceedings of the 11th Public Meeting

28 June 2012
Leeds

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# Foreword

The eleventh Public Meeting of the Industrial Injuries Advisory Council (IIAC) was held in Leeds on 28th June 2012. This event built on the success of the Public Meetings held around Great Britain over the past 10 years.

The meeting allows 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. The current economic climate and government spending cuts necessitated the Council holding a half day meeting in 2011, but this year, in response to stakeholders' views, we returned to a full day agenda. The Public Meeting proved an informative occasion for the Council and we look forward to the next one. 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 will consider going forwards.

IIAC is independent of the Department for Work and Pensions (DWP). It is supported by a Secretariat provided by the DWP and endeavours to work cooperatively with departmental officials to provide advice to the Secretary of State about the Industrial Injuries scheme. However, this report should not be used as guidance on current legislation, or current policy within the DWP, as members may have expressed personal views, which have been recorded here for information.

**Professor Keith Palmer**
**Chairman IIAC**

**Agenda**

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|---|---|
| 09:00 – 09:45 | Registration |
| 09:45 – 10:30 | **Welcoming Remarks**<br>Chairman of IIAC – Professor Keith Palmer<br><br>Followed by:<br><br>**IIAC's approach to scientific decision making**<br>Chairman of IIAC Research Working Group – Prof Paul Cullinan and Professor Keith Palmer<br><br>Work of Scientific Advisor– Dr Marianne Shelton |
| 10:30 – 11:00 | **Comments, questions and answers** |
| 11:00 – 11:30 | Break |
| | **Presentations:** |
| 11:30 – 12:15 | **Asbestos-related diseases** – Prof Mark Britton |
| 12:15 – 13:00 | **Legal definition of employees and contractors** - Prof Diana Kloss |
| 13:00 – 14:00 | Lunch |
| | **Presentation and open forum:** |
| 14:00 – 14:45 | **Hand-arm vibration syndrome** – Dr Ian Lawson |
| 14:45 – 15:15 | **Open forum**<br><br>Facilitator – Claire Sullivan |
| 15:15 | End of public meeting |

# Welcoming Remarks

## Professor Keith Palmer
## Chair of IIAC

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

2. The Industrial Injuries Scheme provides non-contributory, no-fault compensation which 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 listed as a disease in the Scheme's regulations that is associated with an occupational cause; 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 is assessed by medical advisers engaged by the Department. Assessments of disablement are based on functional, not vocational limitations, 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 most diseases can be aggregated.

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 the DWP 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 or 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 produced at the 'command' of Her Majesty and are presented to Parliament by the Secretary of State for Work and Pensions, often forming the basis of legislation. 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 Ministers. Commissioned research reports may be published once a year, 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 have direct relevance to the Council's programme of work. 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 example reviews of osteoarthritis of the knee (in mining, carpet and floor laying and farming), cancer (in coke oven and foundry workers, haematite miners, smelters and outdoor work), Dupuytren's contracture, comparisons between international lists of occupational diseases and the IIDB list, benefits for the terminally ill and the presumption rule and 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 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 measured and 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 for verification and attribution of occupational causation. 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 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 a 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 exposed workers get the benefit of presumption 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, 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.

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 a 2-10 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, 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 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 prescription where necessary. Future advances in research may enable the terms of 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, who 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 review. 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, through advertising in the Society for Occupational Medicine newsletter or on the IIAC website. We also can 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 we 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.

33. Searches are also conducted in the production of the IIAC abstract booklet which is produced every 6 months for Council members. Abstracts are summaries of the research reports. The abstracts booklet is a literature search of occupational diseases in general and those specific to IIAC's interests. This helps 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. 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, IIAC has been

successful in promoting research being completed to allow 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 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**

36. ***Karen Hobson (Occupational Health Advisor, Rotherham Occupational Health Advice Service) – It is interesting to hear about how diseases are attributed to occupation by the Council. Why do medical assessors, at an individual level, wish to attribute diseases to other causes or different diagnoses?*** The legislation provides for a benefit of presumption under certain circumstances – i.e. certain claimants who meet the scheduled terms of prescription do not have to prove their disease is occupational, this is presumed. The rule has time limits however (typically the disease has to start in the job or within a month of leaving it), and presumption does not apply to every prescribed disease. Also, decision makers have the right of rebuttal in cases where it is clear to them that the disease was not due to the occupation. The Department's medical advisors are not instructed to try and disprove claims. However, attribution to occupation when more than one causal factor operates is complex; risk factors may act together rather than in competition, making decision-making challenging. IIAC is considering the rules for presumption, as it wishes to modernise the time rules and to improve the general guidance on attribution for medical assessors, decision makers and other stakeholders. Assessment of the percentage disablement, although often undertaken at the same examination, is a separate question. Here, non-occupational contributing factors are taken into account in considering the degree of disablement, and some off-set to the disablement awarded may be reasonable if other non-occupational factors cause part of the disablement. IIAC is considering how diseases with multiple causes are dealt with during medical assessments to ensure that decisions are scientifically sound.

37. ***David Hadfield (NUM) – There seems to be many ex-miners who qualify for several prescribed diseases but are only awarded small percentage disablements for each disease, which often end up still under the 14% payment threshold upon aggregation. Is this coincidental? Should adjudicators know what other awards the claimant has been awarded?*** Medical assessors need to be aware of any other assessments the claimant may have as they must judge the effect of the disablement on the person against a similar person of the same age and sex, and consider the how that person's total aggregated disablement compares to other scheduled disablements. For example, on the scheduled list of assessments 14% equates to amputation of the whole of the index finger of one hand, 20% equates to amputation of all of the toes on one foot and 30% equates to the loss of use of one eye. It must be ensured that several minor injuries do not aggregate to result in an overall disablement that is greater than those of more severe injuries to ensure the Scheme remains fair and equitable; equally, the total impact must not be overlooked.

