INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 11 January 2024

Present:

Dr Lesley Rushton	Chair
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Professor Max Henderson	IIAC
Professor John Cherrie	IIAC
Professor Damien McElvenny	IIAC
Dr Jennifer Hoyle	IIAC
Dr Gareth Walters	IIAC
Dr Sharon Stevelink	IIAC
Dr Richard Heron	IIAC
Ms Lesley Francois	IIAC
Mr Steve Mitchell	IIAC
Professor Raymond Agius	IIAC
Dr Sally Hemming	IIAC
Mr Dan Shears	IIAC
Ms Patricia Quinn	Northern Ireland Department for Communities (NI DfC)
Mr Andrew Hay	NI DfC
Dr Anne Braidwood	MoD observer
Ms Lucy Darnton	HSE Observer
Dr Charmian Moeller-Olsen	DWP IIDB medical policy
Dr Jenny Wenman	DWP IIDB medical policy observer
Ms Parisa Rezai-Tabrizi	DWP IIDB policy
Ms Georgie Wood	DWP IIDB policy
Mr Lewis Dixon	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Rachel Atkinson

1. Announcements, conflicts of interest statements and sign-off of minutes

1.1. The Chair welcomed all participants and 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. Members were asked to declare any potential conflicts of interest which have not been raised at previous meetings, or declare them as the meeting progressed. The secretariat had sent out a request for members to update their register of interests with a deadline for the end of January.

1.3. The Chair welcomed back Steve Mitchell after a period of absence.

1.4. It was confirmed that members fees would be increased and revised terms and conditions will be sent out to accommodate this.

1.5. The Chair reminded members that an additional on-line members meeting had been arranged for 25 January to focus on COVID-19, members were

asked to attend wherever possible. Where attendance was not possible, members would have the opportunity to comment by email.

1.6. Dr Jenny Wenman was announced as observing the meeting, who will be taking an interest in IIDB matters.

Minutes of the last meeting

1.7. The minutes of the October meeting had been circulated to members to comment on and agree. The Chair asked if members were content to now sign those off, all agreed albeit with some minor revisions and the secretariat would now send for publishing.

1.8. All action points had been cleared or were in progress.

2. Occupational impact of COVID-19

2.1. The Chair introduced the topic by stating 3 papers had been circulated for consideration following a lengthy discussion at the last RWG meeting. To aid members in assessing the evidence for transport and education workers (T&EWs), a short 'pros' versus 'cons' document was produced which summarised the 'for and against' arguments for recommending prescription. This was influenced by reviewing the decision-making process used in the command paper and applying this to the data available for T&EWs.

2.2. A draft copy of the T&EWs paper, where the layout had been rearranged, was also circulated.

2.3. As a summary of this process for the education sector, the authors concluded there was insufficient evidence of a doubled risk in education workers, and they were therefore unable to recommend prescription. It was acknowledged that there were likely to be circumstances where education workers developed infection as a consequence of contact with students.

2.4. Opening the discussion, the Chair felt it was time to draw this topic to a close as it has taken up a great deal of time.

2.5. Education workers were discussed first and there was general agreement with the premise that the data did not support prescription. It was pointed out that data from job exposure matrices (JEM) indicated that some sectors of T&EWs scored similarly with health and social care workers (H&SCWs) which hadn't been reflected adequately in the draft paper. It was agreed this would be rectified.

2.6. A member felt that clarity was required on the data and whether these were sufficient to show doubling of risk i.e., a rational explanation of how the conclusions were reached but agreed with the conclusions.

2.7. There was discussion on the JEM scores for education workers and it was felt that at certain times, the risks were elevated for some sectors (e.g. teaching assistants) and in these instances, the accident provision of IIDB may be a route for these workers to claim in the right circumstances.

2.8. A member agreed with the conclusions for education workers and stated that the risks for certain education workers were very high at some points. The point was made that there was a dilution effect in this group of workers as some were working from home but were included when risks were assessed. It was also pointed out that there are currently high levels of the virus in circulation which could result in a high number of cases in schools. It was

suggested that perhaps IIDB was not necessarily the best vehicle to use for compensation given its legislative limits and maybe an alternative approach would be more appropriate for a fast-changing situation such as a pandemic.

2.9. A member pointed out that the education sector is broad, and reference should also be made to early-years workers who came into the workplace.

2.10. It was felt that the circumstances which might apply to the accident provision could be described to assist people who had been affected, especially for workers in the education sector.

2.11. A member commented that an update from DWP on accident claims relating to COVID-19 would be useful. They also stated that as the H&SCWs command paper was published quite some time ago, an update from DWP on its progress is overdue. The Chair responded that a new Minister for Disabled People, Health and Work had recently been appointed and was hoping to meet with them in the near future.

