RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the online meeting
Thursday 26 November 2020

Present:

Dr Lesley Rushton	RWG
Professor Neil Pearce	RWG Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	RWG
Professor John Cherrie	RWG
Professor Karen Walker-Bone	RWG
Dr Sayeed Khan	RWG
Mr Doug Russell	RWG
Ms Lucy Darnton	HSE
Dr Fareeda Amojee	DWP Medical Policy
Ms Mandeep Kooner	DWP IIDB Policy
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Anne Braidwood (MoD), Ms Maryam Masalha (DWP), Dr Mark Allerton DWP Medical Policy.

1. Announcements and conflicts of interest statements

1.1. The chair set out the protocol for the online meeting.
1.2. Dr Fareeda Amojee from DWP medical policy was welcomed to the meeting - who was present as an observer.
1.3. A member declared they had taken on the role of Deputy Chair British Medical Association Occupational Medicine Committee. This was not considered to be a conflict with their role on the Council. It has however been added to the register of member's interest for transparency purposes.
1.4. Another member stated they had previously worked for the Tungsten/carbide industry which was completed in 2017.
1.5. A member was thanked for their work on editing and contributions to various papers.

2. Minutes of the last meeting

2.1. Subject to minor drafting edits, the minutes of the last meeting were cleared. The secretariat will circulate the final cleared version of the 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.

2.3. An action point relating to the Council's response to the Environmental Audit Committee's recommendations relating to firefighters was discussed. The Fire Brigades Union have published an interim report from UClan on best practice to minimise exposure to toxic fire effluents. The report includes sections with more detailed advice on the use, storage and cleaning of PPE to reduce exposure to potential carcinogens. As the Council's response has not yet been submitted to the EAC, it was agreed to replace the reference to the older FBU guidance in the prevention section of the Firefighters paper with the link to the new report.

3. Silicosis and prescribed occupations

3.1. A member reviewed the current prescription PD D1 Pneumoconiosis (Includes silicosis and asbestosis). In relation to the current occupations impacted by exposure to silica, a paper had been previously presented to RWG and the main Council for discussion.

3.2. The member stated they had been considering the list of occupations plus a catch-all category, with which there was some unease as this may allow the possibility for claims to be made for pneumoconiosis which may not meet the otherwise required standards for eligibility.

3.3. A number of members have been considering whether to restrict the prescription to conditions only related to those caused by exposure to coal, asbestos or silica. These account for the vast majority of conditions. A recent Morbidity and Mortality Weekly Report (MMWR) indicated 99.4% of deaths from pneumoconiosis were due to exposure to coal, asbestos or silica, leaving 0.6% to other causes. This also includes berylliosis which is covered by PD C17, so that probably leaves ~0.5% not caused by these exposures and the member questioned whether this could be disregarded and just restrict PD D1 to conditions casued by exposures from coal, asbestos or silica.

3.4. Mica exposure and Aluminium exposure from munitions factories (in previous decades) are thought to rarely cause some lung conditions with no pathological pattern but dust can be found in the lung.

3.5. There are also examples of where pneumoconisis has been identified using old-fashioned chest radiograph abnormalities but don't necessarily show lung fibrosis. Carbon black has also been implicated, but more from a COPD perspective.

3.6. Taking aside coal, asbestos and silica, there are probably 5-10 exposures which merit consideration for inclusion in a revised PD D1 prescription. It is feasible to remove the catch-all category and have a list of specified agents. These would merit further consideration to esatblish if they cause pneumoconiosis and whether these meet the criteria for prescription. Also, the correct diagnosis is vital.

3.7. Members debated these points and asked if the current list specified in PD D1 could be simplifed, but would need to be done carefully and justified. All but one of the specified exposures were thought to be due to coal, asbestos or

silica. The other was boiler scalers and it is debatable whether this is still an issue although compensation data show 20 claims in the last 10 years

3.8. A member asked if removing the catch-all category from PD D1 would be inconsistent with the prescription for occupational asthma, which has this. This is different due to the diagnosis procedure and exposure related to symptoms.

3.9. An observer stated they had submitted a breakdown of D1 cases labelled by agent, but the codes are unusual and it is difficult to establish definitively what the exposures are.

3.10. It was agreed that this work should continue as PD D1 has not been looked at for some time. A sub-group of members will meet in the near future to examine the evidence – will be brought back to RWG when more progress has been made. The case for consulting other respiratory disease experts will be considered as part of the ongoing review of PD D1.

4. Covid-19 and its potential occupational impact

4.1. An amended draft position paper was submitted for discussion, with contributions from several members. This is still at an early stage with input from other members still required. A member set out the revisions relating to:

- An additional paragraph (13) in the introduction regarding the on-going nature of the Council's COVID evaluations – this is a first draft setting out the Council's approach to evalauting this topic.
- The following sections have been revised and in some cases shortened:
  - Characteristics of the disease
  - ONS results
  - RIDDOR
  - Exposure
- There are new sections on:
  - Risk factors for COVID
  - Occupation and risks of infection, which includes non-occupational risks.

4.2. A member mentioned new data on bus drivers which would need to be included in the paper as they are in the public domain. The summary also needs to be redrafted and it was restated that this is a position paper which sets out the Council's views. At this time no recommendations are being made because even where occupations stand out as being impacted by covid-19, ethnicity, deprivation and region need to be adjusted for to establish if the data are robust. It can be said, though, that Covid-19 has a significant impact on those of working age.

