RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the meeting
Thursday 12 September 2019

Present:

Dr Lesley Rushton	RWG
Dr Sayeed Khan	RWG
Professor Neil Pearce	RWG Chair
Professor Karen Walker-Bone	RWG
Professor Kim Burton	RWG
Dr Ian Lawson	RWG
Dr Chris Stenton	RWG
Ms Lesley Francois	IIAC observer
Mr Daniel Shears	IIAC observer
Mr Andrew Darnton	HSE
Dr Anne Braidwood	MoD
Dr Emily Pickett	DWP medical policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: From the DWP: Ms Lucy Wood, Dr Mark Allerton, Mr Neil Walker, Ms Maryam Masalha

1. Announcements and conflicts of interest statements

1.1. The Chair welcomed new IIAC members Lesley Francois and Daniel Shears who were attending as observers. A welcome was also extended to Dr Emily Pickett who is a medical policy official from DWP

1.2. Funding has been secured to carry out commissioned reviews for this financial year. Ongoing funding for future financial years is under consideration.

1.3. The regulations for Dupuytren's contracture were laid before Parliament on 9 September 2019 and are expected to come into force early December 2019. A member asked if the DWP had an update on the use of physiotherapists in the medical assessment process and what training would be provided. The Department's response was that it was envisaged a dual approach would be adopted with physiotherapists taking a role early in the process with physicians making the decisions on the disability elements. Full training would be provided. More information would be provided at the next full Council meeting in October.

1.4. A member stated they thought there was gap in Council knowledge about the medical assessment process, so it was agreed the member induction pack would be refreshed to include more detailed information on medical

assessment and the claimant journey. Also, it was felt that an organogram detailing medical and IIDB policy roles would be helpful.

2. Minutes of the last meeting

2.1. The minutes of the last meeting were cleared. 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. Coke oven workers and COPD

3.1. A member submitted a paper for consideration outlining their current thoughts on coke oven workers and COPD. This topic originated from reports in the media that a former British Coal workers widow was awarded compensation and that four other test cases were settled out of court after developing COPD as a consequence of their work in coke plants.

3.2. The evidence from published papers has been collated and scrutinised – the member summarised their findings and concerns in their paper.

3.3. *How robust is the evidence in coke oven workers.* There are 4 lung function studies that are relevant. The earlier studies of Walker and Maddison, and the more recent studies of Wu and Hu. The member detailed the issues with each of the papers

3.3.1. **Walker** is a UK study of 881 men, but gives no measure of exposure, does not distinguish different jobs on the ovens, treats bronchitis as an explanatory rather than an outcome variable, and does not give the average age of the subjects. The paper does not demonstrate a low FEV/FVC and thus does not demonstrate that the abnormalities are those of COPD

3.3.2. **Maddison** is a study of 3793 workers, that gives no information about the age of the subjects, and where lung function is examined by job title ranking them by likely exposure. The study reports a multiple regression analysis of FEV/FVC that includes the effects of exposure. These were statistically significant for COPD but unhelpful as the magnitude of the effect is not given.

3.3.3. The two **Wu** papers show relationships between exposure and lung function impairment but not in a typical COPD pattern with a greater reduction of FVC than FEV_1 ; this suggests a fibrotic rather than a COPD effect.

3.3.4. **Hu** is a Chinese study of 713 workers and measures the benzene soluble fraction of coke oven emissions. There was an exposure-related reduction in FEV and FEV/FVC that was of greater magnitude than that in the other studies. However, there appear to be arithmetic inconsistencies in the tables and there was a high prevalence of COPD overall - 7% in the control group which is high for a group of mean age 36 even if it includes smokers. COPD was diagnosed with reference to a local control group which included nearly 50% females.

