

The logo consists of the letters 'I', 'I', 'A', and 'C' in a yellow serif font, separated by small yellow dots. These are centered within a solid green rectangular background.

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**The Industrial Injuries
Advisory Council**

**Proceedings of the
6th Public Meeting**

22 March 2007
Belfast

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Foreword

The sixth Public Meeting of the Industrial Injuries Advisory Council (IIAC) was held in Belfast on 22 March 2007. This event built on the success of the Public Meetings held in various locations across Great Britain over the past 4 years. The meeting was intended to allow members of the Council to hear from interested members of the public and enable those present to obtain a greater understanding of the work of the Council. The occasion provided the opportunity for several important issues to be raised and discussed, including reform of the Industrial Injuries Disablement Benefit Scheme, which the Council will consider at future meetings. The sixth IIAC Public Meeting was an informative occasion for the Council and we look forward to the next event in Birmingham (March 2008). I would like to thank all members of the public who came to the meeting for contributing to the very lively discussions which made it so worthwhile.

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 in providing advice to the Secretary of State. However, its recommendations are not necessarily consistent with current legislation, and during the Public Meetings members may have expressed personal views which are recorded in this report. The report should not be used as guidance on current legislation, or current policy within the DWP.

Professor Anthony Newman Taylor
Chairman IIAC

Agenda

- 09:00 – 09:45 Registration
- 09:45 – 10:15 **Welcoming Remarks**
Professor Anthony Newman Taylor (Chairman of IIAC)
- Followed by:
- IIAC's approach to scientific decision making**
Dr Keith Palmer (Chairman of IIAC Research Working Group)
- 10:15 – 11:00 **Review of the Industrial Injuries Disablement Scheme**
Professor Anthony Newman Taylor
- Discussion and questions**
Mr Hugh Robertson
- 11:00 – 11:30 Break
- 11:30 – 13:00 Presentations:
- 1) **Occupational lung disease** (Professor Anthony Newman Taylor)
 - 2) **Stress as an occupational disease** (Dr Anne Spurgeon)
- 13:00 – 14:00 Lunch
- 14:00 – 15:15 Presentation and open forum:
- 1) **Back and neck disorders** (Dr Keith Palmer)
 - 2) **Open forum**
- 15:15 End of public meeting

Welcoming Remarks

Professor Anthony Newman Taylor Chairman of IIAC

1. Professor Newman Taylor welcomed the delegates of the Belfast Public Meeting and the IIAC members introduced themselves.
2. The Industrial Injuries Scheme provides a non-contributory, no-fault benefit called 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. 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 has been linked with an occupational cause. The Scheme compensates employed earners; the self-employed are currently ineligible to claim IIDB for work-related ill health. Claimants can receive benefit from ninety days after the accident or onset of the prescribed disease; shorter periods of disablement are not compensated. The Scheme incorporates a presumptive element whereby if claimants fulfil the terms of prescription through being diagnosed with the disease and satisfying the occupational criteria, they do not have to prove that their disease was caused by their work.
3. IIAC is a statutory body, established under the National Insurance (Industrial Injuries) Act 1946, to provide independent advice to the Secretary of State for the DWP on matters relating to the IIDB Scheme. 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 attend IIAC meetings to provide information and advice. There are four meetings of the full Council per year.
4. 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's remit does not include advising on individual cases or on decision-making for claims.
5. A permanent sub-committee of the Council, the Research Working Group (RWG), monitors and reviews the 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.

6. IIAC also investigates diseases following referrals from the Secretary of State, correspondence from MPs, medical specialists and others, including topics brought to its attention by its own members.
7. IIAC produces several different types of publication. IIAC Command Papers are produced at the 'command' of the Secretary of State and are laid before Parliament, often forming the basis of legislation. Position Papers are published on important subjects that IIAC have considered, but where it does not recommend prescription or where the matter has not been referred by Ministers. Commissioned research reports are usually 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, which have direct relevance to the Council's programme of work. Finally, IIAC publishes an annual report, a strategic plan and the proceedings from its Public Meetings.
8. IIAC's current work programme consists of reviews of osteoarthritis of the knee, occupational coverage for chronic bronchitis and emphysema, back and neck pain, wood dust and nasopharyngeal cancer and pesticides and Parkinson's disease. IIAC is also involved in conjunction with the DWP in formulating the recommendations for reform of the IIDB Scheme for consideration by the Secretary of State.
9. The Council has completed six reports over the past year covering a wide range of occupational health issues. The review of the list of prescribed diseases began in 1997 was completed and was marked with the publication of a Command paper summarising the Council's recommendations. The Council also published the Command paper 'Extrinsic allergic alveolitis' – a review of metalworking fluid exposures which took only 10 months to complete. The position paper 'Interstitial fibrosis in coal workers' was also published following the issue being raised at a previous Public Meeting.

IIAC's approach to scientific decision making

Dr Keith Palmer

Chairman of the IIAC Research Working Group

- 10.** Dr Palmer introduced the theme of his presentation, which outlined the framework in which IIAC works and the process by which it prescribes occupational diseases. The Council is obliged to conduct its work in accordance with legal requirements as 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.
- 11.** Some occupational diseases are relatively simple to verify in that they have unique clinical features, rarely occur outside work, and have distinct clinical features that can be measured. 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 diseases.
- 12.** 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'. Epidemiology is the branch of medicine that deals with the distribution of a disease in populations and IIAC applies epidemiological principles when considering prescription.
- 13.** 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). 'More likely than not' means for those with exposure a fraction greater than 50%. If one considers there are 50 cases of a disease in a given-sized group of unexposed workers, this represents the background risk, which is common to everyone in the population under consideration. For the disease to be attributed to occupation as 'more likely than not' (e.g. have an attributable fraction that is larger than 50%) there would have to be at least 50 additional cases in a similarly-sized group of exposed workers, over and above the 50 'background' cases which occur as a matter of course. The benefit of presumption that the disease is caused by occupational exposure is with the exposed workers, since only 50 cases in that group are actually due to occupational causes, but all the exposed cases get the benefit of the

group's probability. Thus, 'more likely than not' equates to a more than doubling of risk in a given occupation compared with other occupations.

