INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 29 May 2025

Present:

Dr Chris Stenton	Chair
Professor Gillian Leng	IIAC Chair
Professor John Cherrie	IIAC
Dr Jennifer Hoyle	IIAC
Dr Richard Heron	IIAC
Dr Ian Lawson	IIAC
Mr Dan Shears	IIAC
Professor Damien McElvenny	IIAC
Ms Lucy Darnton	HSE observer
Dr Rachel Atkinson	Medical assessment observer
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Dr Matt Gouldstone	DWP IIDB Medical Policy
Ms Georgie Wood	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: 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.

- Professor Damien McElvenny indicated that he was part of the Manchester University team which submitted bids to carry out the reviews into Parkinson's disease and cognitive impairment in professional sportspeople.
- Dr Jennifer Hoyle is chair for the British Thoracic Society Clinical Statement on silicosis.

1.3. The chair announced that the respiratory disease commissioned review would be published on or around 4 June 2025. The secretariat agreed to circulate a link when it has confirmation of publication.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in February 2025 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
Motor neurone disease draft paper

3.1. The chair introduced the topic by stating that at the IIAC meeting in March, the latest draft of the motor neurone disease (MND)/ amyotrophic lateral sclerosis (ALS) paper was discussed extensively. There did not appear to be consensus amongst members at that meeting whether or not to recommend prescription, but the general feeling was that the case had not been made to recommend prescription.

3.2. The MND paper was not circulated in meeting papers as there have been no revisions since the IIAC meeting in March because:

- There was not a strong consensus amongst members about recommending prescription.
- Other studies due to be published might generate new evidence which could influence the recommendation.
- The outsourced review into Parkinson's disease and cognitive impairment may also inform the recommendation.
- There are a number of IIAC command papers which have yet to be impacted.

3.3. To start the discussion, the chair suggested members review the table of evidence in the draft MND paper which summarised the relevant studies.

3.4. The chair stated that some members thought that the evidence presented in the paper met the criteria to recommend prescription whereas others felt that it did not. Reference was made to the discussion held at the full council meeting in April where members expressed their concerns over the available evidence and the uncertainties which surround it in relation to study design, selection of control populations, and the identification of the disease

3.5. The chair made the point that generally, the Council has 2 criteria to meet in order to recommend prescription:

- To have a risk ratio of more than 2 (to meet the 'reasonable certainty' requirement)
- The recommendation is not likely to be overturned by subsequent research.

3.6. There was some discussion around the relative risks presented in the studies. A member commented that even if the studies were well designed, there was too much variation in the risks reported in the various studies to conclude that the risk was at least doubled. Another member took the view that whilst the

confidence intervals were wide, if these included 2, then this may be accepted as being consistent with a doubled risk.

3.7. A member noted that some results of a study of over 20,000 former footballers in which they were involved (MORtality Study of former professional footballers in England and Wales (MORSE) might be reported over the coming months and should assist the Council. Another member pointed out that even if a number of studies were published, this would not negate the evidence which currently exists.

3.8. The strength of the evidence in relation to MND was compared with that in a previous IIAC command paper (Cutaneous malignant melanoma and occupational exposure to (natural) UV radiation in pilots and aircrew). This had a much larger evidence base, but some members were not convinced of the link – mainly due to uncertainty around the mechanism involved. Similarities were drawn between the Council's deliberations on that topic and MND in professional sportspeople.

3.9. A further comparison was made with the evidence base in relation to the prescription for lung cancer in coke oven workers, recommended in 2011. This had a much smaller evidence base but was considered sufficient for prescription.

3.10. The discussion moved on to consider what the causal pathway might be and what confounders there might be.

3.11. Reflecting on the uncertainties in the evidence base, a member suggested that the Council should err on the side of caution and not recommend prescription at this point as other data might become available in the future that might not support prescription. This was supported by another member who was of the opinion that the evidence, at this point, it not strong enough to recommend prescription. The absence of a clear explanatory mechanism also weighed against prescription.

3.12. There was discussion around the merits of deferring a decision about prescription until further information is available versus recommending not to prescribe at this point and to revisit the topic when more data are available. Deciding to not recommend prescription at this point would ensure that interested parties are clear about the Council's position and could possibly drive further research into the topic.

3.13. It was agreed that the RWG recommend not to prescribe at this point, and that this would be taken to the main Council and a paper could be drawn up for review.

3.14. It was felt that if it was agreed at Council that prescription is not be recommended then a publication should be drafted setting out the Council's position.

3.15. A member commented that the current MND draft paper does not adequately explain why the evidence presented in the table does not meet the requirements for prescription and doubling of risk. Another member commented that a lay-person reading the draft MND paper might assume that the case for prescription had been made.

Procurement exercise to review Parkinson's disease and cognitive impairment (dementia)

3.16. The chair gave an update on the procurement exercise which sought external organisations to carry out reviews into potential links between professional sportspeople and Parkinson's disease and cognitive impairment.

3.17. The bidding process closed 29 April 2025 and 4 bids were received. These were evaluated by IIAC members using a predetermined template.