4.3. The chair stated it would be preferable to have a draft ready before Christmas

4.4. The paper includes data from the Office for National Statistics (ONS) and it has been confirmed that no additional reports will be available to help inform the position paper. Further data and analyses should be available in the New Year, but will nto be available in time for the current Position Paper; these include analyses linked to the 2011 Census (to enable adjustment for ethnicity, deprivation, region), and the development of a Job-Exposure-Matrix (JEM)

4.5. The aim of this position paper is to establish if there is an increased risk of death in particular occupations and whether those with high contact with patients or the public have particularly increased risks. It was pointed out that healthcare workers did not have strongly increased risks. This will need to be fully discussed and carefully considered as this may be due to deaths being reported to the coroner and the extensive PPE now available. If the broad category of healthcare workers is broken down into different jobs such as non-ICU frontline staff, those with little PPE may be at significantly greater risk. A member stated that other supporting data are important to include as well as those from the ONS as the categories used here are broad.

4.6. Infection rates, such as derived from BioBank data, show high risks for healthcare, but it it is important to note that this group will have been more frequently tested. It was also pointed out that clusters of infections have been reported in food preparation workplaces which continued to operate during lockdown so more likely to be close contact in the workplace which caused these clusters. All these points will need to be commented on in the position paper.

4.7. A member pointed out that there are 2 important aspects to consider:

- The risk of contracting Covid-19
- The risk of becoming seriously ill as a result of contracting the disease.

4.8. These 2 aspects are very different and need to be treated separately. The excess risks of ICU admission in BAME patients may be due to confounding by age, since older patients were often not admitted to ICU. The position paper will cover this in the risk factors section.

4.9. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) data from the HSE is being regularly published. These data are a good indication of the scale of the problem but is not a good indicator of occupations impacted because of perceived conflicts in guidance issued. How these data are interpreted and potential bias will be key and wording of the paper needs to be carefully considered.

4.10. It was noted that the paper includes many tables and a suggestion was made to incorporate these into appendices and add brief text intothe relevant sections.

4.11. It was agreed to include information from studies of the virus spreading in clusters in enclosed workspaces such as factories where PPE may have been inadequate – an example of this was an outbreak in Germany.

4.12. It was thought that infection rates and occupation should be included and some evidence is emerging in the literature, particularly a study by Chew et al. A member felt strongly that this section should be bolstered as the position paper has been greatly influenced by the ONS mortality data which appears to indicate the risks in healthcare workers is low. They felt strong evidence is emerging from antibody and infection surveys which indicate this group is at an increased risk. It was stated there are papers in the literature which support this view. Some of the BioBank data also separates out medical support staff and transport workers which support increased risks across several occupations. A member pointed out there may be other occupations such as social care workers, residential care workers at higher risks. This should be reflected in the discussion section of the position paper.

4.13. A member made a comment about potential prescription for IIDB where a disabling element has to be present. The accident provision is available, but

recommendations for prescription for disablement from ‘long covid’ will require more data and evidence.

4.14. There was discussion of the term ‘long covid’. It has been reported that NICE have issued a definition of ‘long covid’ as ‘Post-COVID-19 syndrome’ where a patient has experienced symptoms for more than 12 weeks.

4.15. Work will continue on this report and the chair hoped this position paper could be ready for review by the full Council by 8 January 2021. Members who have responsibility for drafting sections were asked if they could have their contributions ready by 18 December.

5. Future commisioned review into infectious agents

5.1. Given the current coronavirus pandemic and subsequent crisis, a member felt it was appropriate to consider reviewing the prescriptions involving biological agents as this has not been done for many years. There was an information note on hepatitis E in 2014. Funding may be availble to carry out a commisioned review into this topic and the secretariat confirmed the process would be the same as that for respiratory diseases.

6. Neurodegenerative diseases in footballers

6.1. This topic has received a great deal of media exposure over the last couple of weeks.

6.2. Queries have been received from;

- The BBC
- Sky News
- The Daily Mail

6.3. It was initially agreed to invite Willie Stewart (The Glasgow Brain Injury Research Group), the author of a recent report on neurodegenerative diseases in footballers, to a RWG meeting to discuss their findings. The secretariat will try to make arrangements for this to happen at the next RWG meeting in February 2021. This would enable members to ask questions of the data and perhaps gleen information on any other relevant studies which could help any potential investigation the Council may wish to carry out.

6.4. A member who is active in this area stated they felt the Glasgow study was robust and produced strong data, but that these data should be replicated at least once in other studies. The issue is there are no exposure data reported – it’s not clear if heading the ball or concussion or other factors are the causative agents. It may be the case that the Glasgow study could have other analyses which could be completed to support potential prescription. Other studies on this topic have been measuring cognitive function and these studies may be ready to report mid 2021.

7. AOB

7.1. A member reported they have been made aware of a private members bill in the Scottish Parliament which is proposing the establishment of a Scottish IIAC. A link to the members bill will be circulated to all members.

7.2. A DWP IIDB policy official gave an update to members on the assessment process for IIDB which has been impacted by the coronavirus pandemic. DWP is trialling a paper-based assessment for certain prescribed diseases to determine if this could help alleviate the back-log which has built up. A member suggested video-based assessments could be tried and the DWP confirmed this is another approach it is considering.

7.3. The next Council meeting is scheduled for 14 January 2021 and is likely to be held online via videoconference, details to be confirmed.

7.4. The next RWG meeting will be held on 25 February 2021.