INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 23 February 2023

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC
Professor John Cherrie	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Jennifer Hoyle	IIAC
Mr Dan Shears	IIAC
Dr Richard Heron	IIAC (observer)
Mr Stephen Mitchell	IIAC (observer)
Dr Hilary Cowie	Institute of Occupational Medicine (IOM)
Ms Jen Proctor	Observer
Dr Rachel Atkinson	Centre for Health and Disability Assessments (CHDA)
Dr Anne Braidwood	MoD
Ms Lucy Darnton	HSE
Dr Charmian Moeller-Olsen	DWP IIDB Medical Policy
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Mr Garyth Hawkins	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Professor Damien McElvenny

1. Announcements and conflicts of interest statements

1.1. The Chair set out expectations for the call and how it should be conducted. Members were asked to remain on mute and to use the in-meeting options to raise a point.

1.2. The Chair welcomed Dr Charmian Moeller-Olsen from IIDB medical policy. Also welcomed were Mr Steve Mitchell and Dr Richard Heron as recently appointed IIAC members as observers.

1.3. Jen Proctor was welcomed as observer for work experience.

1.4. It was noted that Dr Hilary Cowie from IOM would join the meeting later to discuss the respiratory disease commissioned review and contribute to a discussion on women's occupational health.

1.5. When members were reminded to declare any potential conflicts of interest, Dr Rushton reiterated she was an independent reviewer of the publications referring to cancer risks in firefighters (Agenda item 6). Mr Dan Shears also asked that it be noted that the GMB union represents workers from the transport sector.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in November 2022 were cleared with minor edits required and cleared for publication.

2.2. All action points were cleared or in progress.

3. Occupational impact of COVID-19

3.1. The Chair started the discussion by giving an overview of the sub-topics relating to COVID-19 which the Council is monitoring.

- Other occupational groups who might have a doubled risk
- Other additional complications, including long-covid
- Time frames during which occupational risks were doubled
- Outbreaks
- Accident claims and awards

3.2. The Chair wanted to focus the initial discussion on non-health and social care workers, especially transport workers. Members could raise other points under any other business at the end of the meeting if there was sufficient time.

3.3. Members had prepared a draft paper which aimed to mirror the format of the previous command paper. The Chair was fairly confident that the literature had been scrutinised and felt that the information available to the Council was up to date and nothing had been omitted.

3.4. The Chair went on to say they felt there was as much evidence as there is likely to be at least in the near future on which to make a decision on transport workers. They wanted to focus the discussion on whether members felt the evidence was strong enough to recommend prescription. Sub-groups of transport workers would need to be considered as the risks were not the same across the board. Also timeframes may need to be considered as these are likely to have varied at different times, and the extent of ongoing risks would need to be taken into account.

3.5. A member who had input into the draft paper indicated that the command paper structure had been adopted and a suggested narrative for several sections had been written.

3.6. The section on transport workers had been built upon from the previous command paper – under ‘work patterns’ it was reported that 80% of transport workers indicated that they had never worked at home. It was also noted that like health and social care there was redeployment, often into the transport sector, e.g. retail moved online, so more delivery drivers were required.

3.7. The ‘Transmission pathways and possible risks’ section is being worked on as this was felt to be important to help the Council make a decision. Where direct evidence of exposure is limited, job exposure matrices (JEMs) can provide evidence of the theoretical or likely risks.

3.8. Infection and mortality data have been considered and will follow on from the command paper. It was suggested that work patterns in the USA may be very different to those in Europe, so the N American data may not be applicable.

3.9. The mortality data available has not changed much since the command paper, that showed a striking excess death rate for transport workers.

Proportional mortality data indicated a large portion of deaths of transport workers had a COVID-19 element on the death certificate.

3.10. The published mortality data for England & Wales remain incomplete, whereas Scottish data, although with smaller numbers, are reported over a longer period. Death data are now being re-analysed to separate cases in which COVID-19 was considered to be the underlying cause of death rather than mentioned on the death certificate.

3.11. The infection data are considered to be limited in relation to transport workers, with little differentiation between different transport sectors. These limitations will be discussed in the draft paper. Other issues will include the variations in protection apparent between different companies, transport sectors and geography.

3.12. The Chair invited comments and a member asked if the contributors to the draft paper felt there was a pathway to prescription for transport workers. A member replied to the affirmative indicating that some of the mortality data are quite strong, with excess deaths being striking over the whole time-period.