3.18. The successful bidder was Manchester University, led by Professor Martie van Tongeren. The unsuccessful bidders were informed and feedback given.

3.19. The reviews are expected to be completed in around 12 months.

4. General review of the work programme and prioritisation

4.1. The chair indicated that there are a number of topics which could be taken forward, but the main topic for discussion was the scoping review into women's occupational health.

4.2. The chair stated that the review is now complete and the final report is almost ready for circulation. The Institute of Occupational Medicine (IOM) gave a presentation at the last IIAC meeting and a draft version of the report was circulated for comment.

4.3. It was noted that IOM had sought permission to use the information from the report to cover a slot at the Safety, Health and Wellbeing Live conference in June.

4.4. Commenting on the report, the chair felt that there was little for IIAC to take forward as many of the occupations/diseases investigated were not associated with risks that were close to doubling.

4.5. A member commented that the strongest evidence was for bullying & harassment in the workplace, including sexual harassment. The mental health consequences of this may be something to consider.

4.6. There was some discussion around the wording of the report relating to the original commission and there was a suggestion that the findings within the report could be better illustrated by the use of tables. Most of the findings were contained within the narrative of the report and the differences in risks, for example, between men and women tended to get lost in the text.

4.7. A member agreed that in their view, the predominantly narrative form of the report made it more difficult to identify any 'red flags' which the Council may wish to consider further. However, there did not appear to be any urgent topics which would need to be addressed.

4.8. Another member commented that drawing up additional tables and redrafting the report at this stage would likely be a lot of extra work.

4.9. A point was also made around the terminology of sex and gender which were used interchangeably along with the terms female/woman. The terminology used had to reflect that used in the studies/reviews selected, but there is a difference (as indicated by the recent legislation) and the Council needs to be clear about this. There may be a need to explain that biological sex needs to be used when talking about the differences between men and women in the workplace.

4.10. A member considered that suicide was something to consider taking forward, but this may be difficult for IIDB to cover. Suicide might be a marker for other psychiatric issues.

4.11. A member suggested that they were not minded to take forward or explore mental health/bullying/harassment in the workplace as these are complex issues to evaluate and specify in relation to prescription for IIDB. It was pointed out that the accident provision has been used on occasions to cover some of these issues, and mental health considerations are taken into account when IIDB claims for prescribed conditions are assessed.

4.12. Hairdressers and those who work in nail bars were briefly discussed but it was felt that there were too many confounders to consider their problems.

4.13. The chair suggested that the report be accepted and a foreword written detailing some of the issues discussed prior to publication. This approach was supported.

5. COVID-19

5.1. The chair stated that this topic was a standing agenda item as COVID-19 is an evolving field. The chair had reviewed the published papers recently and indicated there was nothing new to report.

5.2. DWP IIDB policy gave a brief update on the 2 command papers published by the Council.

6. Terms of reference (ToR) and function for RWG

6.1. The chair expressed a view that there was a high degree of overlap between the work of the RWG and the main Council. This has been exacerbated by the COVID-19 pandemic and the need to review rapidly-evolving information at speed. It was noted that there are no specific ToR for the RWG, but there are ToR for IIAC.

6.2. The IIAC ToR specify:

- *The Council has a standing sub-group – the Research Working Group (RWG), which undertakes the detailed scientific investigations required by the Council's work, particularly with reference to the prescription of diseases within the Industrial Injuries Scheme.*

- *The Chair will determine the need for other sub-groups as required by the Council's work programme*

6.3. A flow-chart of the progression of an IIAC investigation had been drawn up by the chair and this was referred to during the discussion.

6.4. Members were invited to give their views. The general opinions expressed were:

- Traditionally RWG focussed on scientific aspects of IIAC's work.
- Topics were brought to the Council which then asked RWG to look into the evidence.

6.5. A view was expressed that there was a degree of 'cycling' between IIAC and RWG and it was suggested that RWG could be given more defined questions to tackle. A greater distinction between the work of the two groups could reduce the 'cycling' of topics between the two.

6.6. It was also suggested that the specifics of every topic do not need to be taken back to full Council meetings every time, but a more high-level update could be given to keep members informed.

6.7. The IIAC chair felt that the discussions and decisions around prescription should be carried out at full Council meetings and the RWG should focus on

interrogating the science, the uncertainties which accompany that, and how things could be presented to the wider Council.

6.8. It was pointed out that in the past, an update from RWG was a standing agenda item and perhaps that should be revisited. A member felt it would be better if RWG produced a summary of the evidence, indicating where there were issues and/or uncertainties.

6.9. It was noted that RWG meeting minutes are not circulated to the wider Council, so there may be a case for summary reports on a topic to be given to full Council.

6.10. Discussion moved on to future work and whether the full Council should be selecting any new topics to take forward, for example issues arising from the commissioned review of respiratory diseases (RD). There were two elements to this:

- Amending existing prescriptions – very little science input required.
- Topics which might benefit from review and where the science needs to be scrutinised.

6.11. Summarising the discussion, the chair stated that the respiratory disease review could take up the majority of RWG's work and that a steer from the main Council would be required to best utilise RWG's time.