38. ***Alan Cummings (Executive, Durham Miners Association) – For PD A14 (OA of the knee) many union members were examined by ATOS Drs but the assessment form has been completed by someone who***

***has not examined the claimant.*** The Department received 30,000 claims for PD A14 when it was introduced. To ensure that claimants had their claims assessed quickly special measures were introduced to deal with the large volume of claims. Otherwise, miners would have had to wait several years to have their case seen. Healthcare professionals, trained to assess OA knee cases were brought in to examine claimants and experienced practitioners carried out disablement assessment as a paper exercise. This process was audited to ensure it was working effectively.

39. ***Alan Cummings (Executive, Durham Miners Association) – How many people progress from simple coal miners pneumoconiosis to pulmonary massive fibrosis (PMF)?*** This information is not recorded for PD D1 (pneumoconiosis). In general clinical experience, however, only a small proportion of patients with pneumoconiosis will progress to PMF. An individual claimant can request a review of his or her claim if there is progression from simple coal miner's pneumoconiosis to PMF.

40. ***Brian Oldale (NUM) – Are there any plans to increase awareness of the Analogous Industrial Injuries Scheme for Trainees?*** The analogous scheme for trainees is being abolished under the Welfare Reform Bill. The Bill aims to enable trainees to claim under the main Industrial Injuries Scheme instead (as part of benefits simplification).

41. ***Chris Skidmore (NUM) – A union member made a claim for PD D1 but was told he did not have any disablement from his pneumoconiosis. He was awarded OA of the knee (PD A14) but was given a low percentage award despite having disablement. He has since died.*** With simple pneumoconiosis there may be changes visible on a chest radiograph but which do not result in any disablement, unlike later stages of the disease. Simple pneumoconiosis may have been recorded on the death certificate but it is unlikely to have been the cause of death. Whilst IIAC does not get involved in individual cases, any cases illustrating areas of particular concern should be sent to IIAC for its consideration.

42. ***Jim Perry (Administrator, Durham Mechanics Trust) – The Tribunal success rate has dropped significantly in recent years. Have the standards changed?*** IIAC has no involvement with the Tribunal Service. If attendees have any concerns about standards they should raise them with the Tribunal Service.

43. ***Dave Hadfield (NUM) – Why does the Department not use the FEV1 test and X–rays to assess Chronic Obstructive Pulmonary Disease (COPD) PD D12? Sometimes claimants are told at the assessment that they do not have COPD but instead may have D1 (pneumoconiosis). This means they then must return to their GP to arrange chest radiographs.*** The diagnosis of PD D12 is based on lung function. Therefore, the FEV1 test is appropriate. Chest radiographs are not effective at diagnosing COPD. ATOS assesses whether a claimant fulfils the criteria for a prescribed disease, it is not a diagnostic centre for patients. A patient's first port of call for a diagnosis should be their primary care trust/GP. The Department does not provide a diagnostic radiology service.

44. ***John Welch (Raley's Solicitors) – The prescription for PD D1 (pneumoconiosis) on changes seen by chest radiograph, but diagnostic use of computed tomography (CT) scans is becoming more commonplace. Is IIAC considering recommending the use of CT scans in assessing PD D1?*** IIAC did consider the use of CT scans in assessing claims for asbestos-related lung diseases. It would be inequitable, however, to restrict claims to those who could provide a CT scan report to support their claim and inappropriate to ask claimants to have a CT scan to support their claim (as this involves significantly more exposure to radiation than an X-ray). The Department prefers to use evidence that accumulates as a natural by-product of diagnosis and treatment.

45. ***Chris Kitchen (NUM) – The prescription for OA of the knee states that miners must have been working underground for 20 years to qualify. Some miners may not have worked 20 years, but worked longer shifts than others and so overall have had same duration of exposure.*** The prescription was based on the evidence available, which was recorded in years, not hours.

## Asbestos Related Diseases
### Professor Mark Britton

46. Asbestos is a naturally occurring fibrous silicate which is separated into two major types, serpentine and amphibole. In the serpentine group is chrysotile or 'white' asbestos, and in the amphibole group are crocidolite ('blue' asbestos), amosite ('brown' asbestos), tremolite and anthophyllite. These materials are mined in a number of countries including Russia, South Africa and Canada.

47. Professor Britton described exposures to asbestos, both historically (e.g. asbestos factory workers throwing asbestos snowballs) and in modern times (e.g. lagged pipework in buildings).

48. Researchers have quantified the exposure to asbestos for a number of occupational job titles. For practical purposes, asbestos exposure is defined as the number of fibres per ml of air (fibres/ml). For example, a person applying asbestos lagging would be exposed to approximately 60 fibres/ml, whereas a person involved in spraying asbestos would be exposed in excess of 50,000 fibres/ml. In addition to this, quantification of cumulative asbestos exposure may be defined which takes into account the number of years of exposure and expressed as a cumulative total fibres/ml years.

49. The asbestos fibres can be seen in lung tissue and in sputum. Some fibres may be encapsulated by cells of the body's defence system which try to digest them. These are called asbestos bodies.

50. There are a number of prescribed diseases which relate to asbestos exposure. These are asbestosis (PD D1), mesothelioma (PD D3), lung cancer (PD D8) and pleural thickening (PD D9). These conditions were the subject of an IIAC review, published as Command Paper 6553, 'Asbestos-Related Diseases' (July 2005) which involved analysis of IIDB and population statistics for asbestos-related diseases, consultations with a variety of experts and DWP officials and reviewing scientific literature.

51. IIAC revisited the topic of pleural plaques in 2009 following a Ministerial request to do so. This was linked to rulings on pleural plaques in the Scottish courts and the debates that stemmed from that decision.