- 14.** In order to establish whether there is a doubling of risk for a disease and attribution 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 study, ideally several of different design, since it is less likely that any decisions based on them will be due to error or overturned by future research. It is also important that the disease and the relevant exposures can be easily verified and that it is a cause of genuine disability.
- 15.** The Council has already recommended prescription for several diseases where the process of attribution to occupation has been complex. These diseases include Vibration White Finger (VWF), carpal tunnel syndrome, chronic bronchitis and emphysema and osteoarthritis (OA) of the hip in farmers.
- 16.** 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 surgical waiting lists more often than expected given the relative frequency of farming 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 prevalent in farmers.
- 17.** 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.
- 18.** The consistent demonstration of a greater than doubling of risk in multiple surveys from more than one country allowed the attribution of OA of the hip in farmers to their occupation on the balance of probabilities.
- 19.** Verification of OA of the hip is straightforward since there are well-defined diagnostic criteria. Dr 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 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, is disabling and has been shown to be at least twice as common in farmers as in other groups.

- 20.** 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.
- 21.** OA of the hip in farmers fulfilled the criteria necessary to be able to diagnose and 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).
- 22.** As part of the review, OA of the hip in other occupations, such as those involved in heavy lifting, was also considered, but the weight of evidence was much less 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.

Review of the Industrial Injuries Disablement Scheme

Professor Anthony Newman Taylor

- 23.** The Industrial Injuries Disablement Benefit Scheme has been in operation since 1948 and was designed to compensate workers who became ill or injured as a result of their occupation. The Scheme is currently being reviewed by the government. Is the Industrial Injuries Disablement Benefit Scheme fit for purpose in the 21st century?
- 24.** IIDB is compensation paid for loss of faculty, the disability arising out of functional changes occurring, due to an accident or a disease. It is a no-fault Scheme – there is no need to establish liability.
- 25.** The current Scheme is not integrated with the government agenda of prevention, rehabilitation, retraining, job retention and return to work. Rehabilitation and prevention are the focus of many international occupational compensation Schemes. Reduced Earnings Allowance (REA) was a measure which allowed for IIDB claimants to retrain and rehabilitate without incurring financial penalty, but this was abolished as part of the Scheme in 1990.
- 26.** The majority of accidents and prescribed diseases are in males in traditional industries such as mining, manufacturing and construction and transport. Accidents generally account for 60% of new claims put into payment, prescribed diseases account for 35% with payments for REA for exposures occurring before 1990 accounting for the rest.
- 27.** The majority of new payments for IIDB are for diseases caused by historical exposures. In 2005/2006, two-thirds of new claims put into payment were for pneumoconiosis and mesothelioma. Claims for pneumoconiosis are likely to decrease over the next decade as the historical exposures leading to the disease no longer occur. More claims for mesothelioma are anticipated as the peak of the mesothelioma epidemic is yet to occur due to the long latency period between the exposure to asbestos and the onset of the disease. Musculoskeletal disorders and mental health disorders – a cause for concern for many of today's workers in numerous industries – are not a predominant feature in the current IIDB Scheme.
- 28.** The majority of claimants of IIDB and REA are over 40, with most claimants being between the ages of 60 and 70. This age distribution reflects compensation of long-tail diseases, such as mesothelioma, which have a long period between first exposure and the onset of the disease. Significantly more men receive IIDB payments than women, reflecting the types of diseases the Scheme compensates which tend to be related to industries which were typically male dominated.

- 29.** There may be a case for treating the different needs of various occupational diseases in separate ways and providing benefits appropriately. For example, weekly payments of IIDB may remain appropriate for diseases such as pneumoconiosis (a progressive pulmonary fibrosis), whereas lump sum payments may be more suitable for diseases such as mesothelioma, where prognosis is poor and life expectancy from first diagnosis is short. Certain diseases, such as occupational asthma, where the sufferer is unable to continue working with a particular sensitising agent, may benefit from retraining to a different job where such exposures do not occur.
- 30.** IIAC is working with the DWP in recommending reforms to the IIDB Scheme. A consultation paper has been published, and deadlines for responses are due in April 2007. The recommendations will be made in July 2007. The Chairman urged any participant of the Public Meeting to submit opinions and evidence to the consultation process for consideration by IIAC and the Department.

Questions and discussion

Facilitator: Mr Hugh Robertson

31. Jim Perry (Durham Mechanics) – What is IIAC’s view on providing IIDB benefits for coal miners with knee problems?

IIAC is currently reviewing evidence in relation to osteoarthritis of the knee in coal miners and will be making its recommendations later in 2007.

32. Jim Perry (Durham Mechanics) –Can colliery blacksmiths with heat cataracts claim IIDB?

Heat cataract is a prescribed disease for which IIDB is payable, although people may not appreciate this and fail to claim. There may also be a lack of medical specialists with the expertise to identify the disease.

33. Kevin Higgins (Advice Northern Ireland) – The welfare to work and budget plans are to make incentives to make work pay and to decrease the numbers of people on Incapacity Benefit. Is reduction in numbers claiming IIDB the aim of the current reform of the Scheme?

It is not the intent of the current reform to reduce the numbers of people eligible for the Scheme. The numbers of people eligible for the Scheme may fall as the most commonly claimed prescribed diseases are due to exposures no longer seen in modern workforces. IIAC continues to consider prescription for new occupational diseases based on emerging evidence. The reform will consider the extent to which new diseases such as musculoskeletal disorders can be included in the Scheme.

34. Kevin Higgins (Advice Northern Ireland) – It is sometimes difficult to obtain a diagnosis of asbestosis, despite fibrosis being observed on a chest X-ray.