6.12. Some discussion on the length of terms of members' appointments followed and discrepancies in the ToR. These require updating. There was also mention of the IIAC annual report and who is responsible for drawing this up.

7. IIDB policy team update

Latency period for diffuse mesothelioma (PD D3)

7.1. DWP IIDB policy team asked for a robust steer from IIAC on what may be a suitable latency period for diffuse mesothelioma so guidance can be shared across all the providers for medical assessments. IIDB policy gave some examples where a shorter than expected latency period could affect claims, for example when there was earlier exposure abroad and more recent lower-level exposure in the UK.

7.2. The questions posed to the meeting were:

- Is this an area where scientific opinion is changing and should guidance be regularly updated/kept under review as a consequence?

- Does a higher level of asbestos exposure correspond to a shorter latency period?
- Is there a minimum and maximum latency period for DM?

7.3. The chair took the lead and expressed the view that scientific opinion is unlikely to change as most of the evidence is based on historic exposures, with any recent exposures being low level. This point was supported by another member.

7.4. The issue of whether higher asbestos exposures are associated with a shorter latency period was tackled next with the chair stating that the evidence overall is that this is not the case and quoting a H&S paper from 2013[1] which reported that. This was backed up by a number of members, however a member commented that the paper quoted was widely criticised and they felt this paper could not be relied upon. Another member commented that a 2023 paper by Brims et al[2] indicated that the median latency period has increased by a decade. This could theoretically mean the latency period tracks asbestos exposure. There was some further discussion around the Frost paper.

7.5. An observer pointed out that new data from lower exposed groups could be difficult to interpret with accuracy due to the low numbers of cases involved.

7.6. There was also discussion around the timings of exposure as this might have been earlier than people recalled or reported on account of unrecognised occupational, domestic or environmental exposures. Members had differing opinions on the matter.

7.7. A member commented that diagnosis can now be made at an earlier stage than it was in the past on account of improved diagnostic tests for example with loss staining for BAP1. This earlier diagnosis could affect the apparent latency period.

7.8. A member was of the opinion that peritoneal mesothelioma needed to be considered separately as the latency period might be shorter than that for pleural mesothelioma, as suggested in the Frost paper. It was postulated that this may be due to a higher amphibole exposure and there may be a different exposure response relationship. There may also be a link with gene mutations which predispose to the development of mesothelioma.

7.9. There was some discussion around what is meant by a minimum latent period and there was some suggestion that further information might be available from the HSE, but it was noted that there could be a high margin of error. There may be a small number of cases where short latency periods are

[1] The latency period of mesothelioma among a cohort of British asbestos workers (1978-2005). G Frost. Br J Cancer. 2013 Oct 1;109(7):1965-73

[2] The Western Australian Mesothelioma Registry: Analysis of 60 years of cases. Brims F et al . Respirology 2024 29(4) 288-294

reported, but it is difficult to determine whether these were caused by the specific exposure or by earlier unrecognised or forgotten exposures.

7.10. The point was raised that scientifically it is difficult to set an absolute minimum latency period, and it's probably better to state that the latency is unlikely to be less than a particular time.

7.11. The chair summarised the questions to be answered:

- Does a latency period need to be specified or should any asbestos exposure be accepted?
- If a minimal latency period is designated, does peritoneal need to be considered separately to pleural?

7.12. An observer postulated that following a catastrophic high asbestos exposure, this may not be cleared from the system so will remain in the body, and have equivalent effects to that of a much higher dose.

7.13. A member felt that the evidence relating to latency period is fairly consistent in the literature. The association with the time from first exposure is strong but the association with extent of exposure is less so.

7.14. IIDB officials were asked what form IIAC's advice should take and what timeframe there was for an answer. The reply was that IIAC can decide what form is best to respond and to take the time it needs to consider the issue.

7.15. A member questioned whether the Council is capable of providing a clear answer as attribution is likely to be based on probabilities.

7.16. An observer suggested not having a minimum latency period and to accept all claims following asbestos exposure. The chair agreed this would be an acceptable position as the number of cases affected is likely to be low and there is probably little further information available which could help address the issue.

7.17. There was mention of differences in approach between IIDB and civil litigation. The latter includes the concept or a meaningful contribution to risk whereas IIDB requires the exposure to have been causative.

7.18. Clarification was discussed on whether mesothelioma is entirely occupationally related and it was stated that mesothelioma is almost always caused by asbestos exposure, but not all asbestos exposure was occupational. However, for an IIDB claim to be successful, the exposure has to have been occupational.

7.19. It was agreed that subject to further review of the literature IIAC could draft a statement along the lines of "… it would be rare but not impossible for

mesothelioma to occur within 10 years of relevant exposure, the median being xxx; the extent of the exposure is not relevant to making a decision; ….”

7.20. The topic will be discussed at the main Council meeting in July.

8. AOB

8.1. It was noted that the IIAC chair is meeting with the Professional Players Federation (PPF) on Monday 2 June.

Dates of next meetings:

IIAC Meeting: 10 July 2025

RWG Meeting: 4 September 2025