52. The pleura comprise two thin membranes which line the lungs and chest wall. Fluid produced in the space between the layers facilitates breathing without causing friction. Exposure to asbestos causes pleural effects such as the development of pleural plaques (calcified pleural and diaphragmatic plaques), benign asbestos pleurisy, diffuse pleural thickening and round atelectasis.

53. Pleural plaques are the most common, and often the only, condition associated with asbestos exposure. Like other asbestos-related conditions, pleural plaques develop many years after asbestos exposure. They occur after low dose, intermittent exposure (similar to

mesothelioma). Pleural plaques are areas of hyaline fibrosis, which are usually on the parietal pleura. The apices and costophrenic angles are spared. They tend to follow the line of the ribs and can be found in the paravertebral gutters and over central tendons of the diaphragm.

54. Pleural plaques do not normally cause symptoms but may have a minor effect on lung function which does not result in any disability. They are not pre-malignant, but are an indication of exposure to asbestos which may itself be a marker for increased risk of associated diseases. They do not require treatment but may be a source of anxiety.

55. In IIAC's review of asbestos-related diseases in 2005, the Council recognised that symptomatic pleural plaques can occasionally occur but that there was a lack of evidence that they cause impairment of lung function sufficient to result in disability. The 2009 review of pleural plaques extensively considered the evidence available and concluded that the evidence on pleural plaques had not changed since the 2005 review.

56. Diffuse pleural thickening affects the visceral pleura, causing the pleura to thicken and the pleural layers to fuse. This condition may produce a restrictive defect which causes disablement. Prior to 2005 diffuse pleural thickening (PD D9) was prescribed for unilateral cases affecting at least 50% of chest wall or bilateral cases affecting at least 25% each side. To be eligible for prescription there had to be a minimum of 5mm thickness at one point within the pleural area affected, as measured on a plain chest radiograph. After examining the evidence in the 2005 asbestos-related diseases review, the Council recommended amending the prescription to remove the requirement for measurements of pleural thickening and instead introduce the requirement for involvement of the costophrenic angle on plain chest radiographs. The occupational coverage remained unchanged.

57. The definition and guidance within the ILO system regarding the Costophrenic Angle Obliteration is as follows:

> *"The lower limit for recording costophrenic angle obliteration is defined by the Standard Radiograph I / I, t / t. If the pleural thickening extends up the lateral chest wall from the obliterated costophrenic angle, the thickening should be classified as diffuse pleural thickening. Costophrenic angle obliteration may occur without diffuse pleural thickening"*

58. Asbestosis has been defined as "fibrosis of the lungs caused by asbestos dusts which may or may not be associated with fibrosis of the parietal or pulmonary layer of the pleura" (Acheson ED, et al. Asbestos: Final report of the Advisory Committee. Vol 2: The ill effects of asbestos on health. HMSO, London 1979). Asbestosis can be defined clinically, radiologically, physiologically and histologically by a history of substantial asbestos exposure, clubbing, crackles, radiological changes on plain X-ray, restrictive defect with reduced KCO (transfer coefficient for carbon dioxide), HRCT (high resolution chest computed tomography) abnormalities and asbestos bodies seen in tissue sections.

59. The CT features of asbestosis involving the lung tissue include curvilinear sub-pleural lines, parenchymal bands, thickened interlobular (septal) and intralobular (core) lines and honeycombing. These CT features are non-specific as they may also be observed in pulmonary fibrosis due to other causes.

60. For asbestosis, PD D1 (pneumoconiosis), diagnosis is made based on a clinical and radiological diagnosis and history of significant asbestos exposure. Histological proof is not necessary. In IIAC's 2005 review of asbestos-related diseases it recommended that:

- Diagnosis of asbestosis should be based on clinical evidence of interstitial lung fibrosis and a history of substantial occupational exposure
- Absence or low numbers of asbestos bodies or asbestos fibres in the lungs should not exclude a diagnosis of asbestosis in claimants with a history of substantial occupational asbestos exposure.
- The list of occupational exposures in the terms of prescription should remain unchanged

61. The association between asbestos exposure and lung cancer has been suspected since the 1930s and was clarified in1955. The involvement of fibrosis in the development of asbestos-related lung cancer has been the subject of much debate. There are two hypotheses. First that asbestosis must be present because the fibrosis itself is necessary to increase the risk of cancer. The second hypothesis is that the asbestos "dose" necessary to produce cancer is at least equal to the dose necessary to produce asbestosis, but asbestosis need not be present. It is also unclear whether there is a threshold dose of exposure to asbestos necessary for the causation of lung cancer, or whether exposure and the risk of the disease proceed along a linear continuum.

62. Increased knowledge of the biology of carcinogenesis makes the hypothesis that fibrosis is a pre-requisite to developing lung cancer unlikely. There is also good evidence that there is an increased risk of lung cancer in the absence of asbestosis. The cumulative levels of exposure that are estimated to cause a doubling of risk are 25-100 fibres/ml years. These factors are also affected but not wholly explained by exposure to different fibre types.

63. The risk of lung cancer increases with exposure to asbestos but there is a smaller relative risk than for contracting mesothelioma. For example, a person subject to 'heavy' asbestos exposure may have a 1000-fold risk for contracting mesothelioma but only a 5-fold risk for developing lung cancer. A worker subject to 'light' asbestos exposure has a substantial increase in risk for mesothelioma but no significant increase in risk for lung cancer.

64. Different asbestos fibre types produce different risks of mortality from lung cancer, such that exposure to amphiboles doubles the risk of dying from lung cancer compared with exposure to chrysotile.

