RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the meeting
Thursday 5 March 2020

Present:

Dr Lesley Rushton	RWG
Professor Kim Burton	IIAC
Professor Neil Pearce	RWG Chair
Dr Ian Lawson	IIAC
Dr Chris Stenton	RWG
Professor John Cherrie	RWG
Mr Doug Russell	RWG
Dr Anne Braidwood	MOD
Ms Lucy Darnton	HSE
Mr Jamal Saddique	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Professor Karen Walker-Bone, Dr Sayeed Khan, Mr Neil Walker, Dr Emily Pikett, Ms Maryam Masalha

1. Announcements and conflicts of interest statements

1.1. A member stated they have external involvement in item 5 on the agenda, VT/TA testing review for PD A11.

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. Environmental Audit Committee (EAC) recommendations for firefighters

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

3.2. The report states "*The Government should update the Social Security Regulations so that the cancers most commonly suffered by firefighters are presumed to be industrial injuries. This should be mirrored in the UK's Industrial Injuries Disablement Benefits Scheme"*

3.3. It refers to risks associated with firefighting and the subsequent diseases firefighters may go on to develop.
3.4. At the January Council meeting, members engaged with the expert witness who gave evidence to the Committee, Professor Anna Stec, who delivered an informative talk.
3.5. Previous investigations carried out by the Council into firefighters have not identified a doubling of risk and the epidemiology appears to be clear on this topic. Previously, the Council had advised firefighters might be eligible to claim under the accident provision.
3.6. This appeared to be supported by evidence from the ANSES report and the Epidemiological Literature Review on The Risk of Cancer among Firefighters by Brantom et al.
3.7. A member reported that it is important that meta-analyses be taken into account, some have looked at prostate and testicular cancer, but risk ratios were not close to being doubled. It was decided to carry out a literature search of recent publications to review current evidence.
3.8. It was noted that the literature on firefighters is international and firefighters from different regions of the world will face exposures from varying sources. Even in the UK, firefighters from urban areas will face different challenges to those from more rural environments.

4. Commissioned review into respiratory diseases

4.1. This follows on from the correspondence received from an electrician who developed lung cancer after working in close proximity to other workers who were processing asbestos. Originally this topic was asbestos exposure and cancer in construction workers.
4.2. This proposal was discussed and some concern raised that the scope was very broad, and it was agreed that it would focus on lung cancer and COPD ie on these disease states rather than the prescriptions at this stage. However, it was envisaged this would be carried out in 2 phases with the outcomes of the initial phase determining how the investigation would proceed in the latter phases with regular updates as necessary.
4.3. The commercial process has been initiated and an advert to place on the IIAC.gov website was discussed and passed. The secretariat explained the process to be followed to appoint a contractor and how the Council would have the final decision on who was to be appointed, with the focus being on quality rather than price. At this early stage, the level of funding available was not being disclosed.
4.4. A member asked if bidders from outside the UK could be considered and this was taken away by the secretariat to clarify.
4.5. It was agreed this advert should remain on the website for an initial period of 6 weeks. Potential contractors will be asked to express a preference for further discussion and scrutiny by the Council.
4.6. The potential contractor will need to focus on the epidemiological evidence rather that toxicological information.

4.7. A member urged caution when bidders score studies following their evaluation and to ensure studies were included which might have otherwise been disregarded.

5. Vibrotactile/Thermal Aesthesiometry Testing Kits in the assessment of sensorineural PD A11

5.1. The Council was approached by DWP officials to ask the Council for advice on whether there is an ongoing need to perform Vibrotactile Thresholds and Thermal Aesthesiometry (VT/TA) tests in the assessment of the sensorineural component of PD A11 and whether it remains cost effective to do so.

5.2. The accepted generic term for these psychophysical tests is Quantitative Sensory Testing (QST).

5.3. The Centre for Health and Disability Assessment (CHDA) are in a position where the equipment used for these assessments needs to be replaced at considerable cost. CHDA stated claims for PD A11had declined and questioned if the tests were still required.

5.4. The CHDA and DWP stated they do not feel claimants would be disadvantaged by not undergoing VT/TA testing, so long as they meet the 'statement and examination criteria for referral for the tests.'

5.5. A member with considerable expertise in hand-arm vibration syndrome (HAVS) agreed to visit an assessment centre to review the assessment process for HAVS claims and presented a paper to RWG with their findings.

5.6. Claimants need to demonstrate degradation in sensory perception in order to meet the criteria of the prescription.

5.7. Whilst the symptom criteria may be met it is only by objective testing that a significant reduction in sensory perception can be demonstrated. For example, light touch and two-point discrimination and grip strength may be helpful as a rough guide in the clinical examination setting and subsequently in disability assessment. However, there is high inter-observer variability with some of these tests (e.g. with regard to light touch the HSE stated in Guidance to Control of Vibration at Work Regulations in 2004 that high inter-observer error makes these procedures of little value in practice and they are not recommended). These qualitative tests are not able to distinguish severity in sensory HAVS which requires a combination of VT and TA. The standardisation of procedures for the latter two tests also overcomes inter-observer variability between assessors and assessment centres. In addition, whilst dexterity may be reduced and demonstrated by PPT in most cases it does not necessarily follow that it is due to reduced sensory perception and should not be relied on alone.