3.13. A member commented that they thought adjusting for ethnicity needs to be carefully considered; if ethnicity creates some susceptibility to infection or death, then it may not be appropriate to adjust for this, their reasoning being this has not been done in the past. It was pointed out that transport sectors may have a higher proportion of workers from diverse ethnic backgrounds.

3.14. However, the counter-argument was made that there are different risks between catching the disease and dying from the disease; catching the disease is where the Council needs to focus. There is a bias in the mortality data as when someone has caught the disease, comorbidities will play an important part in the risks of dying.

3.15. There was further discussion on this point, and it was pointed out it is the probability of being infected at work which is the important factor. It was not clear where the deaths occurred, whilst in hospital or elsewhere. Being in hospital was a risk factor for developing Covid, and a potential source of bias. A member pointed out that age is a comorbidity which is adjusted for and made the point for other comorbidities to be treated similarly. There was not a consensus on adjustment of data for comorbidities, but a member pointed out that compensating (prescribing) for a disease is based on the occupation and not by susceptibility.

3.16. A member felt that there needed to be a clear definition of ‘transport worker’ for the purpose of prescription as there will be large variations in risks within the sector as a whole. The issue of redeployment needs to be carefully considered.

3.17. If prescription were to be considered, a suggested wording could be: ‘…those involved in air, rail or road transport with direct contact with the public or passengers.’.

3.18. A member felt the evidence was strongest for bus, taxi and coach drivers with the risks estimated from the JEM being close to those of health and social care workers (H&SCW). A member pointed out that H&SCWs were potentially at greater risk as they were up to 20 times more likely to come into contact

with someone with COVID-19 compared with the general public. This is not taken into account in the current JEM. Another member pointed out that at least at some stages taxi drivers were transporting mostly keys workers or their relatives, which would have increased their risks.

3.19. Time frames were discussed as there were some thoughts that the risks faced by transport workers were ongoing, as indicated by the Scottish mortality data.

3.20. A plea was made to members to continue to look for further data and report back; a member offered to run searches looking at passenger transport in particular.

3.21. A member asked if there is a strategy to compile data for long-covid. The Chair noted that a member is reviewing the published evidence at intervals via Pubmed. The volume of published work is extensive and a more formal system might become necessary.

4. Review and revision of the pneumoconiosis prescription, PD D1.

4.1. The Chair introduced the topic and stated that members had attended a meeting of the group of occupational respiratory disease specialists (GORDS) where this issue was discussed.

4.2. It was generally felt that there was no need to separate silicosis from mixed mineral dust pneumoconiosis. Also, non-fibrous silicates could be included in a silica-containing dust category.

4.3. Previous iterations of the review included an ‘open category’ but whilst the view was not unanimous it was felt this was not required as no new causes of pneumoconiosis had emerged in the UK over the last 2 decades.

4.4. The GORDS meeting felt it was important to expand the metals category. There are some which clearly fit, such as tungsten carbide, cobalt and beryllium and a case was made to include aluminium. Cerium and indium were also suggested to be included to future-proof the prescription, even though these are very rare causes.

4.5. A member agreed that an open category was not required in the proposed new prescription and felt that the rare metals should be included as there may be some suggestion that exposure to these can occur in dental technicians.

4.6. The Chair felt that members should discuss whether the term ‘substantial’ should be included in the revised prescription as it is present in the current PD D1. Their view was that it should be omitted from a new prescription as it is a difficult term to quantify.

4.7. A revised prescription was proposed and comments were invited by the Chair.

4.8. A member stated that some current claimants may not be eligible under the new prescription and asked if this group would have the benefit removed if their level of disability is reassessed. The reply was that the proposed prescription would be applicable to new claims and those already in receipt of benefit should continue to be assessed under the old prescription. The proposed command paper should make it clear that the revised prescription applies to new claims only and there is no suggestion that current claimants

would have their benefit removed. The situation regarding legacy claims would need to be be discussed further and the legal foundation established.

4.9. Further clarification of the specialist diagnosis requirement was discussed. It was noted that that would not necessarily be a specialist in occupational lung disease. Normally it is likely to be a consultant chest physician but others such as radiologists might be included. The degree of specialism/ expertise would need to be made clear in the PD D1 command paper for lay-readers.

4.10. It was suggested that some examples of situations where a potential claimant could have been exposed be included in the command paper to provide clarity, particularly around silica or hard metals.

4.11. The Chair thanked members for their views and stated the next step would be to further revise the PD D1 command paper, with input from others, for potential review at the next full Council meeting.