65. A meeting of experts, representing 8 countries which do not manufacture asbestos, was held in Helsinki in 1997 to discuss the attribution of lung cancer to asbestos. The Helsinki Criteria were derived from the discussion held at the meeting and were published as a consensus document in the 'Scandinavian Journal of Work and Environmental Health' (23: 311, 1997). The main criteria for attribution of lung cancer to asbestos exposure are:

i) radiological or pathological diagnosis of asbestosis.
ii) fibre count in asbestosis range in same laboratory.
iii) 5,000-15,000 asbestos bodies/gram of dry lung.
iv) more than 5 million fibres with more than 1 μm long per gram of dry lung, or more than 2 million fibres longer than 5 μm long as determined by electron microscopy.
v) Occupational history indicating exposure above 25 fibre/ml years.
vi) One year of heavy exposure, e.g. lagging, or 5-10 years of moderate exposure, e.g. shipbuilding, construction.

66. The outcome of the Helsinki meeting was considered carefully by IIAC. The Council's view was that after consulting the experts and the scientific literature that there was insufficient evidence on which to base prescription on the criteria of 25 fibre ml years.

67. With regard to the IIDB scheme, there was a good case for prescription of lung cancer on the basis of a cumulative asbestos exposure sufficient to give rise to risk of asbestosis. Therefore, IIAC recommended that primary carcinoma of the lung should be prescribed in relation to asbestosis. Despite lung cancer being common in the general population the evidence showed a 4-5-fold risk of the disease in the presence of asbestosis. The question that IIAC considered was whether the risk for lung cancer was at least doubled in those who have substantial exposure to asbestos without asbestosis.

68. The recommendations for prescription of primary carcinoma of the lung were made in the 'Asbestos-Related Diseases' report. These recommendations are:

i) Lung cancer should remain prescribed in relation to asbestosis and that no changes should be made to the occupational categories for asbestosis.
ii) Lung cancer in those without asbestosis but who have a history of substantial exposure to asbestos should be prescribed:
    Exposure for at least 5 years before 1975 and 10 years after 1975 in the following occupations:
    a) Asbestos textile manufacture.
    b) Asbestos sprayers.
    c) Asbestos insulation work.
    d) Asbestos workers in shipbuilding, including those applying and removing asbestos containing materials.
iii) Claimants eligible for PD D8 should be assessed at 100%.
iv) Reference to pleural thickening should be removed from terms of prescription.

69. Malignant mesothelioma is a cancer of the pleura or peritoneum (the membranous lining of the abdomen) caused by asbestos exposure. In recent years we have seen an epidemic of mesothelioma deaths. Peto *et al.* (1995) estimated that the peak of the UK epidemic of mesothelioma caused by asbestos exposure will not be reached until 2020, with two thirds of the cases yet to occur. This is due to the long latency period of the disease, with most cases presenting 40 years after initial exposure to asbestos. It is unusual for the disease to present within 20 years of exposure. Different asbestos fibre types (amosite, crocidolite, etc.) produce different risk estimates for mesothelioma. Most occupational exposures were to mixed fibre types. Risks are also dose-dependent and time-dependent. The amphibole asbestos fibre types are associated with the highest risk of developing this disease. According to national death data published by HSE in 2006 there were almost 1,800 male and 300 female deaths due to mesothelioma.

70. Unlike asbestosis and lung cancer, low doses of exposure are causative for mesothelioma but the risk increases with increased exposure. Nowadays patients include people employed as carpenters, electricians and plumbers who have low dose exposure. In the past most cases of mesothelioma occurred in heavily exposed workers, such as laggers and shipyard workers

71. Mesothelioma presents with clinical symptoms, such as chest pain and breathlessness. The chest X-ray and the CT scan show either a pleural effusion or irregular pleural thickening, possibly resulting in a reduction in thoracic volume. A minority of patients may also suffer systematic symptoms such as sweating and loss of appetite and weight. Diagnosis is confirmed by biopsy often obtained by thoracoscopy; however diagnosis can be difficult and the recent availability of PET (positive emission tomography) scans has helped increase positive biopsy rates.

72. Mesothelioma (PD D3) first became a prescribed disease in 1966. IIAC recommended amending the prescription in 1997 and 2002 by broadening occupational coverage to ‘exposure to asbestos, asbestos dust or any admixture of asbestos at a level above that commonly found in the environment at large’. The 90 day waiting period was also removed due to the short life expectancy of mesothelioma sufferers and all mesothelioma assessments were automatically awarded 100% disablement. A fast-tracking process for claims for terminally-ill claimants was also introduced to IIDB district offices with medical assessments no longer being necessary.

73. The review of mesothelioma, as part of the 2005 review of asbestos-related diseases, focused on examining why there was an apparent discrepancy between the number of people gaining benefit for IIDB and the number of mesothelioma deaths. Following analysis of the data, the discrepancy was found not to be due to claimants being refused benefit but because potential claims were not being made. It was surmised that the reasons for mesothelioma sufferers not claiming IIDB could be that:

- people were too ill to claim

- sufferers were self-employed or non-occupationally exposed and were aware of the scheme's exclusions
- claimants had a belief that the DWP required medical assessments and extensive corroborative evidence for the claim to be successful, or
- that there was a lack of awareness of the scheme.

74. IIAC recommended that the Department highlight the availability of the PD D3 mesothelioma IIDB provisions to potential claimants. The Department consulted with claimants groups, the British Lung Foundation and lung cancer nurses and updated the Departmental website for doctors.

75. As a consequence of this information IIAC recommended that the awareness of the scheme should be promoted. The British Lung Foundation has addressed this need by raising awareness of the IIDB scheme among lung cancer nurses in hospitals (who also deal with mesothelioma patients).

76. The 2005 review found that the occupational coverage for mesothelioma was broad and no amendments were recommended.

77. IIAC raised the problem of poor life expectancy in mesothelioma claimants who would receive a fraction of the total amount payable to those with much less severe prescribed diseases who lived longer. IIAC also highlighted the problem of patients with no knowledge of any asbestos exposure or where the exposure was non-occupational.

