INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the online meeting
Thursday 15 January 2021

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Professor Neil Pearce	IIAC
Dr Chris Stenton	IIAC
Professor John Cherrie	IIAC
Professor Karen Walker-Bone	IIAC
Mr Doug Russell	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Sayeed Khan	IIAC
Dr Andy White	IIAC
Dr Jennifer Hoyle	IIAC
Dr Max Henderson	IIAC
Mr Dan Shears	IIAC
Ms Karen Mitchell	IIAC (audio)
Mr Keith Corkan	IIAC (audio)
Ms Lesley Francois	IIAC
Dr Anne Braidwood	MoD (audio)
Mr Darren Bird	DWP ALB Partnership Team
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: DWP Medical Policy, DWP IIDB Policy, DWP Legal, Ms Lucy Darnton

1. Announcements and conflicts of interest statements

1.1. This was the third IIAC meeting to be held virtually via videoconference, the Chair welcomed all participants and set out expectations for the call and how it should be conducted.

2. Minutes of the last meeting

2.1. The minutes of the last meeting in October 2020 were cleared. The secretariat will circulate the final minutes to all IIAC members ahead of publication on the IIAC gov.uk website.

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

3. COVID-19 and its potential occupational impact

3.1. The Chair introduced this topic and thanked members for their contributions since the last meeting. Consequently the initial draft paper has been edited and includes new inputs from members. A number of the sections have been reduced and some data tables moved to an appendix.

3.2. The discussion section has been expanded for the strengths and weaknesses of the ONS data and the RIDDOR section has been updated with the latest available information. A new section on infection data has also been added.

3.3. The Chair stated the bullet points included in the discussion and recommendations section was to be the main focus of the meeting as these have yet to be discussed by the Council, which needed to decide how to proceed and what to do in the future. When IIAC embarked on this work, another wave of the pandemic was anticipated, but not to the extent to which it has progressed and death data relating to occupation may need to be revisited.

3.4. The Chair asked for comments on the general structure of the paper, its length, language, and terminology etc. It was suggested that some of the individual sections be reviewed in more detail before discussing the discussion summary/conclusions sections as some members will not have seen these before.

3.5. A member commented the paper was appropriately detailed and felt a glossary was required.

3.6. The nomenclature of COVID-19 and SARS-CoV-2 was agreed upon.

3.7. It was felt that paragraph 19 should be amended to reflect the fact that patients who have COVID-19 can have serious complications without being admitted to intensive care (ICU). A member pointed out that post-ICU syndrome and post-COVID-19 syndrome are different and the paper should reflect this. Additional descriptions of potential longer term disabilities will be added to assist the Council in what to monitor in the future.

3.8. The Chair felt it was important to state what types of studies should be carried which would be useful for the Council to use to assist its investigation.

3.9. Members debated and clarified their understanding of the official statistics which have been published for deaths involving COVID-19 and how these deaths are coded on the certificate.

3.10. Following a general discussion, a member stated they felt it was important to publish this paper very soon or wait for a few months to include data from subsequent waves, their preference being to publish as soon as possible. They also felt that in the conclusions, it was important to state that whilst deaths from COVID-19 have occurred in healthcare workers, it is difficult to draw conclusions about doubling of risk because of issues with the data.

3.11. Some other minor edits were suggested; the Chair stated they hoped to be able to clear most of the paper at the meeting with any additional edits to be cleared by correspondence.

3.12. Reference was made to claims for posthumous deaths using the accident provision of IIDB which has to be completed within 1 year of the death. The Council had hoped this qualifying period could be extended, but information received indicated this was set down in legislation and would require a change in the Regulations to allow an extension.

3.13. Members then went on to review the main sections of the draft paper. The Chair stated that this paper is likely to be the first of a number of papers as this is an ongoing investigation. This paper specifies why the Council has taken this approach and what can be expected in the future.

3.14. It was noted that a small study on bus drivers has been included (para 48) as supporting information. It was noted that ONS have not published any further

reports on occupation, but further information was expected later in January/February, but this would need to be clarified. This will be needed for subsequent future reports.