Physicians need to be educated that fibrosis of the lungs in those exposed to asbestos is likely to be asbestosis. In England knowledge of occupational causes of fibrosis has definitely increased over the past 20 years.

35. Kevin Higgins (Advice Northern Ireland) – What is IIAC’s views on broadening the mesothelioma provisions for IIDB to those with asbestosis and other life limiting conditions?

In the 2004 Command paper ‘Asbestos-related diseases’, IIAC recommended IIDB claimants with lung cancer due to asbestos be treated in the same way as mesothelioma claimants due to the poor prognosis and short life expectancy. Asbestosis is a different case as it is a slowly progressing disease.

36. Viv Ferris (Royal College of Nursing) – Many nurses underwent their training and performed their jobs prior to the introduction of

the manual handling regulations. Back and neck disorders are only covered by the Scheme under the Accident Provisions. What is IAC's view on prescription for back and neck disorders due to wear and tear in nurses?

Prescription for back and neck disorders is currently under review by IAC. There is a growing body of research evidence on back and neck disorders in nurses and other occupations, and this topic will be covered in one of the presentations this afternoon.

- 37. Fiona Sterrit (Justice for Asbestos Victims) - What is IAC's opinion on the requirement for verification of the occupational history for asbestosis or mesothelioma under the Scheme? In Northern Ireland many people were exposed to asbestos in the Harland and Wolff shipyards. However, there were also many exposed through employment in small firms who are no longer in operation where verification of the history is not possible.**

Asbestosis and asbestos-related lung cancer require relatively heavy exposures to asbestos to develop. It would be unusual for a person with these conditions not to be aware of their exposure to asbestos.

Departmental advice is that decision makers should accept an occupational history unless there is a reason to doubt it; corroborative evidence of occupational exposure is not an absolute requirement. The Pneumoconiosis etc. (Worker's Compensation) Act 1979 also provides compensation for those people with asbestos-related diseases where no employer can be traced.

Mesothelioma occurs at a much lower level of exposure than asbestosis or asbestos-related lung cancer, such that the person may not be aware of their exposure to asbestos. Mesothelioma is also a rare disease whose causes are almost exclusively due to exposure to asbestos. There is no need for corroborative evidence and compensation is provided for anyone with mesothelioma due to occupational causes. The Minister has recently announced that compensation for mesothelioma will be extended to all individuals exposed to asbestos, including non-occupational exposures.

- 38. Brian Wallis (Medical Support Services) – There are a number of police officers in Northern Ireland that have Post-Traumatic Stress Disorder due to witnessing numerous incidents over several years, rather than one specific incident. Should Post-Traumatic Stress Disorder under the Accident Provisions cover multiple incidents over many years?**

IAC published a position paper 'Stress at work as a prescribed disease and Post-Traumatic Stress Disorder' in 2004. This clarified the criteria for Post-Traumatic Stress Disorder to be accepted as an Accident under the terms of the Scheme.

IAC members posed the following questions to the attendees of the Public Meeting - Is the IAC Scheme ideal? What are the attendees' thoughts on the reform of the IIB Scheme?

- 39. Viv Ferris (Royal College of Nursing) – Obtaining a diagnosis and treatment for an occupational injury or disease can take longer than six months. After a person has been unemployed for more than six months, they are less likely to return to work. To help people return to work there would have to be early interventions for redeployment and retraining to be effective. Where would the money for these initiatives come from?**

Initiatives for rehabilitation, retraining and redeployment would require early case identification within the first 6-8 weeks of the accident or disease occurring. It is unclear whether the capacity for rehabilitation, etc. is available within the NHS.

The Pathways to work initiative provides access to advice about return to work for those out of work for greater than six months. This initiative has had encouraging results. In Wales, the Well Being in Work initiative for NHS Trust workers helps people back to work a month after their injury or disease. If this initiative is successful it may be rolled out to other parts of the country.

REA provided a partial earnings replacement allowing those whose disease would progress if they stayed in the same job to retrain and redeploy to different employment. Restoration of a benefit similar to REA could be linked with a rehabilitation and retraining programme.

- 40. Delia Skan (Senior Medical Officer, Employment Medical Advice Service) – In Northern Ireland a third of workers are employed in the public sectors. If good practises for retraining, rehabilitation and redeployment could be applied to these workers it would make a significant difference.**

- 41. Delia Skan (Senior Medical Officer, Employment Medical Advice Service) – There are a small number of people claiming mesothelioma benefits. Is this due to poor take up of the benefit?**

In its last review of asbestos-related diseases in 2004, IAC was concerned about the low numbers of claimants for mesothelioma and the possibility this was due to low take up. IAC recommended that lung cancer nurses passed on information about benefit entitlement to mesothelioma sufferers. The British Lung Foundation has also held mesothelioma awareness days to highlight issues, including benefit provisions.

