INDUSTRIAL INJURIES ADVISORY COUNCIL

Minutes of the IIAC Meeting – 21 April 2016

Present:

Professor Keith Palmer	IIAC (Chair)
Dr Paul Baker	IIAC
Professor Paul Cullinan	IIAC
Dr Sara De Matteis	IIAC
Professor Sayeed Khan	IIAC
Dr Ira Madan	IIAC
Ms Karen Mitchell	IIAC
Mr Hugh Robertson	IIAC
Mr Doug Russell	IIAC
Professor Anthony Seaton	IIAC
Dr Andrew White	IIAC
Dr Emily Tucker	Strategic Health and Science Directorate
Dr Anne Braidwood	MoD
Mr Steve Brookes	Departmental IIDB policy official
Mr Stuart Whitney	Diffuse Mesothelioma Payment Scheme
Ms Trish Pickford	Open Meeting observer from agenda item 5 onwards)
Mrs Rebecca Murphy	IIAC Secretariat
Dr Marianne Shelton	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Welcome: Mr Stuart Whitney (who works on the Diffuse Mesothelioma Scheme and was attending as an observer), Ms Trish Pickford (Open Meeting observer) and Mr Steve Brookes (Departmental policy official)

Apologies: Professor Neil Pearce, Mr Richard Exell, Professor Damien McElvenny, Mr Andrew Darnton, Mr Keith Corkan, Mr Paul Faupel, Dr Karen Walker-Bone, Mr Neil Walker and Mr Mark Smith

1 Announcements and conflicts of interest statements

1.1 **Open meeting** – As part of IIAC's stakeholder engagement programme the meeting was opened to members of the public from agenda item 5 onwards. One member of the public attended the Open meeting.

1.2 **Publication of IIAC reports** – Members were informed that the following Command papers had been published on the www.gov.uk/iiac website:

- Command paper 'Extrinsic allergic alveolitis: Isocyanates and other occupational causes' (12 April 2016);

- Command paper ‘Diffuse pleural thickening’ (12 April 2016);
- Command paper ‘Cancers due to ionising radiation’ (25 February 2016);
- Information note ‘Lung cancer and diesel exhaust emissions in miners’ (16 February 2016)

1.3 **Re-appointments –** Professor Anthony Seaton, Dr Karen Walker-Bone and Mr Keith Corkan have been re-appointed as independent members, and Professor Sayeed Khan has been re-appointed as an employer representative for another 3 years from the 1 May.

1.3.1 **Conflicts of interest –** No conflicts of interest were raised.

2 Minutes of the last meeting

2.1 The minutes of the January IIAC meeting were cleared with minor amendments. The amended minutes will be circulated for sign off ahead of their publication on gov.uk/iiac.

2.2 The following action point updates were provided:

Action point 5: Dr Anne Braidwood to send information about the review of the effectiveness of medical assessments within the War Pensions Scheme to Professor Keith Palmer. This information will be available for the IIAC meeting in July.

2.3 All other action points were cleared.

3 Industrial Injuries reform

3.1 In the 2015 Summer Budget the government stated its intention to consider how employers and insurers could play a greater role in supporting those suffering from industrial injuries. Since then the Department has been exploring a range of reform options for the Minister’s consideration. A reform options paper was presented by a Departmental policy official at the March RWG meeting. This paper was subsequently circulated to all Council members before being discussed in depth at an extraordinary IIAC meeting on 18 March.

3.2 The Chair had drafted a response paper outlining IIAC’s views about the options for reform presented by the Department; members agreed that they supported the views expressed in the Chair’s paper. There was a general discussion about how health and safety initiatives could be linked in a reformed Scheme.

3.3 IIAC’s response paper had been sent to the Department. The Department’s options for reform and IIAC’s responses are currently being considered by the

Minister. Departmental policy officials will keep IIAC informed about progress in the review of reforms to the Scheme.

3.4 A member had requested statistics from the Compensation Recovery Unit about recoveries for industrial accidents and injuries for all benefits (not just IIDB) under the Freedom of Information Act. These data were included in the meeting papers for the meeting and had been forwarded to Departmental policy officials and analysts for their consideration.

4 Medical assessments

4.1 IIAC has been reviewing medical assessments to ensure they adequately reflect current scientific knowledge and are currently focusing on how medical assessments take into acccount mulitple risk factors and historical injuries.

4.2 The law states that deductions must be made to take into account 'other effective causes' for the prescribed disease in question. At the January IIAC meeting members discussed a PD A14 case where a claimant's assessment was offset by knee surgery 40 years prior to the onset of osteoarthritis (OA) of the knee. There appeared to be no evidence the claimant had suffered any knee problems in the years after the surgery. Although the risk of OA knee is increased by previous knee surgery, it is unclear what the risk would be after so many years; arriving at a scientifically valid offset in such a case would be difficult.