3.15. The strengths and limitations of the ONS data were described and discussed – denominator/enumerator biases have been observed. There are variations in causes of death and also how occupations have been recorded. A member who has been involved in analysing ONS data stated that a new data set is available where information from the 2011 census has been linked to the deaths on 2020 and worked out a way to compensate for variations, prelimary analyses on broad occupational groupings return a similar relative risk to current data.

3.16. There are also disparities in risk between different ethnic groups. A member stated there was no good data where ethinicity has been adjusted for occupation nor occupation adjusted for ethnicity. There does not appear to be a greater risk based on ethnicity when in the same circumstances/situation as other groups.

3.17. The RIDDOR data were discussed and it was noted that a new HSE report was due out on 18 January, but it was felt that this should not be included. A member felt there were biases in the RIDDOR data:

- the requirement for HSE to have reasonable evidence for an occupational cause for reporting versus the disease being acquired from the general population;
- the fact that if a worker was following PHE recommended precautions e.g. a face-mask and subsequently developed COVID-19, this was not reportable and misclassification of occupational classes has been apparent; and
- the ability of physicians to be able to state a worker contracted the disease from their work whereas it may have been from the general population.

3.18. Consequently, it should be noted that the RIDDOR data can be used as indicative, giving a general picture and supporting information only – the main source of data used to inform the paper is from the ONS. The RIDDOR data are useful but needs to be put in perspective. Other members were supportive of not under-playing the RIDDOR information as it may encourage reporting of exposure and deaths.

3.19. Occupation and infection rates was covered in the paper, but much of the studies have been opportunistic and community studies. It should be noted that this is not a comprehensive review although there is little on infection rates. It illustrates this is ongoing work and the limitations of the current data .

3.20. A section on exposure has also been included and a further publication on this topic is awaiting publication. Airborne exposure has been covered which was thought to be important in factory-type settings e.g. meat processing plants where air is recirculated.

3.21. The discussion section was reviewed. An observer suggested that it was generally difficult to link the sections and suggested having a narrative to draw these together.

3.22. A paragraph on doubling of risk from mortality data was discussed and some members felt more precision was required in which occupations were directly impacted. In the first wave there was a great deal of redeployment, especially in the healthcare sector, which impacted on risks that could not be controlled. This could affect the data sources and limits its usefulness. Also the issue of gender disparity was felt to not have been adequately explained.

3.23. Some members were unclear if a prescription was appropriate at this point even though a doubling of risk was apparent, given the limitations of the data and which occupations could be covered and for what. The gender disparity makes this more difficult. Another member stated their views that this was a position paper and not a recommendation for prescription at this point. However, the Council may be moving towards prescription in future reports.

3.24. The members went on to debate further the merits and drawbacks of recommending prescription at this point. Some members thought it was important to state if prescription is not being recommended at this point, given the apparent doubling of risk, very good reasons need to be given. Others had disquiet about the data available.

3.25. A member stated that many studies are underway and in the coming months much more data, which will be clearer, will become available which can help the Council in its future deliberations.

3.26. The Chair summed up this debate and asked members for their views on prescription. A show of hands for and against was inconclusive. A member then made the point that the choices should be very clear. If members want to prescribe at this point, then a great deal more work would be required to produce a command paper which would delay publication further. It was felt it was very important to publish something very quickly given the 12 month qualifying period for posthumous death claims to IIDB. An observer stated that further input from DWP IIDB policy may be able to advise further.

3.27. Further debate and input from members resulted in a conclusion that the COVID-19 paper should be a postion paper which indicates there is a clear association of increased risk of occupation with COVID-19. It will note the doubling of risk but recognising the limitations of the data, the Council felt it would be on a pathway towards prescription. The Chair then detailed which sections required revision, but felt the bulk of the paper was adequate.