78. In March 2005 the British Lung Foundation organised a Mesothelioma Summit to bring together healthcare professionals, policymakers and other interested stakeholders. The outcome of this summit was the production of a Mesothelioma Charter for patients, a Mesothelioma Framework produced by the government's cancer Tsar, published in November 2006, and the launch of a Mesothelioma Action Day, held every year at the end of February.

79. Other government initiatives have since been launched. The DWP in conjunction with the NHS released a leaflet to provide help and advice to mesothelioma sufferers about benefits available to them. These benefits include IIDB, the Pneumoconiosis, Byssinosis and Miscellaneous Benefit Scheme, Worker's Compensation (Supplementation) Act 1948 and the Pneumoconiosis (Worker's Compensation) 1979 Act. Mesothelioma patients in receipt of IIDB may also qualify for constant attendance allowance, exceptionally severe disablement allowance and reduced earnings allowance.

80. New mesothelioma provisions have been introduced since October 2008 in the Child Maintenance and Other Payments Act. Under this scheme (separate from IIDB) a mesothelioma sufferer can obtain a single lump sum payment for asbestos exposures that do not have to be directly occupational.

## Legal definition of employees and contractors

**Professor Diana Kloss**

81. The IIDB Scheme covers employed earners. An employed earner is defined in the Social Security Contributions and Benefits Act 1992 as a person who is gainfully employed in Great Britain either under a contract of service or as an office holder (for example a company director) and is liable to pay income tax under Schedule E on their salary, wages or fees. The following qualifications apply:

- Claimants need not have paid, or indeed be liable for, Class I National Insurance contributions, as they may be exempt from contributions by reason of low earnings and still be covered by the Scheme
- Special constables and agency staff are included; they are self-employed under a contract for services but still liable to pay Class I National Insurance contributions

82. Trainees on work-based training programmes are excluded from the Scheme, but are eligible for a similar compensation Scheme run by the DWP. Those serving in the Armed Forces are also not covered, but may claim under the War Pensions Scheme or the Armed Forces Compensation Scheme. The most important economically active group to be excluded is the self-employed.

83. What is the difference between an employee and a self-employed person? Does a worker have a contract of service or a contract for services? This is an important consideration in several other areas of law, including employment rights and personal injury.

84. Some employers may believe it is in their interest to have a self-employed status for their workers to make a national insurance saving. However, employers who use self-employed contractors should still take out public liability insurance in case there is an accident or injury for which they are liable to compensate the person injured in the law of tort.

85. There are several tests to determine the employment status of a worker:

- The control test – the employer stipulates what is to be done and how it is to be done.
- The integrational or organisational test (which covers professional and skilled workers who have a large degree of personal autonomy in their work but whose work is an integral part of the business).
- The economic reality test: Is the worker ‘in business on their own account’?
- The multiple test – takes all factors considered in the above tests and considers whether the evidence overall points to the person being an employee or self-employed.

86. The tests for deciding employment status are clearly set out in the key cases of Lane v Shire Roofing Ltd [1995] IRLR 493, Commissioners of

Inland Revenue v Post Office Ltd [2003] ICR 546 and Carmichael v National Power plc [2000] IRLR 43.

87. Autoclenz v Belcher [2011] ICR 1157 was a case involving the issue of whether a contract stating that a worker was self-employed was a 'sham agreement' and whether the worker was actually an employee. A employed B as a car valeter. B took A to an employment tribunal for a declaration that he was an employee. The original contract described B as a self employed sub-contractor. Later, A gave B a new document to sign which contained new clauses, again purporting to establish self-employed status. However, in practice the workers were regularly employed under the control of the employer. It was held by the Supreme Court that the documents were a sham, and did not reflect the reality of the bargain between the parties. Courts and tribunals should look at the reality of the situation, not the words of a written contract which does not reflect that reality.

88. The only route to compensation for the self-employed worker is therefore the fault-based tort action where the worker must prove on the balance of probabilities that the employer was negligent and/or in breach of statutory duty, unlike the industrial injuries scheme which is a no-fault scheme.

89. IIAC issued a report in 1993 (Cm 2177) suggesting that the self-employed working in **construction** and **agriculture** be brought within the Scheme. These workers suffer the majority of accidents which occur to the self-employed. However this recommendation was rejected by the government of the day.

90. Employers are required by Employer's Liability (Compulsory Insurance) Act 1969 to carry insurance against liability in tort for the benefit of their employees, but this Act does not extend to the self-employed.

**Comments**

91. Union members discussed cases of self-employed/contractors who were employees in the construction industry they were aware of.

# Hand-arm vibration syndrome
## Dr Ian Lawson

92. The first vibrating tools were used in French underground coal mining in 1839. Alice Hamilton was the first to characterise the vascular component of Hand-Arm Vibration Syndrome (HAVS), Vibration White Finger (VWF), as “dead fingers” in 1918. She accurately described the condition as causing the fingers to appear yellowish or greyish white and shrunken, with a clear line of demarcation between the “dead” and normal part.

93. There is a long history of prescription for HAVS. In 1985 IIAC’s recommendation for prescription of VWF (Vibration White Finger) was accepted (after being rejected in 1954, 1970 and 1975). Vibration-related carpal tunnel syndrome was prescribed in 1993 (PD A12). In 1995 IIAC considered that HAVS be recognised as two separate components: vascular and sensorineural. IIAC recommended that the prescription for PD A11 be extended to include the sensorineural components of HAVS, where the vascular component was also present. IIAC last considered HAVS in its recommendations in the Command Paper ‘Hand-Arm Vibration Syndrome’ (Cm. 6098) in July 2004.