2.12. A DWP official indicated that a number of factors has had an effect on the work assessing the impact of the COVID command paper, including having to lay additional regulations. It was anticipated that work would resume on the command paper sometime in the Spring. The Chair was sympathetic to the explanation but commented that the command paper deals with severe complications of COVID-19. Recent related deaths reinforced the Council's concerns that the process of responding to the command paper was taking a long time. The Chair acknowledged the unprecedented nature of the pandemic, not only for the DWP but also the Council where developments were fast-moving and the consequential lag in published data. The Chair offered the Council's help if required.

2.13. The DWP asked the Council whether long-covid would be addressed. The Chair responded that there was a section in the draft paper which covers this and felt that it was unlikely that long-covid, as it stands, would fit within the IIDB scheme. It would be difficult for the Council to draft a prescription which could be easily implemented within IIDB given the vague nature of the often self-reported symptoms.

2.14. A member commented that the data for long-covid were somewhat descriptive and self-reported, often with no control population and of generally poor quality. Analogies have been drawn with chronic-fatigue syndrome/ME. The conditions described in the command paper could explain some of the symptoms of long-covid. It was felt that this topic would need to be monitored but presently data are not available to support prescription.

2.15. The issue of DWP's response to IIAC's recommendations was commented on by a member who felt that there were a number of command papers which had yet to be considered. The Chair reiterated the disquiet felt by members on the lack of response to its recent command papers, but whilst IIAC is not a lobby group, concerns should still be raised.

2.16. Professor Agius stated again for the record that he is a member of the council for the British Medical Association (BMA). Prof Agius indicated he had no input into the letter recently published by the BMA which was critical of the time taken for DWP to respond to the council's command paper on H&SCWs.

2.17. It was welcomed that long-covid would be addressed in the draft paper as it was alluded to in previous papers and expectations would need to be managed.
2.18. Returning to the topic of the accident provision/COVID-related claims, the Chair felt it would be useful for the Council to have an overview from DWP.
2.19. Regarding education workers, a member reiterated the views expressed about the possible use of the accident provision and commended the bravery of those workers in the early stages of the pandemic. The Chair indicated that the accident provision had been considered for other topics where prescription was not recommended, so would revisit the wording for this. The point was made that this would apply to other occupational sectors as well as education.
2.20. A member said they had looked at the official IIDB statistics and was not able to identify COVID-19 as a reason for claiming. An official agreed to look into this. They also felt that there had not been a significant increase in COVID-related accident claims since the issue was last looked at.
2.21. The Chair moved the discussion to focus on transport workers and asked members to revisit the paper circulated which summarised the evidence. They felt the mortality data were very strong and could be used even though infection data was lacking.
2.22. A member commented that they were concerned that the mortality data were affected by comorbidity. The Chair commented that comorbidities were not taken into account when those conditions were unrelated to the chance of infection or the occupation and used diabetes as an example. A member raised concerns that that workers in this sector may be less healthy than other sectors, which may affect mortality data.
2.23. There was a discussion about the use of death data as a proxy for infection data with points being made for and against.
2.24. One member felt, very strongly, that the data for transport workers were robust and that there was a good case to be made for recommending prescription, at the very least, for bus and (employed) taxi drivers.
2.25. Addressing the concern that transport workers may be less healthy, a member wondered if it this could be checked using other sources of information, such as Biobank. The Chair stated there are data on inequalities within occupations, such as pay and occupation defines how much people earn. This also influences life expectancy.
2.26. Another member expressed their support for prescription but felt the term ‘public facing’ was too vague and suggested using the approach of the Office for National Statistics (ONS) which used specific job titles.
2.27. Returning to the issue of health within transport workers, a member pointed out that some drivers have to undergo medicals and are not allowed to drive if they have serious health conditions, so the assertion that transport workers may be less healthy may not be applicable.
2.28. A member felt that narrowing down the jobs where prescription could apply may strengthen the case for prescription, which was supported by another member who felt that the mortality data was strongest for certain jobs.
2.29. There was some debate over the accuracies of death certificates, but whilst not ideal, were appropriate to use.

2.30. The Chair drew the discussion to a close and set out the options for members to make a decision for transport workers:
- Don't recommend prescription;
- Recommend prescription;
  - Should specific jobs be prescribed for, and
  - Should this be public facing/direct contact?

2.31. The Chair felt that this this needed to be drawn to a conclusion. A member agreed and felt that prolonged deliberation would be unlikely to be helpful.
2.32. The Chair asked members to express a preference for recommending prescription for transport workers and there was a clear majority in favour.
2.33. It was agreed that the paper would reflect the degree of debate and the disquiet felt by some members.
2.34. The Chair summarised the conclusions of the meeting and set out what changes would be made to the paper. The Chair asked all members to revisit the copy of the paper which had been circulated and make any comments prior to the meeting scheduled for 25 January.
2.35. The Chair thanked everyone for their input.

