RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the meeting
Tuesday 4 September 2018

Present:

Dr Lesley Rushton	RWG
Dr Sayeed Khan	RWG
Professor Neil Pearce	RWG
Mr Hugh Robertson	RWG
Dr Sara De Matteis	RWG
Mr Andrew Darnton	HSE
Ms Susan Sedgwick	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat
Dr Ian Lawson	Guest expert

Apologies: Dr Anne Braidwood, Professor Karen Walker-Bone, Dr Clare Leris

1. Announcements and conflicts of interest statements

1.1. Professor Neil Pearce was appointed chair of RWG by Dr Lesley Rushton.

1.2. Dr Rushton updated the sub-group on progress to recruit new IIAC members. The recent recruitment campaign successfully attracted applications from strong candidates. Ministerial approval is awaited for interviews to commence. **post-meeting note: Ministerial approval has been received, interviews to commence week commencing 10 September 2018.

1.3. Dr Rushton suggested the RWG would be comprised of a core group of members and supported by additional sub-groups with experts relevant to the topic under investigation.

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. Hand Arm Vibration Syndrome (HAVS): Objective testing for vascular disease

3.1. The wording of PD A11 (HAVS) was questioned at the July 2017 public meeting as it was felt claimants were being disadvantaged. 2 members audited 100 consecutive claims for PD A11 and found no evidence of claims being refused because they did not meet the senisoneural conditions of the prescription. The audit revealed the wording of the prescription, although not identical to that recommended by the Council, is not disadvantaging claimants with HAVS-associated digital tingling.

3.2. However, it was concluded the vascular component was challenging to assess and suggested the Council looked into assessing whether objective testing could be a solution.

3.3. Dr Ian Lawson, a well-respected expert in this field, attended RWG by invitation to give an informed opinion of the tests available and potential applicability for use in medical assessment centres.

3.4. Dr Lawson gave an overview of the tests currently used in assessing vascular symptoms of HAVS.

3.5. Dr Lawson stated in review of the literature in 2004 (updated in 2009) and other publications including the sensitivities and specificities of the two tests currently used, there was sufficient doubt as to their usefulness and failed to persuade the Health and Safety Executive to recommend their use when publishing guidance. Dr Lawson noted that, regarding one test, the Finger systolic blood pressure (FSBP), publications had highlighted the fact that if a person reported a history of blanching episodes they were more likely to have a positive test,

3.6. Consequently, Dr Lawson stated it is difficult to justify the regular use of these tests in the diagnosis and staging of vascular HAVS. The best supporting evidence for digital blanching is to request photographs in advance of a face to face assessment. These are best taken in the ‘hold-up’ pose with the individual’s face clearly identifiable. These photographs can then be used to support a history of blanching that should include its onset and progression in relation to vibration exposure.

3.7. It was decided to proceed with a position paper on this topic to suggest a relaxation of the IIDB guidance to allow photographs as evidence when taking the history.

4. Melanoma and occupational exposure to UV/sunlight

4.1. Following correspondence from a merchant seaman who had developed skin cancer whilst working in hot climates, RWG decided to review the literature relating to melanoma and occupational exposure to sunlight/UV radiation.

4.2. There is consistent evidence of an increased incidence of skin melanoma in aircraft crew. A systematic review and meta-analysis of 14 studies published after 2013 and for the most part carried out among northern Europeans (10),

reported summary risks of 2.22 (95% confidence interval 1.67-2.93) in pilots and 2.09 (1.67-2.62) in cabin crew.

4.3. There was a brief discussion at the June meeting about whether the airlines count compulsory rest time after long haul flights before flying again as 'work'. This may be relevant if some of this is spent in the sun. Thus, the Council might want to consider whether a fuller literature review should be carried out and whether it needs to talk to the CAA, an airline such as BA, or the pilots/air crew associations about what constitutes 'work'.

4.4. A member stated informal discussions with some relevant bodies had established long-haul flights with significant stop-overs for air crew were now reduced for British companies, as the routes were generally operated by foreign companies. However, it was ascertained that whilst aircrew were on rest days on stop-over, they were regarded as being in work and paid for their time.

4.5. Concern was expressed as to whether exposure to natural UV light was regarded as being occupational, so it was suggested this be clarified with a legal opinion.

4.6. RWG felt that the evidence of increased risk is strong and warrants further investigation, so decided to recommend to the full Council that a formal call for evidence be issued and publicised to all Council members.

5. Asbestos exposure in non-recognised occupations (bystander)

5.1. This follows correspondence from a MP about a constituent who worked as an electrician and developed lung cancer after working in close proximity to other workers who were processing asbestos. The claim for IIDB was subsequently turned down as the occupation was not listed in the prescription.

5.2. A literature search was undertaken to check for any new evidence on risks in workers with bystander exposure, but there were doubts whether risks would be sufficiently elevated to meet the prescription threshold.

5.3. A draft paper was provided by a member where the data indicated a small proportion of electricians have had sufficient exposure to asbestos to produce raised proportionate mortality rates for very specific, and relatively rare, asbestos-related diseases but that the majority haven’t, which probably swamps the picture for the far more common condition, lung cancer.

5.4. RWG decided to pursue the matter in more detail but to widen the scope to include construction workers as the term ‘electrician’ may be too specific. Also to widen the scope to include silica exposure.

5.5. It was felt the prescriptions for asbestos-related diseases could potentially be updated as little reference is made to exposure levels and the prescriptions do not cover occupations where currently workers may be likely to be exposed to asbestos. Some discussion was also had around mesothelioma in teachers who may have developed the disease whilst working in older buildings where asbestos was present.

6. Osteoarthritis of the knee in footballers

6.1. Various organisations representing footballers have engaged with the secretariat to ask the Council to look at osteoarthritis of the knee in footballers. The secretariat received correspondence which referenced a paper by 'Fernandes et al' which was included for discussion.

6.2. Subsequently the Professional Footballers Association wrote to the IIAC Chair formally requesting the Council consider the topic of osteoarthritis of the knee in footballers as an occupational disease – this correspondence also referred to a paper by Fernandes et al..

6.3. The cross-sectional study by Fernandes concluded the prevalence of all knee osteoarthritis outcomes were two to three times higher in male ex-footballers compared with men in the general population group. Knee injury is the main attributable risk factor. After adjustment for recognised risk factors, knee osteoarthritis appears to be an occupational hazard of professional football.

6.4. Members felt the Fernandes paper was important evidence, but that further investigation was required.

7. AOB

→ The NUM has engaged with a MP to question why idiopathic pulmonary fibrosis and pleural plaques are not prescribed diseases.

→ A response was drafted, which has been issued to the MP, reiterating the position of the Council on these diseases as published on the IIAC Gov.uk website.

→ In light of a recent judgement in favour of a coke oven worker who suffered chronic bronchitis because of harmful fumes and won £15,853 in a court battle against the UK government, attention was drawn to this ruling with a view to determine if there are any implications for IIAC or anything to take forward.

→ Coke oven workers are covered for lung cancer (PD D10).

→ PD D12 (COPD) refers to coal dust and mineworkers but is implicated in coke oven workers.

It was decided to take this to full Council and discuss investigation of COPD in coke oven workers and potentially COPD due to occupation more widely.