94. HAVS is a common occupational disease. There are 4 million workers exposed to hand transmitted vibration (around 7% of the population). There are around 30 million cases of HAVS worldwide, with around 220,000 cases of VWF and 300,000 cases of sensorineural HAVS in Great Britain according to research commissioned by the HSE. Seventeen per cent of the new claims for prescribed diseases under the IIDB Scheme were for HAVS (PD A11) in 2003-2010.

95. HAVS has two main components – the sensorineural and the vascular components. The sensorineural component is characterised by numbness, tingling and loss of sensation. The vascular component, otherwise known as VWF consists of episodic finger whiteness. There is also a musculoskeletal component of HAVS characterised by pain, stiffness, arthritis, bone cysts and reduced grip strength. The musculoskeletal component is not clearly understood and reduced grip may be part of the sensorineural component. Carpal tunnel syndrome is a separate condition which may be associated with vibration exposure and is being considered as part of the IIAC review of WRULD.

96. There are many tools which give rise to hand transmitted vibration:
- Percussive metal working tools (fettling tools, impact wrenches, needle guns, hammer drills, pneumatic clinching/flanging tools, percussive chisels, chipping hammers, riveting tools, nibblers, nut runners)
- Grinders and other rotary tools (hand-held polishers, sanders and grinders, pedestal grinders, flex-driven grinders and polishers, wibblers and rotary de-burring tools)
- Percussive hammers and drills used in mining (jack hammers, rock (etc.) hammers, rammers)

- Forest and garden machinery (chain saws, anti vibration chain saws, brush saws/strimmers, hedge trimmers, mowers, de-barking machines/shredders)
- Other processes and tools (shoe pounding-up machines, concrete vibro-thickeners, concrete levelling vibrotables, motorcycle handlebars)

97. Diagnosis - The diagnosis of HAVS consists of a history of significant exposure to vibration with the appropriate symptoms combined with supportive evidence from clinical examination and standardised tests. For HAVS, the time between first exposure and the onset of finger blanching or sensorineural symptoms varies. In most cases it is several years before the symptoms are evident. However, in some cases symptoms of HAVS could occur after a latent interval of as little as six months or as much as twenty years or more, although such cases are rare.

98. The sensorineural component consists of nerve damage characterised by:
- Numbness*
- Tingling*
- Reduced sensory perception
- Reduced manipulative dexterity

* which excludes the temporary symptoms called threshold shift that occurs following exposure

99. The vascular component is also known as Raynaud's Phenomenon (RP). The affected fingers become white with loss of sensation. Whiteness maybe followed by blue discolouration (cyanosis). As the circulation is restored the affected part becomes red (reactive hyperaemia). There is a clear demarcation line between the normal skin colour and this whiteness; this is known as blanching. Blanching is typically circumferential e.g. around the finger and the nails on the affected finger are often reported as white. In a few cases it may only be the front or back of the finger that is affected. The finger, if cut, does not bleed.

100. During medical examinations, the history must be carefully recorded to assess the severity of blanching (e.g. number of attacks and extent of blanching). In diagnosing the severity of blanching it has to be established as to how far the whiteness extends up the finger and how many fingers are affected and how extensive are the symptoms during the worst attacks.

101. Severity of the vascular and sensorineural components is staged using the Stockholm Workshop scale for each finger and hand. The grading of the vascular component can be paraphrased into four grades:
- VWF attacks in tips of fingers only – Mild
- VWF attacks of the distal and middle phalanges (rarely proximal) – Moderate
- VWF frequent attacks of the whole finger and most digits – Severe
- VWF attacks causing trophic changes to the skin – Very severe

102. The grading for the sensorineural component is as follows:
- Stage 1 – Intermittent numbness with or without tingling

- Stage 2 – Intermittent or persistent numbness and reduced sensory perception
- Stage 3 - Intermittent or persistent numbness with reduced tactile discrimination and / or manipulative dexterity. Stage 3 SN cases are severe.

103. A desirable diagnostic test for HAVS must be able to determine true negative results and true positive results. In other words it must have a high specificity (true negative rate) with few false positives and a reasonable sensitivity (true positive rate). The tests must be repeatable, acceptable to those tested and cost effective with few false negatives.

104. In the 2004 IIAC Command paper 'Hand Arm Vibration Syndrome' IIAC considered a variety of standardised tests available to assess the sensorineural and vascular components of HAVS, such as:

<u>Sensorineural tests</u>

- Grip strength
- Pain thresholds
- Semmes-Weinstein monofilaments
- Vibrotactile threshold
- Thermal threshold
- Purdue pegboard test

<u>Vascular tests</u>

- Cold provocation test (CPT)
- Finger systolic blood pressure (FSBP) test

105. The Department for Business, Innovation and Skills (BIS) (formerly the Department for Trade and Industry) Coal Health Compensation Scheme used the CPT test to diagnose the vascular component of HAVS. However, a large volume research study of ex-coal miners questioned the value of the test in diagnosis of the vascular component (Proud et al, 2004). . An Administrative Court judgement held that the test could not to be used to support a negative diagnosis.

106. In its 2004 review, IIAC recommended that taking a carefully recorded history is the most effective way to diagnose the vascular component of HAVS. The CPT or FSBP tests were not sufficiently useful for IIAC to recommend their use to diagnosis PD A11.

107. IIAC recommended that diagnosis of the sensorineural component of HAVS should rely on taking a good clinical history. In addition the use of standardised tests, including the vibrotactile threshold, thermal aesthesiometry and the Purdue peg board tests were also recommended to enable the severity of the condition to be staged.

108. The legal requirements of prescription are that the disease is a risk of the occupation and not a risk common to all persons, and that attribution in an individual case is established or presumed with reasonable certainty. IIAC's approach to attribution to occupation involves two methods – a) the clinical features of the disease must be unique or rarely occur outside work or b) there must be epidemiological evidence of a doubling of risk. The clinical features of HAVS are not unique; identical symptoms occur commonly outside work, e.g. Raynaud's disease occurs in 5-10% of men.