Occupational Lung Disease

Professor Newman Taylor

23. The lungs can be thought of as having two compartments: the conducting airways and the peripheral gas exchanging parts of the lung. The conducting airways are the trachea, which branches into bronchi and smaller bronchioles, which lead into the alveoli blind ending sacs, where gas exchange occurs. Inhaled material reaches the lungs via the airways. To be inhaled, particles must be small enough to be suspended in the air or be present as a gas, vapour or fume. Soluble gases and vapours, such as SO₂ and NH₃, which dissolve in the fluid lining their surfaces, cause irritation and inflammation in the eyes, nose and airways. Insoluble gases, (e.g. phosgene) and fumes (e.g. cadmium) are not dissolved in the conducting airways and are able to penetrate to the alveoli, causing acute pulmonary oedema.
24. Pneumoconiosis (including silicosis and asbestosis) and byssinosis account for significant numbers of the current IIDB case load in Northern Ireland. It is possibly surprising that byssinosis is still prominent in Northern Ireland given the disappearance of the flax industry in the 1960s and 70s. There are also relatively few cases of mesothelioma. It is unclear whether this is due to a falling number of cases in Northern Ireland, due to the early introduction of measures to control exposure to asbestos, or to a lack of uptake of IIDB in this region.
25. In attributing a disease to a specific occupational cause, some disorders are easy to recognise while others are not. Accidents where a substance has been inhaled leading to an acute reaction in the lungs and diseases with specific clinical features, such as occupational asthma, lie at the 'easy' end of attribution. Diseases where cases attributable to occupation are clinically indistinguishable from non-occupational cases are more difficult. In these circumstances, IICAC relies on epidemiological evidence where an inference is drawn from population studies comparing the frequency in exposed and non-exposed populations to the individual case (where attribution is on the bases of "more likely than not"). For some diseases, the epidemiological evidence is straightforward and attribution to an occupational cause is easy (e.g. asbestos and mesothelioma). In others, identifying occupational causation from epidemiological evidence is difficult, especially when the disease has a dominant non-occupational cause and is common in the general population, such as lung cancer, chronic bronchitis and emphysema, which are primarily caused by cigarette smoking.
26. The agents which predominantly cause occupational asthma include isocyanates and flour. These are also the most common agents for which IIDB is paid for occupational asthma. As well as the listed agents causing occupational asthma for which IIDB is payable, there is an open category

where verification that an agent is responsible for a claimants asthma can be verified by an inhalation test.

- 27.** Asbestos became widely used in the late nineteenth and twentieth centuries due to its remarkable insulation properties. Different types of asbestos exist (chrysotile, amosite, tremolite and crocidolite), and most occupational exposures are to a mixture of these. Asbestos was eventually banned in UK due to its adverse effects on respiratory health and mortality by the late twentieth century. Inhaled asbestos is responsible for several respiratory conditions. These include benign (i.e. non malignant) conditions, such as pleural plaques, diffuse pleural thickening and asbestosis, and malignant diseases, such as mesothelioma of the pleura and peritoneum and lung cancer. Pleural plaques are not a prescribed disease as they do not impair lung function or cause respiratory disablement. Lung function can be reduced in diffuse pleural thickening, where the lining of the lungs becomes thickened causing constriction of the lungs. In asbestosis, fibrosis occurs in the alveoli, causing stiffening of the lungs, which limits the ability to breathe in, and impairment of gas transfer. Diffuse pleural thickening and asbestosis are prescribed diseases.
- 28.** Mesothelioma is a malignant tumour of the pleura (the lining of the lungs) and, the peritoneum (the lining of the abdomen). In the UK, there has been a high incidence of cases of mesothelioma clustered in areas historically associated with asbestos work, where ship and railway manufacture and repair were undertaken. Before the 1960s the Royal Naval Devonport dockyards used considerable quantities of crocidolite and amosite asbestos. However, from the mid 1960s alternative insulation material was used and respiratory protection provided. The measures at the Royal Naval dockyards have resulted in a decrease in the number of cases of mesothelioma since the early 1990s. However, these preventative and protective measures were not implemented in the construction industry until the 1970s or 1980s with a consequent continuing increase in the incidence of mesothelioma. The peak incidence of mesothelioma caused by this continuing asbestos exposure will probably not be reached until 2011-2015, with two thirds of the cases yet to occur. In Western Europe, Britain and France are expected to have the highest numbers of mesothelioma deaths, with Switzerland having the lowest.
- 29.** Mesothelioma is almost exclusively caused by asbestos and can be caused by relatively low levels of exposure to asbestos. This was reflected in the IIDB prescription as “exposure to asbestos, asbestos dust or any admixture of asbestos at a level above that commonly found in the environment at large”. Claims for mesothelioma are now ‘fast-tracked’ by the DWP meaning there is no 90 day waiting period, claimants are automatically awarded 100% assessments and there is no absolute requirement for corroborative evidence of occupational exposure.

- 30.** In contrast to mesothelioma, which other than in those exposed to asbestos is a rare tumour, lung cancer is common, primarily caused by cigarette smoking, making its relationship to asbestos exposure more difficult to discern. Asbestos was linked to lung cancer in 1947, when it was observed that cases of asbestosis were more likely than cases of silicosis to die of lung cancer. Subsequently, in 1955, Doll provided unequivocal evidence of a greatly increased risk of lung cancer in those with asbestosis who had worked in an asbestos textile factory.
- 31.** The risk of lung cancer is unequivocally increased in cases of asbestosis. However, it has been unclear whether the risk of lung cancer was increased in those exposed to asbestos, independently of asbestosis. Recent evidence has indicated that asbestosis is not a necessary precursor of lung cancer, but lung cancer and asbestosis probably occur at similar levels of asbestos exposure. Asbestos-related lung cancer in the absence of asbestosis was prescribed in 1982 in those with diffuse pleural thickening, as an indicator of asbestos exposure sufficient to cause lung cancer.
- 32.** In 2004, IAC reviewed the terms of prescription for asbestos-related diseases. New evidence indicated that diffuse pleural thickening was not a reliable indicator of levels of exposure to asbestos sufficient to cause lung cancer.
- 33.** IAC found that certain workers, asbestos textile workers, asbestos sprayers and insulation workers, there was a greater than doubling in the frequency of lung cancer as compared to the number expected.
- 34.** IAC recommended, therefore, that lung cancer in the absence of asbestosis be prescribed for “exposure to asbestos for at least 5 years before 1975 and 10 years after 1975 in the following occupations i) workers in asbestos textile manufacture; ii) asbestos sprayers and iii) asbestos insulation work, including those applying and removing asbestos containing materials in shipbuilding.
- 35.** Some diseases such as cancer are ‘all or nothing’; one either has it or not. Other diseases, such as chronic obstructive pulmonary disease (COPD) are ‘more or less’ conditions’; it is less whether one has it than how much of it one has.
- 36.** COPD is a serious and progressive disease and is associated with a high mortality. COPD is an umbrella term which encompasses several conditions, which include chronic bronchitis and emphysema. The British Thoracic Society has defined COPD as a slowly progressive disorder, characterised by airways obstruction (reduced FEV₁ and FEV₁/FVC ratio), which does not change markedly over several months and where most of the impairment of lung function is irreversible.
- 37.** The major cause of COPD in general is cigarette smoking. However other causes, including occupational causes contribute to the burden of

disease. The American Thoracic Society estimated that some 15% of COPD may be attributable to occupation. The difficulty is in identifying the occupational causes of COPD in a disease common in the general population. COPD is currently prescribed in relation to coal dust for underground coal miners, cadmium fume and byssinosis. IAC is currently reviewing whether there are any other occupational causes of COPD which should be prescribed.