3.28. It was noted a section on prevention would be required.

3.29. New data are emerging all the time and these will help inform the Council's decisions in future reports.

4. Discussion on occupations missing from PD A11

4.1. A notification of a private members bill put before the Scottish Parliament was cirulated to members which detailed a proposal to introduce a Scottish version of IIAC, which was provided to members for information only.

4.2. A member noted in the proposal that certain elements relating to occupations impacted might be applicable to IIDB, particularly PD A11, which covers hand-arm vibration syndrome. Local authority gardeners were given as an example which are not covered by PD A11.

4.3. The member summarised their observations and presented the Council with a comprehensive paper which introduced the idea of exposure equivalence

which is an alternative to finding evidence for a doubling of risk, a key measure for recommending prescription, where epidemiological evidence is sparse.

4.4. The member commented that it might be possible, where a condition has been prescribed for recognised occupations, if subsequently a different occupation has been identified, to read across from existing data to cover the new occuption if the exposure levels are the same.This would allow the new occuption to be added to the list of those already known in the absence of epidemiological studies.

4.5. This has been considered in the past but the member felt it was worth revisting this approach. It was agreed that this discussion paper would be reviewed in full at the next RWG meeting in February 2021.

4.6. Another member also commented that job exposure matrices (JEM) are being widely used to link job titles to exposures and some may be applicable to vibration which is important in PD A11. It was suggested that HSE be approached to establish if the list of occupations impacted by vibration exposure is different to that prescribed for under IIDB.

4.7. The point was made that there may be a specific instance for PD A11, but the concept may be applicable across other prescriptions. It was also felt that this proposal should be shared with external experts in their fields to ascertain their views.

5. RWG Update

Pneumoconiosis/Silicosis

5.1. PD D1 which covers respiratory conditions such as pneumoconiosis/silicosis has not been reviewed for some time and it was felt it was important to reassess and restructure its qualifying criteria to make it simpler for claimants and IIDB decision makers.

5.2. A number of members co-operated to put together discussion papers for the meeting which was discussed briefly by members. It is at an early stage and requires more work to be done on occupations to be included on the qualifying criteria as ~98% of cases are due to coal /asbestos/ silica.

5.3. It will be important to understand what is going on in practice to help inform opinions for review as essentially this prescription has not been examined since 1953.

5.4. It might be the case that some exposures are removed and dealt with separately and reduce PD D1 to 5 or 6 applicable main categories.

5.5. It was noted that diagnostic criteria are an important component of this prescription where medical techniques are different now to when the prescription was drawn up.

5.6. It was agreed that RWG would review this in more detail at its next meeting in February 2021.

Neurodegenerative diseases in footballers

5.7. There has been substantial media interest in this topic and the Council has been approached by a number of media outlets seeking its views.

5.8. It was agreed at the last RWG meeting in November last year that the author of a recent paper which sparked the media interest, Dr Willie Stewart Consultant Neuropathologist at Queen Elizabeth University Hospital

Glasgow, should be invited to attend the next RWG to discuss the outcomes of his paper.

5.9. This has been provisionally agreed for 25 February, with the caveat that Dr Stewart is due to attend/ participate in a coroner's inquest around a case they assisted with.

6. Commissioned review into respiratory diseases

6.1. Since the review was last discussed by the Council, the advert inviting expressions of interest to carry out this work has been live on the IIAC gov.uk website.

6.2. To date, 3 applications have been received.

6.3. It was agreed that the closing date be extended by a further 2 weeks to allow any further additional prospective candidates to apply.

6.4. The secretariat have secured legal support to help with contractural matters and the final specification is being drawn up which will form part of the next stage to appoint a suitable contractor.

6.5. The evaluation panel has been appointed and these members will be taken through their responsibilities relating to impartiality. The evaluation criteria will also be determined.

7. AOB

IIAC work programme

7.1. The working document outlining the interests of the Council is listed on the IIAC gov.uk website.

7.2. Whilst many of the topics are extremely important, it was felt that the work ongoing with COVID-19 will take up a great deal more of the Council's time.

7.3. However, members were urged to continue to identify topics which the Council should consider.