4.3 Members discussed the rationale for deductions (offsets) based on risk factors (e.g. an increased risk of OA knee from a prior injury, where the injury had subsequently healed) rather than the effects of a current injury or disease. Departmental lawyers provided the Chair with a copy of Regulation 11 of the Social Security Contributions and Benefits Act 1982 which prescribes the conditions by which "other effective causes" should be taken into account in assessing disablement and a summary document detailing case law in "chance" cases (e.g. where the other effective cause may occur by "chance" ie. a risk factor). Departmental lawyers stated that they were unable to provide legal guidance about the interpretation of the legislation in relation to risk factors due to a potential conflict of interest; the Secretariat will discuss this matter further with them. Council members were concerned to ensure full engagement.

4.4 Assessing the effects of pre-existing conditions can be particularly complex, often involving judgement calls where scientific evidence would be very hard to come by. Similar to IIAC's advice on rebuttal, members discussed whether offsets should be restricted to very clear cut cases, since there is a legal requirement to apply them but in many circumstances it is challenging to do so. Only making offsets in clear cut cases would simplify the decision making process, thus, potentially increasing efficiency, consistency and equity.

4.5 What is guidance and policy intention about making offsets to disablement assessments for risk factors? The Departmental medical assessments

guidance handbook will be circulated to all IIAC members. Further information on this will be sought.

4.6 How many claims are affected by this issue? How often are offsets applied to cases? IIAC's recent audit of 50 medical assessment cases suggested that offset decisions were relatively common and sometimes problematic. However, the cases selected for audit were consecutively collected examples of prescribed diseases deemed more complex or problematic for decision making. Thus, this audit may not be wholly representative of how offsets are dealt with within the Scheme as a whole. Departmental medical policy officials and members discussed the feasibility of obtaining prospectively collected medical assessments data. Trade union representatives may be able to provide anecdoctal evidence about how regularly problems occur due to offsets made in disablement assessments.

SUMMARY – IIAC has been reviewing medical assessments within the IIDB Scheme to ensure they are up-to-date with current scientific and medical knowledge. There is a statutory list of percentage assessment awards for certain physical injuries (e.g. severe facial disfigurement is awarded 100%).

The note above considers the scientific rationale for offsets for other effective causes for disablement in multicausal diseases.

5 Stakeholder engagement

5.1 The April IIAC meeting was opened to members of the public from this portion of the meeting onwards. Attendees were welcomed by the Chair.

5.2 IIAC has been discussing effective means of engaging with stakeholders, focusing on different media and events to engage with different groups. The Code of Practice for Scientific Advisory Committees recommends bodies are open, transparent and engage with their stakeholders.

Conference presentations

5.3 A member had given a presentation about IIAC at a RMT health and safety meeting which had been well-received. The Council's representatives of employees stated that they were planning to update and publish a guide for workers on the provisions of the IIDB Scheme.

5.4 Another IIAC member was due to give a presentation about IIAC at the Society for Occupational Medicine conference in June.

5.5 The Secretariat is formulating a core presentation pack for members to use when talking about IIAC at external events.

Publications

5.6 Two members had drafted an article on IIAC for 'Pulse' magazine, a free weekly publication aimed at GPs. The article had been submitted to Pulse's

clinical editor. A member agreed to chase up the editor to enquire whether the article will be published.

5.7 Occupational Health at Work (OHW) is a non-peered reviewed bimonthly publication edited by John Ballard. This magazine already publishes newspieces when IIAC recommend new prescribed diseases and exposures, and may be receptive to an in-depth article on IIAC. A Council member volunteered to draft an article for OHW.

5.8 The journal Occupational Medicine publishes brief articles on a range of topics. An IIAC member had recently had one such article published and agreed to circulate it to all IIAC members to illustrate the style and format of the text.

5.9 At the last IIAC meeting members suggested it would helpful for the Department to consider holding a stakeholder meeting with representatives from the National Union of Mineworkers (NUM) to answer their specific queries. The Secretariat had sent a letter to Departmental officials asking them to consider this option.

5.10 A researcher from the London School of Economics has been researching the role of scientific advisory committees in formulating public policy. IIAC had been included in his research and a number of members had been interviewed. A draft of the research report was emailed to all members for information.

6 Depression and anxiety in teachers and healthcare workers

6.1 Following a request at a Public Meeting the Council has been considering clinically diagnosed depression and anxiety in teachers (as classified under ICD-10). Work-related ‘stress’ is outside the scope of this review; stress is a symptom rather than a clinical disease.

6.2 An RWG member has reviewed the literature about occupational depression and anxiety in general and depression and anxiety in teachers. The search was widened to include healthcare workers. However, preliminary consideration of the evidence suggests a lack of robust evidence that risks of clinically diagnosed depression and anxiety are more than doubled for any particular occupational group. Many of the areas of study may be prone to self-report to record the diagnosis/outcome. This area of study can be prone to self-selection bias. For example, the personality traits of teachers and healthcare workers (e.g. caring and empathy) may cause them to be more likely to select these professions.