The clinical stages are hard to measure and confirm and episodes of VWF are rarely witnessed by the examining doctor. VWF and sensory symptoms also have common natural counterparts.

109. Evidence has accumulated which allows a better understanding of how common sensorineural disease is and how often it can occur in the absence of blanching (roughly 20%). The sensorineural symptoms are often more disabling than the vascular components of HAVS. In the 2004 Command paper (Cm. 6098) IIAC recommended:

- prescription be widened to HAVS, include the sensorineural-only symptoms of HAVS
- symptoms must be cold-induced with clearly delineated episodic blanching occurring throughout whole year *and /or*
- both persistent numbness or persistent tingling of the digits or both *and*
- a significant and demonstrable reduction in both the sensory perception* and manipulative dexterity* *and*
- symptoms of HAVS must post-date exposure to Hand Transmitted Vibration (HTV)
- the occupational coverage for PD A11 remained unchanged (i.e. prescription was based on a list of occupations)
- secondary evidence may be considered

* Measured by standardised tests discussed above (Vibrotactile thresholds, Thermal thresholds, and Purdue pegboard test).

**Comments, questions and answers**

110. ***Chris Skidmore (NUM) – Miners have claimed for VWF under the DTI Scheme and were awarded benefit. When they claimed for PD A11 they were turned down. Why is this?*** The threshold for eligibility was much lower for the DTI Scheme compared with the Industrial Injuries Scheme. The IIDB Scheme aims to provide benefits for occupational accidents and injuries that cause significant disablement. The DTI Scheme and the IIDB Scheme are not comparable.

111. ***Brian Oldale (NUM) - When the prescription for PD A11 was extended to include the sensorineural component of HAVS it referred to the requirement for 'continuous tingling and numbness' rather than 'persistent tingling and numbness' as described by the Stockholm scale. Why?*** IIAC recommended that severe HAVS be compensated and suggested that prescription should be based on continuously present numbness and tingling.

112. ***David Goodwin (Regional Health & Safety Officer, HM Revenue and Customs) – Have you considered contraction of the tendons due to vibration exposure?*** IIAC is currently reviewing evidence relating to vibration-induced Dupuytren's contracture, an upper limb disorder involving finger the tendons. A report is likely this year or early next year.

113. ***Karen Hobson (Occupational Health Advisor, Rotherham Occupational Health Advice Service) – In my experience many claimants may pass the tests and satisfy the occupational questions, but fail to qualify for PD A11 as they are unable to give an accurate clinical history. People often find that they cannot remember the history of their disease and the specific order of their symptoms.*** As the attacks are rarely witnessed by the examining doctor the requirement for a clinical history is essential to ensure compensation is directed appropriately. The claimant needs to provide a history of their condition that is consistent with their symptoms. The medical assessor's are looking for a history that need not be exact, but is reasonable and consistent.

## Open Forum

### Facilitator: Claire Sullivan

114. The members of IIAC thanked the attendees for their participation in the Public Meeting.

115. ***David Goodwin (Regional Health & Safety Officer, HM Revenue and Customs) – Is there any way of assessing the amount of internal damage occurring in HAVS? Are there any post-mortem differences in the hands of those with and without HAVS?*** There are well documented histological changes to the blood vessels and nerve supplies associated with HAVS. However, every nerve has a blood supply and every blood vessel has a nerve supply. It is unclear whether the pathological differences start in the blood supplies or in the nerves.

116. ***Dan Shears (National Health, Safety & Environment Research & Policy Officer, GMB) – Has IIAC considered exposure of HGV and security drivers to diesel oil, following the reclassification of diesel oil as a Class I carcinogen by the International Agency for Research on Cancer (IARC)?*** IIAC is aware of the IARC reclassification and will review the relevant IARC monograph of evidence when it is published.

117. ***Dan Shears (National Health, Safety & Environment Research & Policy Officer, GMB) – HGV drivers sometimes develop 'claw hand'. Could this be due to vibration through the steering column?*** Whole body vibration has been associated with musculoskeletal symptoms in drivers. However, the levels of hand-transmitted vibration received through a steering column are relatively low. IIAC would welcome any information the GMB has about this issue and will search for any research evidence.

118. ***John Gibson (NUM) – After the prescription for HAVS changed to include the sensorineural components, claimants for PD A11 had their claims reviewed. However, their benefits generally remained unchanged with their previous overall assessment being split between the sensorineural and vascular symptoms. Should a claimant not get a higher assessment when the sensorineural symptoms are taken into account?*** Assessments consider the overall loss of function due to the prescribed disease. Thus, the effects of the sensorineural symptoms would have already been taken into account in the assessment for VWF. The terms of prescription for HAVS were changed to enable claimants with the sensorineural symptoms only to be eligible to claim PD A11, and they are in a minority.

119. ***Joe Gaskell (NUM) – Some of my members have also seen their assessments for PD A11 split between the vascular and sensorineural parts of HAVS. In other parts of the country members found their assessments tended to be increased. Different parts of the country seem to assess cases differently.*** Departmental medical policy advisors asked Mr Gaskell to send any cases to them for their consideration.

120. ***Karen Hobson (Occupational Health Advisor, Rotherham Occupational Health Advice Service) – Beta blockers are sometimes used to treat COPD, but can cause false spirometry readings. Some claimants have been turned down for COPD as they failed the lung function test due to their use of these inhalers. What is the Council's view on this?*** IIAC is currently considering the issue of inhaler use and assessment for COPD, and has been asking the opinion of respiratory experts. There is an argument that the assessment must take the person as you find them; consistency of assessment is essential.

