INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 20 February 2025

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC Chair
Professor John Cherrie	IIAC
Dr Ian Lawson	IIAC
Mr Dan Shears	IIAC
Professor Damien McElvenny	IIAC
Dr Sharon Stevelink	IIAC
Ms Lucy Darnton	HSE observer
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Dr Matt Gouldstone	DWP IIDB Medical Policy
Ms Georgie Wood	DWP IIDB Policy
Ms Vanessa Robbins	DWP IIDB Policy
Dr Marian Mihalcea	Medical assessment
Dr Sasa Markovic	Medical assessment
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Jennifer Hoyle, Dr Richard Heron, Dr Clare Leris

1. Announcements and conflicts of interest statements

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

1.2. Members were reminded to declare any potential conflicts of interest.

1.3. The Chair announced that this was the last official meeting for the IIAC Chair, Dr Lesley Rushton, who was retiring after 7 years' service to the Council.

1.4. The IIAC Chair was congratulated on her achievements which included leading the Council through the pandemic and overseeing the publication of 3 papers on the topic.

1.5. As the appointment of the new Chair is imminent, Dr Rushton agreed to stay on for a hand-over period.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in November 2024 were cleared with minor edits required for publication.

2.2. All action points were cleared or in progress and had been circulated ahead of the meeting.

3. Neurodegenerative diseases (NDD) in sportspeople

3.1. The discussion initially focused on outsourcing the remaining elements of this topic, i.e., Parkinson's disease and cognitive impairment / dementia in professional sportspeople.

3.2. The advert requesting expressions of interest was published on the IIAC website, closing date 26 February. The Chair indicated that there had been interest from several parties to date.

3.3. The Chair moved the discussion onto the amyotrophic lateral sclerosis (ALS) in professional sportspeople paper which had been redrafted to remove the sections on exercise. Several questions/comments had been raised following circulation of the paper and these were collated into a separate document.

3.4. Nomenclature was raised and it was suggested that the term 'motor neurone disease' (MND) be used throughout the paper, specifying that ALS was a subset of MND. The appropriate spelling of neurone ('neuron' or 'neurone') would need to be clarified.

3.5. Another issue raised was the reliability of standardised mortality ratio (SMR) and standardised incidence ratios (SIRs) in rare diseases in younger people where confidence intervals relating to disease prevalences in reference populations may be wide. It was suggested that this adds to the uncertainty around the risks in some of the studies. It was felt that the inclusion of more information on the reference populations used in the papers - where this is available - would suffice to deal with the issue.

3.6. On this point, a member raised the issue of the 'healthy worker effect' and whether this would apply to neurological diseases. It was felt this was a valid point and further clarity would be sought.

3.7. Proportional mortality ratios (PMR) were considered to be less reliable than SMRs or SIRs in establishing absolute risks in populations where the overall SMR might be low, so less weight should be given to these when considering risks. It was suggested that these terms be properly defined in a glossary for the paper.

3.8. The Chair moved the discussion onto some concerns which members expressed around case ascertainment in some of the studies and their contribution to the uncertainty in the risk estimates. It was felt that the issue should be covered fully in the discussion section of the paper. With football, a

player may play for a club in a different country but may also represent their home country for international games.

3.9. The ascertainment of ALS cases within professional sport was thought to be a potential source of bias when social media were used to identify cases but were not used in the reference populations. There was further discussion around the potential weaknesses of a number of the studies with some members having concerns and others not being overly concerned. It was suggested that the authors of some of the studies might be contacted to address some of the questions raised

3.10. It was suggested that the attempt at carrying out a meta-analysis be discussed in the paper setting out the reasons why the outcomes could not be included because of the high degree of heterogeneity between the different studies.

3.11. A member pointed out that for IIAC's purposes, it is looking for consistency and good quality as well as the actual numerical risk estimates, so if there are concerns about studies, these need to be considered. IIAC has to be reasonably certain that the recommendations it makes will not be overturned by subsequent studies.