6.3 Members discussed a draft information note and made suggestions for amendments to highlight the difference between ‘stress’ and depression and anxiety. The document should make clear why only teachers and healthcare workers were considered or the terms of searching should be extended. Low mood and anxiety are common experiences in everyday life. This review

focuses solely on clinically diagnosed depression and anxiety. The note should emphasise that whilst the threshold for prescription has not been reached, IIAC recognise that occupation can be a risk factor for depression and anxiety and note that it is a major cause of long term sickness absence. The document should highlight that this topic will be kept under regular review.

6.4 There is evidence of an increased suicide risk in doctors and farmers. Suicide itself is not within the scope of the Scheme, but could be indicative of an increased risk of mental health disorders. Consideration should be given to the relevance of such data and the complexities (e.g. it has been thought that these groups have greater access to the means of suicide, rather being are more depressed than other occupational groups).

6.5 A Ministry of Defence official stated that she may have relevant information on anxiety and depression in relation to the War Pensions Scheme and the Armed Forces Compensation Scheme to inform the Council's review.

7 Information notes for sign off

a) Occupational osteoarthritis of the knee

7.1 IIAC has been considering this matter in connection with construction workers following a request originally about joiners by an MP on behalf of a constituent. PD A14 currently covers coal miners and carpet fitters only.

7.2 Prescription for coal miners was possible by combining limited direct evidence of a greater than doubled risk of OA knee in miners together with a large amount of indirect evidence of a greater than doubled risk of OA knee due to kneeling and squatting under heavy load (activities typically undertaken by coal miners). Kneeling and squatting under heavy load is associated with a high risk of OA knee. The case for prescription for carpet fitters was supported by sufficient direct evidence of an increased risk available according to occupational title.

7.3 Construction work covers a broad range of occupations, not all of which are likely to be associated with activities at risk of OA knee. Most studies group all construction workers together and do not give risk estimates for each separate occupation. During the course of the review the Council has sought direct evidence by job title and indirect evidence by activity to support prescription (i.e. whether any construction trades kneel or squat as much as carpet fitters and floor layers or underground coal miners). The Council has also written to several researchers, officials from the HSE and trade union and made a call for evidence on gov.uk/iiac asking for further exposure information to enable specific construction trades at risk of OA knee to be pinpointed.

7.4 On blance there is insufficient direct or indirect evidence to make the case for prescription. However, the evidence base is likely to increase in due course and the Council will continue to monitor emerging evidence. Members agreed to sign off the information note.

b) Carpal tunnel syndrome and twisting and turning

7.5 The Council has been considering carpal tunnel syndrome (CTS) due to twisting and turning activities following a request from a member of the public in relation to tanker driving. Relevant papers had been considered but tended to specify exposures in different ways, such as 'bending and turning' or 'tightening with force', making it difficult to amalgamate data to provide sufficient evidence to consider whether the threshold for prescription had been reached for any specific exposure. As such, it is currently not possible to recommend prescription for CTS for twisting and turning occupational activities. Members agreed to sign off the information note.

c) Sportspersons and neurodegenerative disease

7.6 IIAC last considered sports injuries in 2005. The current review was launched following renewed media interest in this area. Two members had been reviewing the literature in the course of their normal work and had drafted an information note about sportspersons and neurodegenerative disease in the context of the IIDB Scheme, including Parkinson's disease, Alzheimer's disease (AD) and amyotrophic lateral sclerosis.

7.7 There is sparce evidence of an increased risk for Parkinson's disease, confined essentially to boxers, in whom there is no clear evidence that risks are more than doubled. AD and head injury appear associated, as judged by the general literature, but with few studies of head injury/repeated head trauma specifically in professional sportspersons.

7.8 There are several reports of high risks of ALS in Italian professional football players. However it is difficult to draw strong conclusions from these results as the estimates come mainly from the Italian football league (in the context of a drug inquiry), have not been seen in other football leagues, and are based on repeated reports in essentially the same cohort. Increased risks of ALS have also been reported, although infrequently, in professional American footballers, but this occupational exposure is less relevant to the UK. Findings on ALS have not been tied in with a potential mechanism, such as degree of head trauma.

7.9 There is a body of evidence about mild traumatic brain injury (MTBI) and dementia. However, susceptibiity to dementia appears to depend on environmental and genetic factors making ascertaining the risk due to occupational factors complex.

7.10 Members suggested that the summary be expanded to include discussion of dementia and PD. The amended information note was signed off by the Council.