5.8. RWG members debated the papers with some expressing concern that the tests may not be cost-effective given the reduced claimant numbers. However, it was pointed out that the Council is not responsible for carrying out a cost benefit analysis and its advice should focus on the evidence provided.

5.9. Following discussions, it was decided that Vibrotactile Thresholds and Thermal Aesthesiometry (VT/TA) tests are an important component of the assessment process and should continue.

6. Correspondence

a) Dupuytren's contracture onset & criteria for prescription

i. The NUM wrote to IIAC requesting clarification of the criteria relating to DC "where the onset of the disease fell within the period or periods of use specified in this paragraph" which was taken from the prescription terms.

ii. This was circulated to members for comment on how to respond with the resultant response included in meeting papers for information and ease of recall.

iii. Questions were raised (from NUM, British Dupuytren's Society and DWP officials) around the nature, onset, and eligibility for benefit under the (revised) Dupuytren's prescription.

iv. A member provided a discussion note and a flow chart to capture the various questions raised on the involvement of the interphalangeal and metacarpophalangeal joints (MCPJ) in the disease state and their relevance to the prescription criteria.

v. Members debated the questions raised by the member in their report.

vi. It was decided the MCPJ should not be disregarded and should be taken into account in the assessment and eligibility criteria for the prescription.

vii. Other questions relating to disease onset were directed to the original command paper from 2014 where it was stated that having palmer thickening or nodules was not sufficient and contracture had to be apparent. The Tubiana Scale was felt appropriate as detailed in the recent Information Note published by the Council. Moderate disease is indicated by 30-60^{o} flexion on this scale.

viii. Also, it was felt the time-scale prescribed should be adhered to and claimants outside of this would not qualify. This was covered by the original command paper.

ix. The recently published information note which outlined the Council's reasoning for adjusting the prescription wording will be updated, to include a diagrammatical representation of the Tubiana Scale for clarity.

b) NIHL in firearms officers.

i. MP correspondence received about a constituent who suffers from noise induced hearing loss (NIHL) as a result of his work as a firearm's officer who feels his work should be included in the prescription - firearms training officers are covered by the prescription PD A10.

ii. This was referred to the Council for its advice and brought to the Council meeting in January.

iii. The HSE were asked what evidence maybe available on firearms training officer's noise exposure; the HSE will investigate this. This occupational group was added to the original prescription as an addendum.

iv. Members debated whether this topic need to be added to the work programme to investigate further.

v. Members felt that the work programme was full at this present time but this topic could be considered for a review in the future. The MOD offered to make a contribution by looking at what data they may have available.
vi. It was felt, whilst the Council do not comment on individual cases, that the critera of the prescription are not met on this occasion and a response to the MP will be composed.

c) Neurodegenerative diseases in professional football players.
i. A request was received with the support of two charities, Coaches Across Continents and The Jeff Astle Foundation asking IIAC to "identify neurodegenerative brain disease as a 'prescribed disease' where the risk activity/occupation is participation in professional football."
ii. A paper was incuded with the letter of request which considered the legal requirements for prescription and drew attention to a number of studies published between1999 – 2019, particularly a recent study which showed a high risk of mortality from several neurodegenerative diseases..
iii. Members considered the evidence provided and whether this was sufficient to recommend to full Council that this topic be added to the work programme.
iv. Members commented that although they felt the mortality study provided for scrutiny was valid and of good quality, it is still a single study. The Council requires clear and consistent evidence across a number of studies before prescription can be considered.
v. It was also noted there were no exposure data and there was no further information on these patients other than they played football.
vi. The point was made that a number of different disease states are reported and no mechanisms of action are apparent.
vii. It was decided to invite the author of the field study[1], consultant neuropathologist Dr. Willie Stewart of Glasgow University, to a Council meeting before deciding how to proceed.
viii. A member noted that a number of other substantial studies of this topic are underway, so the outcomes of these may also influence how the Council decides to proceed.

7. AOB

7.1. Silicosis and prescribed occupations

7.1.1. Members were provided with a paper[2] documenting the demographic risk factors, including industry and job, of workers reported to have silicosis in the UK between 1996 and 2017.

7.1.2. Silicosis is recognised in the list of prescribed diseases and it was felt work could be carried out to update these prescriptions to reflect modern

[1] Mackay D.F, Russell E.R, Stewart K, Maclean J.A, Pell J.P., Stewart W. Neurodegenerative Disease Mortality among Former Professional Soccer Players. New England Journal of Medicine, 2019 Nov. 7; 381(19): 1801-1808

[2] Barber CM, Fishwick D, Carder M, van Tongeren M. Epidemiology of silicosis: reports from the SWORD scheme in the UK from 1996 to 2017. Occup Environ Med. 2019 Jan;76(1):17-21.

working practices and occupations. This would be carried out separately to the commissioned review into respiratory diseases.

7.1.3. It was decided to form a sub-group to look at occupations and any exposure data available. This sub-group will report back with any recommendations to change the regulations where silicosis is involved.

7.2. Melanoma in air-crew

7.2.1. A member who has been working on the command paper to be published following extensive research into this topic, wanted to clarify it was aggregated length of employment in the relevant field which was most relevant to quote in the paper. Aggregated flying hours is also discussed in the paper, but it was felt aggregated employment was the best format to use.

Next meetings:

Full IIAC –2 April 2020

RWG – 28 May 2020