4.12. For information, the Chair mentioned a letter which had been received from an assessor asking about a potential link between sarcoidosis and silicosis. However, the epidemiology doesn't suggest that those who have been exposed to silica are more likely to develop sarcoidosis. A response will be drafted setting out the views.

5. Noise induced hearing-loss (NIHL) and assessment protocols.

5.1. Advice was sought from the Council around the role of cortical evoked response testing in the assessment of NIHL as there are issues relating to the availability of expertise and equipment needed to carry these out.

5.2. A member commented that neurologists may be best placed to carry out the tests as opposed to 'ear, nose & throat' specialists.

5.3. An observer from the MoD gave an overview of their process as hearing loss is a relatively common occurrence in the military. That can be related to acute acoustic trauma (e.g. from blasts) or sustained (chronic) noise exposure. Currently, pure-tone audiometry is used to assess, which is subjective. If difficult or inconsistent results are obtained, this could be due to poor claimant compliance or lack of understanding of the process.

5.4. An observer from CHDA explained the current assessment procedures and there was discussion about the techniques used.

5.5. The MoD observer offered to write to those involved setting out the MoD procedures accompanying guidance.

5.6. It was noted that the problem related to practicalities and there was no need to consider carrying out a review of the NIHL prescription.

6. COPD in mineworkers – 20 year rule

6.1. A representative from the National Union of Mineworkers (NUM) had been in contact to ask the Council to look again at the prescription for COPD PD D12. They felt that the requirement for 20 years work underground was outdated as modern working practices meant miners were typically working 12 hour shifts as opposed to 8 hour shifts when the prescription was written. Consequently, more working hours would be accumulated over the same number of years

than was the case in the past. The NUM reported that members with less than the 20 years underground experience had developed COPD.

6.2. The chair reported that the 1992 command paper on which the prescription is based described the risk of COPD as doubled following cumulative dust exposures of 60-120 mg/m3-yrs which is equivalent to 20 years work in dust concentrations of 3-6 mg/m3.

6.3. A member provided data on exposures in mines indicating that these have fallen since the time of the original prescription. Work carried out by the HSE in 2002 indicated geometric mean dust concentrations of about 2–2.5 mg/m3 in large mines and about 3 mg/m3 in smaller mines.

6.4. It was noted that the likely reduction in average exposures at least compensated for the longer working hours and if these are used as the comparitors then no adjustment to the prescription is needed. However, this would be for the full Council to decide.

6.5. The exposure data discussed was from a paper in 2002, so it was felt that it would be appropriate to ask if the HSE has more recent data on dust exposures and working hours. A member also offered to look for additional information.

6.6. This will be reviewed again when further information is available.

7. Firefighters and cancer

7.1. This topic was reviewed by IIAC in 2020/21 in response to the environmental audit committee (EAC) which recommended cancers in firefighters be added to the list of prescribed diseases.

7.2. There have been recent publications which have created a lot of interest and resulted in correspondence lobbying the Council to change its position.

7.3. Members reviewed the publications and identified matters on which further clarification from the authors would be required. These were collated and passed to the main author, Professor Anna Stec, asking for a response broadly;

- The numbers used in the studies;
  - mortality data
  - population data
- Statistical methods used.

7.4. The papers do highlight the issue of clean-up of uniforms, equipment etc appears to be inadequate.

7.5. Professor Stec has not replied to the request to date so a strategy to respond to the issues identified will be formulated after a reasonable period of time has been given to respond.

7.6. The IIAC Chair has previously declared an interest in this topic as they were asked to review one of the papers prior to publication.

8. Neurodegenerative diseases (NDD) in sportspeople

8.1. The Chair introduced the item stating that it is a complex topic. A recent literature review yielded 5 systematic reviews with approximately 145 references between them covering a number of diseases including

Alzheimer's disease, Parkinson's disease and motor neurone disease, and a number of different sports including soccer, rugby and American football..

8.2. A member commented that they felt this was a complicated topic that was probably too big a task for one person to undertake and suggested a strategy be developed to take this forward. The Chair agreed and a sub-group was suggested to spread the workload. It was also suggested that the work be contracted out or a commissioned review be discussed.

8.3. A sub-group will be assembled with a view to discussing how to take this topic forward.

9. AOB (1)

9.1. Correspondence had been received from the NUM around late onset of Dupuytren's contracture after leaving employment where the exposure occurred. A response was sent setting out the Council's view that palmar changes would have to have started to occur whilst in employment in order to qualify for the prescription, but medical evidence of this would not be required.

9.2. It was agreed that the prescription was working; a revised information note has been drafted and will be published when cleared by the full Council.