121. ***John Gibson (NUM) – To what extent do medical examiners factor in obesity, and other causative factors, in considering diagnosis for vibration-related carpal tunnel syndrome?*** Medical assessors rely on obtaining a good occupational history. Other factors may be considered and off-sets made where appropriate. However, the Council's review of the presumption rule will include consideration of how occupational attribution should be made in cases of carpal tunnel syndrome when other risk factors are also present.

122. ***John Gibson (NUM) - Is there going to be a review of the schedule of losses?*** The Medical Assessments Working Group (MAWG) will be considering a wide range of issues, including whether there is scope to modernise this schedule. The schedule of disablement dates to World War II. It is difficult to map losses due to diseases against losses due to physical injuries. It should be noted that IIAC can only make recommendations. It is for Ministers to decide whether to accept and implement those recommendations. Ministers may accept the Council's scientific argument but other political factors may come into play as to whether changes are implemented.

123. ***David Goodwin (Regional Health & Safety Officer, HM Revenue and Customs) – What are the survival rates for mesothelioma?*** Mesothelioma is generally associated with a poor prognosis - 99% of cases die within 3 years, and most of those die within a year. However, a handful of cases survive longer than 3 years, when the disease is of the epitheloid type and it is caught early. Cases with prolonged survival are likely to have been histologically mis-diagnosed and may not have mesothelioma.

## List of delegates

| Surname | First name | Organisation |
|---|---|---|
| Appiah | Cecilia | Occupational Health Nurse |
| Babbings | Sandra | Professional Occupational Health Medical Services |
| Baker | Paul | IIAC Member |
| Basu | Subhashis | Sheffield Occupational Health Service |
| Bearpark | Heather | Specialist Community Public Health Nurse, University of Huddersfield |
| Bellas | Angela | Professional Occupational Health Medical Services |
| Britton | Mark | IIAC Member |
| Carlin | Audrey | Asbestos Support Team, Derbyshire |
| Catherall | Juliette | Benefit Advisor, Bradford Cancer Support Group |
| Cavilla | Ian | Chief Medical Advisor, Atos Healthcare Services |
| Cawley | Misty | Trainee Solicitor, Simpson Millar LLP |
| Connell | Malcolm | DWP |
| Claughan | Lawrence | Executive, Durham Miners Association |
| Collett | Oliver | Thompsons Solicitors LLP |
| Cooper | Steve | NUM |
| Cullinan | Paul | IIAC Member |
| Cummings | Alan | Executive, Durham Miners Association |
| Darnton | Andrew | HSE |
| Elliott | Rebecca | Senior Lecturer, Leeds Metropolitan University |
| Ellis | Colin | Occupational Health Advisor, Rotherham Occupational Health Advice Service |
| Exell | Richard | IIAC Member |
| Farrer | Elaine | Jobcentre Plus |
| Faupel | Paul | IIAC Member |
| Finn-Oldroyd | Melanie | Regional Health and Safety Officer, HM Revenue and Customs |
| Fryatt | Alison | DWP |
| Gaskell | Joe | NUM |
| Gibson | John | NUM |
| Gledhill | Judith | Thompsons Solicitors LLP |
| Goodwin | David | Regional Health & Safety Officer, HM Revenue and Customs |
| Gordon | Joanne | Asbestos Support Team, Derbyshire |
| Grey | Aimee | Occupational Health Nurse Advisor, University of Huddersfield |
| Hadfield | Dave | NUM |
| Hampton | Mick | DWP |
| Hegarty | Catherine | IIAC Secretariat |
| Henderson | Des | NUM |
| Hobson | Karen | Occupational Health Advisor, Rotherham Occupational Health Advice Service |

| | | |
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| Johnson | Alan | Executive, Durham Miners Association |
| Jones | Andrew | Convenor, UCATT |
| Kendall | David | DWP |
| Kesey | Catherine | Clinical Support Manager, Professional Occupational Health Medical Services |
| Kitchen | Chris | Secretary, NUM |
| Kloss | Diana | IIAC Member |
| Lamb | Keith | Welfare Officer, Durham Colliery Mechanics Trust |
| Lawson | Ian | IIAC Member |
| Leris | Clare | Medical Policy, DWP |
| Liddle | Robert | Durham Miners Association |
| Lowman | D | NUM |
| McElvenny | Damien | IIAC Member |
| Minns | Michelle | Occupational Health Nurse Advisor, University of Hull |
| Miller | Sandra | Occupational Health Nurse Advisor, University of Hull |
| Millman | Andrew | Occupational Health Consultant, York Teaching Hospital Foundation Trust |
| Mills | Tommy | NUM |
| Ogden | Rita | Occupational Health Specialist Practitioner, Bradford College |
| Oldale | Brian | NUM |
| Palmer | Keith | IIAC Chairman |
| Perry | Jim | Administrator, Durham Mechanics Trust |
| Redfearn | Sarah | Occupational Health Nurse Advisor, University of Hull |
| Roach | Gareth | IIAC Secretariat |
| Shaw | Tony | NUM |
| Shears | Daniel | National Health, Safety & Environment Research & Policy Officer, GMB |
| Shelton | Marianne | IIAC Secretariat |
| Siziba | Morren | Leeds Metropolitan University |
| Skidmore | Chris | President, NUM |
| Skonkwani | Silas | Occupational Health Nurse, William Cook |
| Sullivan | Claire | IIAC Member |
| Taylor | Denise | DWP |
| Thomson | John | NUM |
| Tomlin | Helen | Thompsons Solicitors LLP |
| | | |
| Turner | Andrew | IIAC Member |
| Watkin | Terry | Chairman, Durham Colliery Mechanics Trust |
| Welch | John | Raley's Solicitors |
| Whitty | Fergus | IIAC Member |
| Whitworth | Joe | Welfare representative, Durham Miners Association |
| Williams | Maria | DWP |
| Wright | Sue | Welfare Benefits Worker, Harrogate CAB |