RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the meeting
Thursday 14 September 2017

Present:

Professor Paul Cullinan (Chairperson)	RWG
Professor Damien McElvenny	RWG
Professor Keith Palmer	RWG
Professor Neil Pearce	RWG
Dr Anne Braidwood	MOD
Mr Hugh Robertson	RWG
Mr Andrew Darnton	HSE
Ms Nina Choudhury	DWP legal services
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Ira Madan, Professor Karen Walker-Bone

1 Announcements and Conflict of interest statements

1.1 The command papers on latex anaphylaxis and nasal carcinoma were laid before parliament on Tuesday 12 September

1.2 The position papers detailing the work carried out on trichloroethylene and cancers, noise induced hearing loss and depression in teachers & healthcare workers were also deposited in the libraries on 12 September.

1.3 All the papers have been published on the IIAC Gov website

1.4 Conflict of interests – none declared.

2 Minutes of the last meeting

2.1 The minutes of the last meeting were cleared with minor amendments. The Secretariat will circulate the final minutes to all RWG members ahead of publication on the IIAC gov.uk website.

2.2 All action points have been cleared or are in progress.

3 Medical assessments

3.1 Prior to the RWG meeting, several papers and references were shared for discussion. A substantially revised version of the draft report on medical assessments seen in Manchester in July 17 was presented.

3.2 A member raised a concern that the RWG may not be the appropriate forum to debate this paper as it has wider implications that require input from the full

Council. It was agreed that only the scientific and factual elements of the paper would be discussed at RWG.

3.3 Professor David Coggon provided expert analysis relating to stochastic and non-stochastic disease states and the use of offsets for 'other effective causes'. Routes to disablement could be through the prescribed disease or occupational injury or through other means. For stochastic diseases there is a good case that deductions are not appropriate; for non-stochastic diseases, there is in principle a case for their application, but many challenges in practice in doing this in a robust consistent way; for disablement by the alternative (non-PD/injury) route, offsets make sense scientifically, although there may be non-scientific policy considerations to weigh. RWG agreed the scientific reasoning detailed in the paper was valid and appropriate.

3.4 DWP IIDB operations carried out a quick survey of claims conducted over a week looking at how often offsets featured and what their impact was. In this small sample, it appeared that any costs incurred by the exchequer if off-sets were to be removed could be fairly small. It was felt a further audit over a couple of weeks may yield more robust data.

3.5 In civil claims for compensation, a member contributed by correspondence, that there are essentially two relevant common law rules; the so called "eggshell skull rule" and the "crumbling skull rule." The former holds a 'wrongdoer' liable for all consequences resulting from his or her tortious (usually negligent) activities even if the victim suffers an unusually high level of damage due to a pre-existing vulnerability or frailty or medical condition, including latent conditions. In criminal law, the defendant is held to taking their victims as they find them. The latter "crumbling skull rule" applies where a claimant has a condition or injury that pre-dates the tort and would have naturally deteriorated or worsened over time. In this instance, the 'wrongdoer' is not responsible to the degree that the injury would have worsened over time. The legal aspects of this paper will be deferred until the full Council has the opportunity to comment. However, the paper contributes useful information to the "taken as seen" argument.

3.6 Appeals cases do not specify off-sets as a reason in outcomes, so it is difficult to assess what time and cost savings could be achieved if O(pre) deductions could be eliminated as a reason for appeal. However, some 40,000 appeal decisions for all reasons were cleared in a recent decade, >40% in favour of the appellant, and overwhelmingly in face-to-face hearings, while anecdotally, scale of benefit award is a common reason for appeal; thus, potential for cost savings may well exist.

3.7 The paper was circulated to DWP operations staff for comment and the responses raised some interesting points. The decision making on claims is driven by legally binding Commissioners' decisions. Even if a ruling may appear doubtful scientifically, DWP is duty bound to accept it and apply it to future claims. A member was concerned that there was an ambiguity in the law. Arguably, Regulation 11.2 may define an 'other effective cause' as anything other than the prescribed disease/injury, in which case a risk factor for the prescribed disease, and which acts through the prescribed disease, should not logically be another effective cause. This has connotations for the thrust of the medical assessments paper and is something the full Council should debate, with input and advice from the legally qualified Council members.

3.8 If there is an appetite to suggest changes to the legislation, there may be a question around timing due to time in Parliament being taken up by Brexit.
3.9 It was suggested that full Council be made aware of the paper by circulating it by email for comment, if there are time constraints.