3.12. The discussion then focussed on the table of evidence which had been compiled from all the studies which had been considered. There were varying degrees of acceptance of this amongst members. At face value, the evidence set out in the table could appear convincing, but when factors such as quality and methodological challenges, and the overlapping study populations the evidence is much less conclusive. Members were divided in their opinions.

3.13. A member made the point that the Council should take account of all the evidence, not just epidemiological, for instance the magnitude of the risks from non-professional sports or sports without head trauma.

3.14. A member asked if there was any information around the mechanism of the disease following head trauma. It was felt that there didn't appear to be any obvious mechanistic link between the events associated with head trauma and ALS.

3.15. It was suggested that a final version of the ALS paper be shared with an expert ALS neurologist for their views, which may help inform decision making.

3.16. There was no consensus amongst members about whether or not to recommend prescription to the main Council, which is ultimately responsible for making the decision. It was pointed out that if the decision is made to prescribe, then it would be necessary to define what sports would be eligible,

which could prove challenging. There are ongoing legal cases involving a number of different sports, rugby being a prime example.

4. Commissioned review of respiratory diseases

4.1. The Chair indicated that the phase 3 final report has been completed and was circulated in meeting papers. Members were complimentary about the report and sign-off was agreed.

4.2. There was some discussion on how the phase 3 reports and the other 6 individual reports could be published. A brief paragraph will be drafted to introduce the report to provide context. It was also agreed that IOM could also publish (or provide a link) on their own website.

5. COVID-19

5.1. The chair stated that this topic would remain on the agenda to discuss any developments.

5.2. The literature is being monitored and several papers have emerged which indicate more than doubled risks in 2020 for some UK key workers. There are a few papers which also show doubled risks post-2020 (mostly in the USA) and there is evidence of differential risks in different phases of the pandemic in the UK.

5.3. The point was made that nothing new has emerged that would add anything to the recommendations already made by the Council.

5.4. It was noted that there is much public focus on long COVID and the Council had received correspondence asking whether IIAC has considered or will consider including long COVID within the proposed prescription.

5.5. It was agreed that the issues around long COVID remain the same as described in the last command paper. There has been a lot published on long COVID, with a large number being case reports or case series.

5.6. The suggestion was made that long COVID appears to be falling into 2 broad categories:

- A chronic fatigue syndrome (CFS) – like illness.
- Complications of severe acute illness.

5.7. A recently published meta-analysis showed that around 50% of long COVID cases satisfied the criteria for CFS.

5.8. There was little else for the Council to take forward on long COVID.

5.9. A member felt that IIDB may not be the best vehicle for compensation for long COVID and that setting up a specific scheme through legislation may be required if compensation for the condition is to be considered.

5.10. It was agreed that a response to the correspondent would be drafted.

6. General review of the work programme and prioritisation

6.1. The Chair thanked members who completed and returned the template, discussed at the last meeting, to aid prioritisation of topics which the Council may need to consider. A number of topics emerged which members felt were important:

- Simplifying the prescriptions for asbestosis/lung cancer and silicosis/lung cancer;
- Non-melanoma skin cancer & outdoor work;
- COPD & construction;
- Cleaning & asthma;
- Nightshift work.

6.2. It was suggested that the occupational asthma prescription PD D7 could cover cleaners, although it is debateable whether the causative agents could be classed as sensitising agents.

6.3. The Chair indicated that the causes of occupational asthma are complex and are incompletely understood. The conditions is normally diagnosed on the basis of symptoms such as worsening asthma at work and improvements away from work. Epidemiological studies indicate substantially increased risks of asthma in cleaners but this has not been reflected in clinical diagnoses. One possible explanation is that some forms of occupational asthma might develop gradually without obvious short-term symptoms and so not follow the classic occupational asthma pattern. A member added this is speculated to occur with irritant substances and so that rather than allergy might be the mechanism of asthma in cleaners.

6.4. It was suggested that cleaners could be exposed to a number of different chemicals which they may not be aware of – there are also many different types of cleaners.

6.5. It was also pointed out that the commissioned review of respiratory diseases identified COPD in studies of asthma, which may be a source of information.