3. Firefighters and cancer

3.1. The Chair introduced the topic by reminding members of the paper published by Professor Anna Stec which showed very high risk estimates for cancers and non-malignant diseases in Scottish firefighters. This paper sourced data from freedom of information (FoI) requests to firefighter pension schemes. These data, which are publicly available, showed an unexpected pattern of declining numbers of firefighters receiving a pension.
3.2. Upon further scrutiny of the data, it was established that the data used did not contain numbers of firefighters which had deferred their pension, had moved their pension to another scheme or had cashed-in their pension.
3.3. The Chair indicated that they had submitted a FoI to the pension schemes to obtain the missing information. This request has been acknowledged and a full response is awaited.
3.4. When the response has been received, the Council will determine a strategy on how to respond to Professor Stec's paper.
3.5. Relating head injuries to firefighters, a member commented that there may be provision within their pension schemes, termed a qualifying injury, which may enable receipt of an enhanced pension. This may skew the data from the pension schemes which were requested via the FoI request. The Chair commented that the Council needs to clarify why the paper from Professor Stec has not prompted a new review into this topic. The FoI could confirm that the Stec data are out of step with other findings, including that of IARC.

4. Neurodegenerative diseases (NDD) in professional sportspeople

4.1. The Chair reminded members that it had been agreed to look at individual degenerative diseases of concern and amyotrophic lateral sclerosis (ALS) (motor neurone disease) had been selected to consider first.
4.2. This had been discussed at RWG and the corresponding paper was circulated to members for information.

4.3. A paper which summarised all the evidence had been produced and also circulated.
4.4. The Chair invited the members leading on the topic to take members through the salient points.
4.5. A member indicated that the evidence summary set out to clarify for professional sportspeople;
- Is this a risk related to extreme physical exertion and therefore all athletic activities; or
- Is this associated with sports where head trauma risk is apparent, including repeated minor trauma?

4.6. The member felt there was very limited information overall, especially in non-contact sports. Obtaining the epidemiological evidence had proven to be difficult; there is little information on sport other than soccer or American football.
4.7. There are data on American football and soccer where there are a number of overlapping studies, some with methodological issues.
4.8. The Chair observed that the risk estimates appeared quite high but were in a variety of different populations and sports. The members leading on the topic were asked if they had views on the primary causes, i.e. being in a particular sport, head injury, concussion etc. The member indicated they felt the majority of the evidence for raised risks was for head trauma. Mostly from American football (also soccer) – this could be extrapolated to other sports, but the epidemiology was lacking.
4.9. A member commented that there may be evidence in soccer players which linked duration of career and playing position, so this may indicate an exposure/response relationship, but further work is required. Limitations of the evidence are apparent in the studies where all NDDs are grouped together, so relationships with ALS are diluted.
4.10. It was remarked that it would be helpful to have the views of an expert in NDDs and an interest in sport, to determine how realistic it is for the NDDs to have similar aetiology. The Chair agreed this could be useful.
4.11. A member pointed out that ALS is connected with frontotemporal dementia (FTD). Another member asked if there were any non-sport-related occupations where repeated head trauma is present and if so, any links to NDDs.
4.12. An observer indicated they had relevant information which they would share and pointed out the broad spectrum of NDDs which may be associated with head trauma. This was thought to have a genetic link where the presence or absence of genes may determine which NDD a person may develop after head trauma. They also may be able to recommend experts to assist, which was welcomed.
4.13. A member suggested that an exploration of low risk vs high risk of head injury be carried out as professional American football is not prevalent in the UK. The Chair commented that this could be an instance where exposure equivalence may need to be applied.
4.14. A member also commented that other occupations such as pilots may also be at risk of NDDs and if this is not related to head trauma, could it be linked to hypoxia; similarly for sports.

4.15. A member pointed out that some of the sports where head injury may be a factor utilise self-employed people, so it would be more appropriate to focus the investigation on areas which employ sportspeople, such as rugby, soccer, cricket etc. It was observed that there are a number of high-profile court cases where players are pursuing the sports bodies, so interest in IIAC's investigation and conclusions is likely to be high.

4.16. A member made several points relating to the discussion:

- There is a concussion research centre at the University of Loughborough
- Are there occupations which have elements of jobs which can increase the risk of head trauma (e.g. playing a sport as part of a job).
- Women's rugby and football need to be considered – should the Council consider partnering with organisations?