4 Occupational exposure to silica.

4.1 The information note 'Cadmium and Rheumatoid Arthritis' was published on the IIAC website 15 May 2017.
4.2 Further literature searches were carried out to include the disease states, scleroderma, systemic sclerosis and systemic lupus erythematosus and occupational exposure – post 2004.
4.3 Following analysis of information in the literature, a member produced a draft of a paper for discussion. This is an update on a previous report as more evidence reporting an association with silica and connective tissue diseases is apparent..
4.4 A likely barrier to prescription is the variable approach to defining and assessing exposures and how this could be translated into a prescription schedule. However, if the evidence on risks of SLE and scleroderma is strong enough in workers with silicosis, it may be possible to prescribe for this subset of exposed workers.
4.5 It was decided to expand the literature search to include silicosis and risk of the diseases in question.
4.6 A check would be made also for evidence on risks by job title. Another member offered to share in this work.

5 Aerotoxic syndrome (toxic cockpit syndrome)

5.1 Several papers were shared with the group for review following a BBC Scotland report that flight safety could be degraded because pilots are breathing contaminated air following a study by the University of Stirling.
It was agreed that having reviewed the study by the University of Stirling and other information provided, RWG would not proceed any further with this topic as the review did not suggest an identifiable disease which could be the subject of prescription.

6 Questions arising from the IIAC public meeting

6.1 **Coal mining, pneumoconiosis, silicosis and lung cancer**
6.1.1 At the Public meeting in July, the NUM drew the Council's attention to an apparent anomaly in PD D11, primary carcinoma of the lung where there is accompanying evidence of silicosis. They pointed out that coal mining is not explicity included in the prescription and this had led to a case needing to be appealed.
6.1.2 A member wrote a paper which looked at the differences in the prescriptions for PD D1 and PD D11, reviewed the history of silicosis in coal miners, and made recommendations.

6.1.3 RWG concluded that there is a need to draw decision-makers' attention to the Council's view that the present terms of PD D11(b) do allow for prescription in coal miners with silicosis and lung cancer in certain circumstances (e.g. tunnelling, hard heading and brushing involving cutting hard rock, usually sandstone). The exposure definition in PD D1 (1) would also identify qualifying circumstances for the coal miner claimant with silicosis and lung cancer.

6.1.4 The wording of both D1 and D11 look somewhat dated. RWG agreed, however, there is no need to change the prescription at present and the matter should be dealt with initially through improved guidance. An information note or position paper will be prepared.

6.2 **HAVS: query on wording of A11**

6.2.1 Following a question from the NUM about the difference in the wording of the prescription for PD A11 and the guidance in the Medical Assessment Handbook, the Council advised it would consider whether the guidance reflected the Council's intention when the prescription was last reviewed in 2007. The wording for HAVS prescription symptoms states "significant, demonstrable reduction in both sensory perception and manipulative dexterity with continuous numbness or continuous tingling all present at the same time in the distal phalanx of any finger" whereas the IIAC report recommending changes to the prescription set out in 2004 stated "intermittent or persistent symptoms of numbness and/or tingling in the digit".

6.2.2 The history of the matter was revisited. It was found that the question had been asked before, and that two audits had previously been carried out, albeit only on a small number of claims. Correspondence with the minister was reviewed. Before deciding how to proceed, RWG asked the secretriat to investigate if there had been a more recent exploration of the matter. Otherwise, it was suggested to carry out a further audit to look at a larger number of claims to see if claimants were being disadvantaged by the current wording.

6.3 **Tinnitus**

6.3.1 A question was asked by the Durham Miners Association (DMA) if tinnitus could be considered as a prescribed disease.

6.3.2 The Council had looked at this topic previously but reported difficulty in prescribing for tinnitus as it is a symptom rather than a disease. Eligibility for IIDB may exist under the accident provision for this condition.

6.3.3 Having reviewed the available information, it was concluded that tinnitus is a subjective symptom and as there appears to be no definitive test available, RWG decided not to proceed with this topic. However, RWG will check if a test is available for tinnitus.

6.4 **Effects of working in hot & humid conditions**

6.4.1 An attendee asked if the Council could consider working in very hot and humid conditions for prescription. Very often breathing is faster and workers have to drink ~8l of water to maintain hydration.

6.4.2 RWG debated the matter and decided that it was unlikely there would be a disabling disease which would warrant a prescription, although chronic kidney disease and calculii might be a possibility; serious acute events would be covered potentially under the Scheme's accident provisions. It was decided to do an initial literature search before deciding to proceed any further with this topic. However, as heat may be the initiator in these cases, it may be possible to pursue the accident route in IIDB.

7 AOB

7.1 A member commented that the public meeting in Manchester raised some very valid issues and it was a very useful event.

7.2 It was agreed that current vacancies on the RWG could be addressed by inviting Dr Sara De Matteis and Prof Sayeed Khan to join the group.

7.3 It was noted that one member of the RWG is attending the Scottish Government Social Security hearing in October.

Date of next RWG meeting: 23 November 2017
Date of next full council meeting: 19 October 2017