8 RWG Update

8.1 The RWG Chair gave a brief update of matters discussed at the March meeting.

8.2 **IIAC abstracts booklet update** – This booklet was circulated to IIAC members in February. A table was included in the meeting papers showing the division of labour for each member to consider particular topics; these topics will be discussed at the May RWG meeting.

8.3 **Occupational risks and exposure to trichloroethylene** – As part of a horizon scanning exercise the RWG considered occupational exposure to trichloroethylene (TRIKE) and polycyclic biphenyls (PCB) based on their classification as carcinogens by the International Agency for Research on Cancer (IARC). The occupational risks of PCB for any cancers is less than doubled, thus this exposure does not warrant further consideration by the RWG. At the May RWG meeting members will consider the evidence relating to TRIKE.

8.4 **Hand Arm Vibration Syndrome and jack hammers** – An MP has asked on behalf of his constituent about prescription for Hand Arm Vibration Syndrome (HAVS; PD A11) for the use of jack hammers for work involving underpinning foundations during subsidence engineering. PD A11 covers only the use “of hand-held powered percussive drills or hand-held powered percussive hammers in mining, quarrying, demolition, or on roads or footpaths, including road construction”.

8.5 A literature search did not identify any relevant evidence about jack hammers in underpinning foundations or used in construction. A call for evidence was made on www.gov.uk/iiac but no information was received. The RWG consulted with a vibration expert at the Institute of Sound and Vibration Research who suggested that there is an increased risk of HAVS from use of jack hammers, but magnitude of risk was dependent on many factors, such as what surfaces the tools were being used on and for what duration. The prescription does not specify the duration to be used; the evidence is complicated and unclear in this area. The RWG is liaising with Departmental medical policy officials about the terms of prescription and coverage for ‘demolition’. The correspondent has mentioned that he is currently appealing his decision. Members agreed that the Secretariat should write back to the correspondent and state that the Council will consider this matter if necessary following the outcome of the appeal.

8.6 **Noise induced hearing loss and nail guns** – An MP has asked on behalf of his constituent why use of nail guns is not prescribed for PD A10 (noise induced hearing loss; NIHL). The meeting papers included a discussion document about the review thus far.

8.7 The Secretariat identified a Health and Safety Laboratory (HSL) research report which provided some relevant hygiene data. The RWG has consulted with a HSE Specialist Noise Inspector about whether the noise exposure data reported in the HSL report is likely to reach the threshold for noise (98dBA L_{eq}) where prescription may be warranted. The HSE official had stated that the threshold level could be reached if a worker was firing 13-52 shots a minute for 8h a day (or 26-104 shots a minute for 4h a day). However, framing a prescription by specifying the number of fires of a nail gun per day would vary from the other currently prescribed occupational exposures for PD A10 where duration is not specified.

8.8 Furthermore, the estimate was subject to several areas of uncertainty – small sample size in the HSL study, representativeness of the tools assessed, wide variation in noise measurements between different vibrating tools, depending on the make and model of the tool, its state of repair and how it is being used and on what surface. This degree of uncertainty was seen as a barrier to prescription – it was felt that it would be difficult to prescribe for exposure to nail guns.

8.9 The noise exposure from a nail gun is similar to an acute acoustic trauma. However Ministry of Defence officials have reviewed NIHL and acute acoustic trauma from firing guns, but the scientific mechanism behind this process is not well understood. Acute acoustic trauma resulting from an identifiable occupational accident may be covered under the Accident Provisions.

8.10 Members discussed the complexities and difficulties of prescribing for PD A10. The science and underlying data to support the magnitude of risks associated with NIHL contains important uncertainties. The dose response relationship is unclear. Wide variation exists in normal hearing in the general population. Historically the prescription for PD A10 was based on occupations where there were groups of workers in inherently noisy occupations where many suffered from deafness. The Council published its last report about NIHL in 2002. A member drafted a discussion paper about the difficulties of prescrining for PD A10 which will be circulated to all IIAC members.

8.11 Idiopathic interstitial fibrosis in miners - The Council has received correspondence from an MP on behalf of a representative from a miner's union about idiopathic interstitial fibrosis (IF) in coal workers exposed to asbestos. IIAC considered this matter previously and published a position paper in 2006. The Council considered at that stage that certain forms of IF are part of the coal worker's pneumoconiosis, and the associated disability would be covered by within PD D1 (pneumoconiosis) or PD D12 (COPD). At that time, there was no evidence to support prescription for IF in its own right. However, members will reconsider this matter at the May RWG meeting.

9 Any other business

9.1 **IIAC work programme** - As part of the recommendations of the 2015 triennial review IIAC published its work programme on the gov.uk/iiac webpages. An updated version of the work programme was tabled and signed off by members.

9.2 **Million Women Study on Breast Cancer** – This study is close to reaching a conclusion on breast cancer and shift work; IIAC will monitor publication of its findings closely.

Date and time of the next meeting: 7 July 2016