4.17. The Chair agreed and reminded members that a scoping review into women's occupational health will be carried out.

4.18. A member stated that the court cases relating to rugby had yet to receive a group litigation order, but this will be monitored and the Council updated.

4.19. The members leading the investigation felt the next stage would be to draft a paper and ask relevant experts to review. They felt that there may not be much more information on professional sportspeople, there is some limited information on other occupations, but not doubled risks. Extrapolation to other sports may need to be considered where the data allows, but external experts may be able to advise on this.

5. **Commissioned review on respiratory diseases**

5.2. The Institute of Occupational Medicine (IOM) stated that the Council had been provided with final draft reports for:

- Silica and COPD
- Silica and lung cancer
- COPD and cleaning products.

5.3. The report on farming is almost complete and work is ongoing on chromium and lung cancer. The searches on asbestos and lung cancer are being repeated to focus on occupational circumstances associated with asbestosis and therefore high exposure.

5.4. Feedback from members initially indicated that for 'silica and lung cancer' and 'asbestos and lung cancer, IOM needs to be mindful of silicosis and asbestosis and look for evidence of a doubling of risk in the absence of these conditions and where these are apparent.

5.5. It was agreed that members with respiratory disease expertise would meet as a sub-group to discuss the reports received and then meet with IOM to discuss further.

5.6. A member had reservations about the heterogeneity of cleaning products, giving examples, where papers have not specified what was covered. They felt it was important to try to define the taxonomy of cleaning agents and to look at these critically. IOM said they would report the details of cleaning products (where mentioned) but producing a taxonomy of cleaning products was beyond the scope of the review.

6. **Work programme update**

6.2. Provision of additional scientific support – the Chair indicated that following the recent confirmation that funding had been secured to provide additional scientific support, work was underway to explore the options how this could be used. This will be discussed with members in subsequent meetings.

7. **AOB**

a) Promotion of IIAC's work

The Chair thanked members for their suggestions on how to promote IIAC's work, which was a recommendation from the recent DWP's internal review of the Council. The Chair felt there were 2 main routeways to do this:

- Talking about IIAC and IIDB to occupational groups and within stakeholder groups, also conferences.
- Publishing papers in journals e.g., Occupational Medicine

7.2. Members discussed various options for raising the profile of the Council. It was suggested that a standard IIAC presentation be made available. The Chair suggested that when command papers are laid before Parliament and published, a separate article summarising the findings be submitted for publishing in a journal.

7.3. A member suggested that online webinars could be a medium to use which has been successful for other similar committees.

7.4. The summarising of command or position papers for the lay-person was also suggested, which could be used to circulate to interested parties such as employer or employee groups. This could be in the form of an information note. The importance of having a lay-person in the Council was discussed and it was felt this could be covered by the employee and employer representatives.

7.5. A member offered to take a lead in helping with 'plain English' versions of papers. The Chair asked if members could consider volunteering to help with promoting the Council.

b) Summary of the benefits awards - statistics

7.6. The IIDB publicly available claim statistics were shared for information as they are now hosted on a different site. It was noted that some prescriptions do not attract any claims, which could be due to lack of awareness. A member observed that the prescription for asbestosis had declining claims which was opposite to that which might be expected. This may also be due to lack of awareness, so promoting the work of the Council is important.

c) PD D1 pneumoconiosis and progressive massive fibrosis (PMF)

7.7. A stakeholder had indicated that claims for PD D1 were being disallowed where PMF was diagnosed. It was agreed to speak with the stakeholder when a meeting has been arranged.

d) Organophosphate poisoning

7.8. Correspondence was received relating to organophosphate poisoning in aircraft cabin air. The Committee on Toxicity (CoT) has looked at this extensively (including recently) and the Chair suggested this topic should not be added to the work programme until CoT releases its next report, which was prompted by a request from another Government department to look at this

again. The Chair and secretariat will meet with the CoT secretariat to discuss the topic and will report back.

7.9. Responding to the correspondent will be considered.

7.10. A DWP official indicated that other claims for similar conditions had been received and it may be the case that the DWP may ask IIAC for further guidance at some point.

e) Other business

7.11. A DWP official raised the following issues:

- spirometry – currently only carried out for PD D12 – consideration needs to be given to whether other prescriptions require this process and if it needs to be outsourced. The official will discuss outside of the meeting.
- PD A10 – audiograms are still an issue, especially around changes of circumstances. DWP may ask if the Council could look at this prescription. DWP will summarise the issues for the Council to potentially consider.

7.12. The Chair drew the meeting to a close and reminded members that there was a special meeting to discuss COVID and other occupations. A member asked if DWP officials could provide an update on accident claims relating to COVID.

Date of next meetings:
RWG – 29 February 2024
IIAC – 18 April 2024