9.3. It was agreed that Dupuytren's contracture could be an agenda item for the Public meeting in July.

10. Commissioned review into respiratory diseases

10.1. Dr Hilary Cowie joined the meeting to update members on progress made on the commissioned review.

10.2. A brief presentation was delivered which covered:

- 6 priority exposure disease combinations had previously been agreed for further consideration:
  - Silica & COPD
  - Silica & lung cancer
  - Cleaners & nurses and COPD
  - Farming/pesticide spraying & COPD
  - Hexavalent chromium and lung cancer
  - Asbestos and lung cancer.
- Phase 2 underway
  - Literature searches complete
  - Screening of searches partially completed
  - Data extraction partially completed
  - Commentary on extract data underway
- A further meeting with selected IIAC members will be scheduled to discuss further and a future timetable was suggested.
- Where there is a lot of literature for a sub-topic, latest authoritative reviews are identified initially (e.g. IARC monographs) and publications following that selected.

10.3. A member commented that silica and lung cancer is not currently prescribed in the absence of silicosis. A WHEC reported indicated there was evidence to suggest that silicosis was a marker of heavy exposure, rather than the cause

of the cancer associated with silica exposures. Its presence was not necessary for silica-related lung cancer to develop. There was modelling for dose responses carried out for lung cancer with/without silicosis so it would be useful to know if this had moved on and if any further data is available. It was reported that there were some new publications and these will be reviewed by IOM.

10.4. A member commented they felt the commentary in the silica/COPD document was helpful but would like to see more information about the quality of the studies and which were likely to be the most informative. IOM agreed and stated this would be included with data extraction and future commentary.

10.5. Another commented that the timetable looked well-paced and appropriate.

11. Work programme prioritisation

11.1. The IIAC Chair indicated that they would be looking at ovarian cancer and asbestos and a meeting had been held with IOM to discuss the possibility of working together on a scoping review for selected non-malignant topics concerning women's occupational health. At the end of the discussion with IOM, the IIAC Chair agreed to draft a note to assist IOM with a proposal and quote.

11.2. IOM indicated they would be able to carry out a general scoping review but for more in depth or detailed review, additional specialists may need to be brought in. They felt 3 aspects would be important:

- Gender-specific health outcomes which affect women and not men;
- Jobs which are predominantly female workforce and exposures
- Jobs which both sexes carry out, but where the impacts on women are different.

11.3. The IIAC Chair will draft a paper setting out what IIAC's requirements may be.

12. AOB (2)

12.1. A DWP official asked for some advice on pneumoconiosis and idiopathic pulmonary fibrosis related to recent correspondence the Department had received.

12.2. The Chair replied that IIAC had published a position paper in 2006 (position paper 17, interstitial fibrosis in coalworkers) which covered this topic and indicated that the idiopathic pattern (UIP) is not associated with coalmining. The Chair was not aware of anything which had emerged to change the Council's view.

12.3. The discussion moved back to COVID-19. A DWP official indicated that accident claims involving COVID had been monitored. Members were interested in what was being allowed and the occupations involved. Many symptoms reported were related to long-covid across a variety of occupations.

12.4. Members were also interested to know the nature of the event (or series of events) which prompted the claim. Further enquires will be made.

12.5. Discussion moved onto long-covid. Current definitions allow multiple of symptoms being reported over a varying time period post-infection. A member felt there wasn't currently a pathway to recommend prescription for this

condition. However, it was suggested that for certain symptoms of long-covid there may now be tests available. A member described dysautonomia which is a reported symptom of long-covid and can be diagnosed through autonomic function tests. Mast cell activation syndrome is another potential symptom to consider, but tests for this are not widely available.

12.6. The potential issue of bias in the data against women was brought up, especially in relation to teachers which are predominantly female and white. A member felt that perhaps an over-reliance on death data, where no excess risk was apparent might contribute to under-recognition. Some of these factors may need to be considered in a further report.

12.7. A member pointed out that the majority of people with long-covid are self-reporting with generic symptoms such as general fatigue and no specific diagnosis. From accident claims, some of these people have pre-existing conditions which are reported to have worsened.

12.8. Anecdotal evidence from the education sector indicated a number of teaching assistants reporting long-covid symptoms, with sporadic absences from work rather than long periods off sick – possibly related to disciplinary procedures.

12.9. Another member reported sleep apnea being exacerbated in long-covid related to weight gain. It was felt that more information and data would become available, but this is likely to be general rather than occupation-specific.

Date of next meetings:
IIAC – 30 March 2023
RWG – 25 May 2023