3.4. *Can a qualifying level of exposure be quantified*. Lung cancer in coke oven workers is related to hydrocarbon (benzene soluble material : BSM) exposure. COPD risk is likely to be related to a wider range of exposures including coal dust. These do not necessarily occur together and there is very little published evidence about anything other than BSM exposure. That doesn't really matter as the only evidence that allows an effect to be quantified in terms of exposure comes from the Hu paper and that is expressed in relation to BSM exposures.

3.5. There were other concerns such as smoking and definition of disease and whilst these relevant concerns were applicable to many of the past and future Council investigations, it was felt these should be dealt with in a wider review.

3.6. Due the variability in the evidence, it was felt the evidence may not, at this point, be strong enough to recommend prescription, though it was felt there is an association.

3.7. A position paper will be drafted for full Council to review at the next meeting in October.

4. Osteoarthritis of the knee in footballers

4.1. A paper, along with evidence tables, was presented for consideration having been compiled by a member with significant input from other members with musculoskeletal expertise.

4.2. The topic arose as stakeholders had engaged with the secretariat to ask the Council to assess osteoarthritis (OA) of the knee in footballers and provided supporting information in a paper by Fernandes et al.

4.3. It was stated that the understanding of disability relating to OA has changed over time. More emphasis is now placed on how the patient reports discomfort and less on radiographic evidence; this may show the presence of OA but the patient may not experience pain.

4.4. Investigators have sought to understand the risk of OA that is not attributable directly to injury, but efforts to achieve this are being hampered by the lack of consensus methods on how to describe injuries and the fact that many studies rely on recall.

4.5. Studies of radiographic OA produce significantly higher risk estimates of the risk of OA but this is of limited relevance to the Council because radiographic OA does not necessarily reflect symptomatic OA or disability.

4.6. The data for self-reported "physician diagnosed" OA are inconsistent and are open to misclassification. Two from three studies suggested a doubling of the risk of knee arthroplasty but the third found no risk associated.

4.7. There is inconsistency around pain and loss of function attributable to the knees later in life. The Fernandes study contributes importantly to this literature but has limitations; for example there wasonly a 25% questionnaire response amongst the former footballers and even lower rates of participation to X-rays - this may have caused response bias in that those with knee problems were more likely to participate.

4.8. Whilst the evidence for a doubling of risk is clear when there has been an injury to the knee, in the absence of knee injury the evidence is not consistent and insufficient to warrant prescription. In the case of footballers who suffer an injury, this may be covered under the accident provision of the industrial injuries scheme. However, this would need to be verified as OA may develop years after the accident and it was not clear if there is a time limit from when the accident happened and making a claim. It was stated the DWP has a legal definition of an accident which would be shared with members.

4.9. Given the outcome of this extensive investigation, it was felt a command paper focusing on knee injury and the accident provision of the scheme would be appropriate. This will be fully debated by the full Council at its next

meeting.

5. Melanoma and occupational exposure to UV/sunlight

5.1. This topic was initiated by correspondence received from a former mariner who developed skin cancer (non-melanoma) as a result of exposure to sunlight. Following on from this, it was decided melanoma needed to be looked at by the Council.

5.2. At the full Council meeting in July, the paper was debated at length with some members expressing concern that should this be recommended for prescription, where there is no explanation of mechanism of action and there is no exposure to describe.

5.3. It was pointed out that when a prescription is drafted, recommendations are made to minimise the exposure from an employer and employee perspective, but in this case the exposure is unknown.

5.4. However, other members stated it would be difficult to not prescribe as the evidence is very clear. It was pointed out that pilots are 2nd on the list of death from melanoma.

5.5. There is evidence the risk of developing melanoma is linked to time spent flying, so it was felt that any prescription should reflect this and should be cumulative given the sometimes transient nature of employment of cabin crew.

5.6. Precedent has been set in the past where an unknown cause of an industrial injury has led to prescription, but this is no longer on the prescribed list.