- 38.** The diagnosis of COPD is made by demonstrating a reduction in the forced expiratory volume in 1 second (FEV_1) and in the ratio of FEV_1 to FVC (forced vital capacity). In a normal individual, FEV_1 increases with age from birth until the mid 20's when lung function reaches a plateau. Lung function then declines with age, but at a rate and to a level that will not usually cause any discernable problems in a normal life span. The rate of decline of lung function is increased in individuals who smoke to a level where airflow limitation can cause severe breathlessness on exertion or cause death.
- 39.** Taking age, gender and height into account, lung function values in the population will be equally distributed above and below the average. The lung function of the majority (95%) will lie within two standard deviations of the average values. Studies have shown that those whose lung function lies more than two standard deviations below the average value are some fifty times more likely to die of COPD as compared with those whose FEV_1 is average or greater. In considering prescription for chronic bronchitis and emphysema, IAC looked for occupational exposures where there was evidence that the proportion of individuals whose lung function was more than two standard deviations below their predicted average values having taken smoking habits into account, was at least doubled as compared to the general population.
- 40.** Several studies have found an increased risk of death from COPD in those exposed to cadmium fumes. The higher the exposure to cadmium fumes, the greater the risk of death from COPD in exposed workers. Excess deaths from COPD in cadmium-exposed workers might have been due to smoking. However, there was no concomitant increase in lung cancer in cadmium-exposed workers, which would be anticipated if smoking was the cause of the excess mortality from COPD. In addition the frequency of reduced FEV_1 and other (clinical) indicators of emphysema were markedly increased in those exposed during life to cadmium fume. In 2002 in its 'Conditions due to Chemical Agents' Command paper, IAC recommended that emphysema be prescribed for workers exposed to cadmium fumes.
- 41.** Prescription for chronic bronchitis and emphysema in coal workers was based on a study of British coal miners which showed that the risk of having an FEV_1 more than two standard deviations below the predicted average value was more than doubled in both smokers and non smokers in those with high as compared to low coal dust exposure. This was observed in both smokers and non-smokers.

42. Byssinosis is a response in the airways of the lungs to the inhalation of dust emitted during processing of cotton, flax and soft hemp fibres worldwide. Studies in the 1950s and 60s in the Lancashire cotton mills characterised the severity of the disease in a graded scale from 1 to 3. In grade 1 byssinosis, chest tightness occurs on every first day of the working week. With continuing exposure, grade 2 byssinosis occurs and chest tightness will be observed on every first day and other days of the working week. In the most severe cases, grade 3 byssinosis occurs where there is evidence of permanent incapacity from reduced ventilatory capacity.
43. The majority of dust exposure occurs in the carding or preparation rooms in cotton, flax and hemp spinning factories. Workers in card rooms showed a greater reduction in lung function on the morning shift of the first day of the working week compared to workers in other working areas in the factories.
44. Shilling in the 1950's found that the prevalence of byssinosis depended on the position of the worker in relation to the card engines. The prevalence of byssinosis in workers who worked on the card engines was 70% compared to 50% and 25% in workers who were near or far respectively from the engines. The type of cotton also affected the prevalence of byssinosis, with the disease being observed in 70% of workers exposed to coarse fibres compared to 35% of workers exposed to fine fibres.
45. It was unclear whether byssinosis caused COPD. Mortality studies from female textile workers showed a greater than doubled increase in the proportional mortality ratio (PMR) for chronic bronchitis and emphysema in textile workers as compared to the general population. The PMR for lung cancer was not increased in textile workers, suggesting that the increase in chronic bronchitis and emphysema was not due to smoking. In the 1995 Occupational Health Decennial Supplement, byssinosis and chronic bronchitis and emphysema were one of the main causes of death in female textile workers in England and Wales. A recently reported cohort study of cotton and silk workers in China has found a greater loss of FEV₁ in the cotton workers, primarily in those with a history of repeated episodes of byssinosis. COPD is currently prescribed in textile workers with a history of byssinosis.
46. Completion of IIAC's review of the occupational exposures for COPD is anticipated by Autumn 2007. Examples of the occupational exposures under consideration are textile dust (cotton and flax), surface coal workers, and welding. Chronic bronchitis and emphysema (or its updated term, COPD) is an important part of the Scheme, accounting for a significant part of the IIDB caseload. This presentation shows the type of type of evidence IIAC requires to be able to prescribe for different occupational exposures.

Comments and questions

- 47.** There are approximately 40 claims in Northern Ireland for IIDB for mesothelioma per year. It is difficult to analyse trends with small numbers of claims. The number of mesothelioma deaths continues to rise with an increasing proportion of carpenters, plumbers and engineers. The number of mesothelioma deaths may be under-represented. Some coroners will automatically order a post-mortem if any exposure to asbestos is likely to have occurred, but other coroners will not.
- 48.** The risk of mesothelioma increases with increasing levels of asbestos exposure. Several asbestos fibres will produce changes at a cellular level. There is no clear cut-off point below which asbestos is not harmful. However, the risk of contracting an asbestos-related disease from contact with asbestos boarding or cement which is intact or properly sealed is very small.
- 49.** Northern Ireland has a large population of agricultural workers. IIAC has considered evidence relating to COPD in animal and poultry workers. There is a lack of suitable evidence to assess whether there is a greater than doubled risk of loss of lung function in animal confinement workers. Evidence shows there is an accelerated decline in FEV₁ in Canadian grain silo workers. However, studies suggest exposure to grain dust in Europe may not be as high as in Canada. In many cases of occupational exposures related to COPD, there is insufficient evidence of a greater than doubled risk of loss of lung function to be able to extend the current prescription.