6.6. It was suggested that if this topic was to be taken forward, that the chemical substances cleaners use be investigated for links to asthma given the wide diversity in cleaning jobs. It was noted that it may be difficult to track what cleaners are exposed to given their requirements to work in different

environments and locations. This may mean that this topic would be difficult and complex to review.

6.7. Referring to the wider work programme, a member recalled that it had previously been suggested that a ‘tidy up’ of some of the prescriptions could be carried out where, for example, occupations or terminologies were outdated. This approach would not require an in-depth review of the prescriptions and could be achieved by a single command paper. This could benefit claimants as well as making the prescriptions easier to administer.

6.8. At the last IIAC meeting, the MoSCoW (Must, Should, Could, Won’t) approach to prioritisation was discussed. This might be helpful for IIAC but is not necessarily generally applicable. Topics which fall into the ‘Must’ category would likely come from Ministers or from new evidence as with COVID-19, and most topics are likely to fall into the ‘Should’ or ‘Could’ categories which is essentially the current situation.

6.9. It was felt that the new IIAC Chair would probably have a view on the next set of topics to review. The incumbent IIAC Chair agreed that the work programme could be discussed with the new Chair.

Women’s occupational health review

6.10. The Chair indicated that the review is now complete and the draft final report is almost ready for circulation – this will likely be for the next IIAC meeting.

7. AOB

PD D9 (diffuse pleural thickening, DPT)

7.1. A stakeholder raised the point that underground miners may not meet the occupational criteria for the prescription. It has been established that there was asbestos in coal mines and some miners develop DPT.

7.2. DPT is caused by asbestos exposure, but there are also other causes. The topic was discussed at previous meetings and it was concluded that the current prescription is adequate to cover circumstances where there is substantial exposure to asbestos within a coal mine. It was pointed out that D9 does not specify an occupational element, but refers to exposure to asbestos. There was some debate around whether the levels of asbestos in coal mines were sufficient to cause DPT. It was felt that while that is not the case generally there may be certain activities and circumstances that result in substantial exposures.

7.3. A member stated that there was very little information available about UK mines, but there was information about activities in US mines which may have

resulted in asbestos exposure. UK miners may have had multiple jobs underground, so may not be able to recall where asbestos exposure occurred.

7.4. There was discussion around asbestos exposure in general in other occupations and it was felt that this is likely to be a growing problem with relatively low level exposures in non-industrial settings.

7.5. Members were in agreement with the conclusion that the D9 prescription is adequate but felt that the PD D8/8A and PD D9 prescriptions could be reviewed in due course. In the meantime, it may be appropriate to review the decision-making guidance and make some changes if deemed necessary.

7.6. A member felt having access to decision-making or assessment guidance would be useful.

PD A14 (osteoarthritis of the knee)

7.7. Information was circulated to members which indicated that underground jobs which qualify for the prescription had been previously reviewed and a comprehensive reply was given to the stakeholder that raised the concerns.

7.8. It was clear that the intent of the prescription was to prescribe for those who spent a substantial part of their day kneeling and bearing additional loads at the same time.

7.9. Members felt there was not a case to make any changes to PD A14 and a response to the stakeholder would be drafted.

Revision of IIAC's decision-making guidelines

7.10. The guidelines which indicate how IIAC come to its decisions was updated and a revised draft circulated to members in meeting papers.

7.11. It was felt that 'exposure equivalence' should be included

7.12. A further draft will be provided to the next full Council meeting.

PD A15 Dupuytren's contracture (DC) in typists

7.13. Correspondence was received which asked for the evidence for DC developing in typists be reviewed.

7.14. A member stated that they looked at some of the literature but could not find anything related to repetitive hand movements (e.g. typing) which were even approaching a doubling of risk.

7.15. It was pointed out that there are other causes of DC, so a response will be drafted to the correspondent stating there is insufficient evidence to link DC with typing.

Date of next meetings:
RWG – 29 May 2025
IIAC – 10 April 2025