5.7. At the July meeting, in order to gauge the views of members and arrive at a consensus, a show of hands was requested to determine if melanoma in air crew should be prescribed. There was a large majority in favour of prescription with 2 members voting against. Consequently, it was decided to write a command paper with the aim of providing a draft copy to the next full Council meeting in October 2019.

5.8. This draft paper was discussed by RWG as the author had revisited some of the points raised, such as:

5.8.1. Further discussions were had with Public Health England on windshields and UV penetration – these will be written up and included as necessary. The mutagenic properties of UVA, which can pass through windshields, are well recognised but it is thought the dose would be low.

5.8.2. There was still some doubt around whether leisure exposure to UV can be ruled out as a causative agent. More information on time schedule data would be useful to inform the discussion. Fatigue may also play a part.

5.8.3. A member raised concerns that employers would need to know what caused the cancer so that they could implement preventative measures. It was agreed that UV exposure is almost certainly the cause but still can't ascertain whether substantial exposure occurs as a results of work including stop overs etc or whether these workers have a lot more leisure time exposure as a result of the perks of their job. It was felt that in that case employers should be able to do something about prevention.

5.8.4. It was felt delving deeper into socio-economic class would add little value to the evidence as it is so clear cut.

5.9. The author stated they would investigate current air crew work patterns and what had happened in the past. It was also stated the CAA and BALPA would be contacted again to determine if anything could be added to the draft paper.

5.10. The draft paper will be submitted to full Council at the next meeting in October 2019.

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

6.1. 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.

6.2. It was decided that members would assess the scope of a review and define the parameters to assess, but a member asked that the scope not be limited to the confines of the industrial injuries scheme. It was suggested to assess the construction industry in parallel with occupations already prescribed.

6.3. This will form part of the proposed work programme covered by the next agenda item.

7. Proposed ongoing IIAC work programme

7.1. A draft work programme was presented at the meeting which had been drawn up by the Chair and secretariat. This was formed from items raised at the public meeting, correspondence, horizon scanning and members own experiences.

7.2. The items on the work programme were nominally prioritised according to perceived length of time the investigations were expected to take.

7.3. Members agreed to adopt the work programme and it will be put before the full Council at its October meeting.

7.4. A member volunteered to take the lead looking at the impact of glyphosate.

8. AOB

a) Correspondence

i) Further correspondence received from a member of the public regarding ANCA vasculitis following silica and asbestos exposure, along with IIAC's final response was provided for information. A member with respiratory disease expertise had reviewed the evidence the case of ANCA vasculitis and overall felt that, currently, there is insufficient high quality and consistent evidence in the published literature for this to be prescribed in association with silica exposure.

ii) Given the amount of time spent on this topic, it was felt an information note setting out the evidence and the Council's position would be appropriate. This will be drafted and presented to the next full IIAC meeting in October.

b) Environmental audit committee report

i) A recommendation from the House of Commons Environmental Audit Committee (EAC) report: 'Toxic chemicals in everyday life' has now been referred to the Council by the minister following the Government's response.

ii) It refers to risks associated with firefighting and the subsequent diseases firefighters may go on to develop.

iii) It was pointed out diseases encountered by firefighters had been looked into a number of times. Members had engaged with the Firebrigades Union and advised firefighters may be covered by the accident provision of the industrial injuries scheme. It was agreed the Council will need to formulate a response to the EAC report.

c) Carpel tunnel syndrome (CTS)

i) Following the public meeting, a member was asked if they could advise if there may be similar issues for CTS and the use of hand vibrating tools as had been encountered with HAVS.

ii) The issue raised was in relation to the possibility of there being similar problems with assessing doctors when dealing with CTS from the use of vibrating tools.

iii) The recent data provided on CTS suggests there may be an issue but only by carrying out an audit of cases similar to the HAVS exercise would it become clear.

iv) It was decided to ask the DWP if there were any obvious reasons for the relatively low successful claim numbers before embalking on an audit.

Next meetings:

Full IIAC – 24 October 2019

RWG – 28 November 2019