Stress as an occupational disease

Dr Anne Spurgeon

50. This presentation focuses on stress-related conditions and the difficulties that face IAC in prescribing them under the IIBD Scheme. There are two categories of occupational stress which have been considered by IAC: general stress-related illness and the more specific Post-Traumatic Stress Disorder (PTSD).
51. The HSE define stress as 'the adverse reaction people have to excessive pressure or other types of demand placed upon them'. This definition was developed in the context of management guidance for prevention and control and represents a consensus expert view. Within this definition several categories of pressure have been identified:
- i) **Demands** - overload, time pressure, long hours, inadequate resources
 - ii) **Control** - lack of participation in decision about the way work is organised
 - iii) **Support** - lack of support from colleagues
 - iv) **Relationships** - being subjected to unacceptable behaviours (e.g. bullying at work)
 - v) **Role** - lack of understanding about roles and responsibilities
 - vi) **Change** - lack of consultation or information when undergoing organisational change
52. Individuals may respond to these pressures with adverse physiological, psychological and behavioural reactions. An example of physiological responses would be an increased heart rate and elevated blood pressure. Psychological responses would include the development of conditions such as anxiety and depression, while changes in behaviour might include altered patterns of eating and sleeping or abuse of substances such as drugs and alcohol. Possible outcomes of these responses together or alone might be demonstrable effects on physical or mental health, effects on social behaviour or on performance at work.
53. Prescription of any disease within the IIBD Scheme must meet criteria which are described in statute. This process involves identifying a health outcome (disease or condition), quantifying the exposure necessary to cause the disabling condition and attributing the illness to an occupation on the basis of research which describes epidemiological distributions and clinical features.
54. Defining a health outcome in relation to stress-related conditions poses a number of challenges for IAC. There is poor consensus on case definition and on the assessment of severity of stress-related disorders.

The nature of the conditions makes quantitative or objective testing of the disablement difficult. There is a general reliance on symptoms which makes independent verification of the conditions difficult. There are differing opinions on whether stress can be labelled as a disease. Mental health problems such as anxiety or depression may be more readily identifiable but there is frequently disagreement between experts on diagnosis.

55. The assessment of exposure is important when IIAC are considering whether a disease should be prescribed for the IIDB Scheme. The source of stress-related disorders may be occupational or non-occupational. Stress at work may affect stress at home, and vice versa. While a number of triggers have been identified, there is no agreement on a reliable method by which to confirm with consistency, the presence or absence of particular stressors, or the degree of exposure to these.
56. The attribution of a stress-related condition to occupation is difficult, not least because these conditions are very common in the general population and are not unique to any particular occupation. In addition these conditions do not have distinctive clinical features when related to occupation; the causes are often multi-factorial; risk factors may be influenced by personal perceptions and most importantly from IIAC's point of view, there is no strong evidence to identify a doubling of risk for the condition in specific occupations.
57. IIAC have been unable to recommend that any adverse health outcomes ascribed to stress at work be included on the schedule of prescribed diseases.
58. Post-traumatic stress disorder (PTSD) is a recognised psychiatric disorder which can be compensated under the Accident Provisions of the IIDB Scheme. PTSD must have arisen as consequence of an identifiable accident (which can be a single event or a series of single events over a short period of time) arising out of their work for a claim to be eligible for IIDB. IIAC recommended in its Position Paper that a diagnosis of PTSD should only be made where the person has experienced, or witnessed at first hand, a life-threatening event (or series of single life-threatening events over a short period).
59. The definition of PTSD has two elements:

i) Condition	ii) Exposure
- Response to event - intense fear, horror, helplessness.	- Traumatic single event.
- Avoidance of related situations.	- Life threatening or potential to cause serious harm to self or others.
- Flashbacks.	- Outside realms of normal experience.
- Persistent psychological distress & anxiety.	- Readily perceived as such by others.
- Impaired social	

functioning.

60. In summary, at present PTSD can be compensated through the Accident Provisions of the IIDB Scheme. However, no adverse effects ascribed to occupational stress are included in the list of prescribed diseases for which IIDB is payable.

Comments and questions

61. Work-related stress is not a listed occupational disease for state benefits in any other country, although may be compensated where countries operate an open list system. The same problems identified by IIAC in prescribing work-related stress exist in other countries.
62. In Northern Ireland there are cases of police officers who claim for PTSD after multiple incidents ranging over numerous years. PTSD is currently defined by the World Health Organisation and the American Psychiatric Association as occurring only in response to a single, traumatic event.
63. The response to a stressor depends on the individual, their sensitivity to stress at certain times in their lives and compared to others. No job is inherently more stressful than any other. The emphasis in occupational health research and practice is to define the levels of stress and what causes stress in an occupation. There is limited evidence examining the levels of stress between different jobs.
64. Some people thrive on stress. People in stressful jobs who do not thrive on stress may leave stressful jobs. Thus, a population of workers in a stressful job may be represent a biased sample as it may include a higher proportion of people who thrive on stress and a lower proportion of those who are sensitive to stress. Thus worker selection may affect research outcomes. For this and a variety of other reasons, important research questions about stress may not be capable of being fully addressed.
65. Evidence shows that unemployment is stressful and, itself, has an adverse effect on mental health.
66. The lack of ability to include workers suffering conditions such as stress-related illness in the current provisions for IIDB, is one of the reasons for considering reform of the Scheme.

Back and neck disorders: the case for and against prescription

Dr Keith Palmer

- 67.** According to the HSE's Self-reported Work-related Illness (SWI) survey, 1 million musculoskeletal disorders are caused or made worse by work, with just under half of those disorders being due to back pain. Back and neck disorders are clearly an important occupational health problem, but one which poses a tough challenge for prescription.
- 68.** Spinal pain is common. The exact frequency of back pain depends on the definition of the condition - where it is felt and how long you feel it for. The prevalence of ever having had low back pain is 60-80%, compared with a prevalence of 17-31% of having current low back pain. For neck pain, the prevalence is greater than 60% for ever having had the condition, with 14% having had greater than a week of neck pain in the past month.
- 69.** For most people spinal pain is episodic. If one considers a cross-section of individuals attending their GP with low back pain, most cases will be new episodes, a small number will be persisting ones and some will have acute-on-chronic episodes. After three months, the back pain in many individuals will have improved or gone away, but around half will have got worse or remained the same.
- 70.** The traditional concept of back pain is that there is a larger proportion of individuals with acute low back pain ('the mountain') compared to a small proportion of individuals with chronic low back pain ('the molehill'). In practise, low back pain follows a less defined path, with individuals having back pain that fluctuates over time, sometimes being worse, sometimes better along a continuum. This poses a challenge to prescription as back and neck pain are transient problems.
- 71.** Most people with back pain get back to work relatively quickly. However, a small fraction develop chronic health problems, remaining off work for a significant period of time. It is challenge clinically and in compensation to identify those individuals likely to develop long-term problems.
- 72.** There has been an epidemic of back pain disability nationally, with an 8-fold increase in the number of days of sickness and invalidity benefits claimed for back pain in the last 50 years. Paradoxically, the physical demands of work have fallen over this period. The current back pain epidemic cannot be explained by physical risk factors alone, and seems due in part to psychosocial and cultural differences.
- 73.** The sensation of pain, or nociception, is felt by the brain. According to Loeser's model of chronic pain, personal factors such as pain behaviour, suffering and the degree of pain all alter the experience of pain.

- 74.** There are personal and cultural predisposing factors to the experience of pain. Personal factors include gender, personality traits, personal gain and mental health. Cultural factors include an individual's beliefs about illness, media publicity and the availability of compensation Schemes.
- 75.** These influences can be quite strong. A one-year follow-up study looked at the psychosocial predictors back pain in patients registered with GPs in South West England. The study found that the worse the state of distress observed at the beginning of the study, the greater the risk of new pain or old persistent pain occurring by the end of the study.
- 76.** In the same study, individuals with pessimistic views about the long-term outlook of their back pain were more than twice as likely still to have problems with their backs in 12 months time. The excess risk of persistent back pain remained after the data was adjusted for mental health beliefs and pattern of pain at the start of the study.
- 77.** A prevalence study of workers undertaking similar jobs in the UK compared to Mumbai in India showed that back pain was reported less often in Mumbai than in the UK, suggesting that cultural factors may influence perceptions about back pain.
- 78.** Psychosocial factors are clearly an important part of the experience of back pain. But spinal pain is multi-factorial and it is well recognised that physical risk factors can also make things worse.
- 79.** Evidence shows that blue-collar workers, who have more physically strenuous work, take longer to return to work following an episode of back pain than white-collar workers. The National Institute of Occupational Safety and Health in the USA has reviewed evidence relating to back pain and concluded that there was strong evidence that lifting/forceful movements and whole body vibration were causal risk factors.
- 80.** As outlined in an earlier talk, when considering the case for prescription for any occupational disease, IIAC looks for a workable and robust diagnosis, a disease that causes genuine and lasting impairment, exposures that can be verified within the Scheme by lay administrators, and sufficient evidence to make occupational attribution likely in the individual case.
- 81.** The scientific evidence should come from several independent studies. There are numerous studies on spinal pain, and this criterion for prescription is readily satisfied.
- 82.** Although many cases are acute and resolve by themselves, back pain is sometimes a cause of genuine permanent and disabling impairment and so for some people this condition is also met.

- 83.** Certain exposures, such as increased load, repetition and posture, have been associated with increased back pain. It would be difficult for the IIDB Scheme decision maker to verify those exposures. However, prescription for back pain could be based on job titles, if there were evidence that any specific jobs were associated with increased back pain, so this criterion might be achievable.
- 84.** For diseases with no unique clinical features and with both occupational and non-occupational causes, IAC seek epidemiological evidence of a greater than doubled risk that the disease occurs in exposed compared to non-exposed individuals to fulfil the attribution question. However, for very common definitions of the outcome it is difficult to demonstrate a greater than doubled risk. (More than 60% of the general population have experienced back and neck problems. It is not possible to have a greater than doubled risk as it is impossible to have 120% affected.). For less common outcomes (e.g. very severe back pain), a doubling of risk might be possible; but this consideration sets a limit on the range of outcomes where a 'balance of probabilities' attribution can be made.
- 85.** Much of the epidemiological evidence on back pain is expressed in the form of odds ratios rather than relative risks. Dr Palmer illustrated that for common diseases odds ratios can give a misleading impression of whether the balance of probabilities argument has been met. This demonstrates the care that needs to be taken when interpreting the research literature for prescription.
- 86.** To fulfil the criteria for prescription back and neck disorders must also be diagnosable. However, back and neck pain are symptoms and not diseases. To corroborate their existence, a patient might be examined by a doctor for local tenderness or painful/restricted movement or asked to undertake a 'functional capacity evaluation' (e.g. shuttle walk test, '1 minute of standing' test) or to fill out a standardised disability questionnaire. But none of these methods provide an independent measure of the outcome; they are semi-objective, all requiring the co-operation and input of the claimant.
- 87.** Could X-rays and CT or MRI scans be used to provide independent corroboration for back and neck disorders? In many cases, the amount of pain and disability felt does not correlate well with degenerative changes observed on X-rays and CT or MRI scans. For example, X-rays of several thousand people in Wales showed significant lumbar disease (grade 3-4) in 18% of men and 12% of women, but any grade changes were noted in 74% of men and 59% of women. The people recruited for this study were not patients with back pain but ordinary members of the general population. Similar results were observed with X-rays for cervical disease in the general population. After a certain age most people will have some degree of degenerative changes observed by X-rays.
- 88.** MRI scans of patients without back pain also show up a broad range of back conditions and are poor in corroborating the presence of active

back problems. Disc bulging, disc protrusion and annular tears are observed in 73%, 50% and 37% respectively of MRI scans of patients *without* back pain.

89. There are major doubts that objective disease verification is currently possible within the IIDB Scheme. Ongoing research may identify subgroups in which an objective diagnosis can be supported but this lies in the future.
90. Back pain is an example of a tough case for prescription. IIAC's recommendations on prescription for back and neck disorders are likely to be published Autumn 2007.

Comments and questions

91. Not all back and neck pain sufferers have MRI scans. It is unrealistic to ask claimants for back pain to undergo an MRI scan for the purposes of prescription, although the most severely disabled patients are likely to have MRI scans as part of their diagnosis.
92. Back pain and disability from back pain are poorly correlated. Many factors are involved in back pain other than physical, organic and medical disease. This makes prescribing for back pain challenging.
93. Advice from healthcare professionals has changed in recent years, with patients with back pain advised to remain active within the limits of their symptoms; it seems that a positive attitude and encouragement to keep active within the limits of pain is helpful in most cases in reducing long-term disability.
94. Individuals can claim for back pain as part of the Scheme's Accident Provisions if the condition arose from an identifiable incident. (This talk concerned the possibility of back pain becoming a Prescribed Disease.)

Open Forum

Facilitator: Mr Simon Levene

- 95.** The open forum provided the members of IIAC and the attendees of the Public Meeting an opportunity to discuss any matters relating to the Council's work and the IIDB Scheme.
- 96.** In the UK, the consultation period for the reform of the IIDB Scheme ends on 22 April 2007. Reforms of the Scheme occurring in Great Britain will likely be paralleled in Northern Ireland.
- 97.** There is a case for considering the reform of the 90 day waiting period for claims. Evidence suggests that successful rehabilitation for certain musculoskeletal disorders and mental health conditions relies on early intervention within a matter of weeks. Rehabilitation may not be as successful if a claimant's condition has worsened during the 90 day waiting period.
- 98.** REA provided a means to encourage sick and injured workers back to employment. Introduction of a benefit similar to REA combined with the current Incapacity Benefit provisions for early access to return to work assistance should be considered.
- 99.** The self-employed are not eligible for IIDB under the current provisions of the Scheme. In civil litigation a self-employed person is treated as an employee if they have no control over their working environment and are effectively an employee.
- 100.** The members of IIAC thanked the attendees for their participation in the Public Meeting and urged them to contribute to the current consultation process for reform of the IIDB Scheme.

List of delegates

Name		Organisation
Asherson	Janet	IIAC Member
Aylward	Mansel	IIAC Member
Black	Derek	Information Office
Britton	Mark	IIAC Member
Capper	David	Queen's University
Cockcroft	Anne	IIAC Member
Clarke	Diane	Social Security Policy and Legislation Division
Connolly	Ronnie	Social Security Agency
Creane	Janis	Social Security Policy and Legislation Division
Crowther	G	CMA, Occupational Health and Welfare
Cullen-Voss	Peter	IIAC Secretariat
Dales	Joan	Royal College of Nursing
Dawson	Mildred	Social Security Agency
Donnelly	Martin	Disability Living Allowance Advisory Board
Ensor	Su	Job Centre Plus
Ferris	Vivienne	Royal College of Nursing
Fuller	Terry	Ulster Supported Employment Limited
Giboney	Donna	Dept Enterprise Trade & Industry
Gillan	Geoff	University of Ulster, Coleraine
Goodwin	Margaret	Grampian Country Pork
Griffin	Liz	Standards Assurance Unit
Hajee	Zarina	IIAC Secretariat
Higgins	Kevin	Advice Northern Ireland
Hinton	Jim	Decision Making Services
Johnston	Denise	Occupational Health Co-ordinator, Bombardier Aerospace
Kloss	Diana	IIAC Member
Joyce	Dave	National Health & Safety and Environment Officer Communication Workers Union
Levene	Simon	IIAC Member
Lamb	Keith	Durham Mechanics
Lawson	Ian	IIAC Member
Lee	Brian	Justice for Asbestos Victims
McGinley	Stephen	Standards Assurance Unit
McHenry	Karen	Social Security Policy and Legislation Division

Meeke	Ann	Social Security Agency
Mitchell	Wilfred	Federation of Small Businesses
Newman Taylor	Anthony	Chairman IIAC
Nic Giolla Cathain	Monica	
Murphy	Bernie	Social Security Agency
O'Neill	John	Social Security Policy and Legislation Division
Palmer	Keith	IIAC Member
Perry	Jim	Durham Mechanics
Pierre	Diane	IIAC Secretariat
Pollock	Ruth	Bombardier Aerospace
Rafferty	Ray	Unison
Reed	Susan	Department for Work and Pensions
Robertson	Hugh	IIAC Member
Roy	Doreen	Social Security Policy and Legislation Department
Shelton	Marianne	IIAC Secretariat
Skan	Delia	Senior Medical Officer , EMAS
Spurgeon	Anne	IIAC Member
Sterrit	Fiona	Justice for Asbestos Victims
Stidolph	Paul	IIAC Secretariat
Sullivan	Claire	IIAC Member
TBA	TBA	Durham Mechanics
TBA	TBA	Justice for Asbestos Victims
TBA	TBA	Justice for Asbestos Victims
Tilt	Richard	Independent Review Service
Toner	Kevin	Dept Enterprise Trade & Industry
Turner	Andrew	IIAC Member
Wallace	Brian	Medical Support Services
Ward	Rob	Job Centre Plus
Watkin	Terry	Durham Mechanics
Whitty	Fergus	IIAC Member
Wright	Lucille	IIAC Member