INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid meeting
Thursday 10 July 2025

Present:

Professor Gillian Leng	IIAC Chair
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Dr Richard Heron	IIAC
Professor John Cherrie	IIAC
Professor Max Henderson	IIAC
Professor Damien McElvenny	IIAC
Dr Jennifer Hoyle	IIAC
Dr Gareth Walters	IIAC
Dr Sally Hemming	IIAC
Ms Lesley Francois	IIAC
Dr Sharon Stevelink	IIAC
Mr Lee Pendleton	IIDB observer
Dr Rachel Atkinson	Medical assessment observer
Dr Marian Mihalcea	Medical assessment observer
Dr Matt Gouldstone	DWP IIDB medical policy
Ms Sophie Malendewicz	DWP IIDB policy
Ms Georgie Wood	DWP IIDB policy
Mr John Latham	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Dan Shears, Mr Steve Mitchell, Dr Clare Leris, Ms Lucy Darnton

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

1.1. The Chair opened the meeting by welcoming all participants.

1.2. Members were asked to declare any conflicts of interest now or when an agenda item was due to be covered.

1.3. Ms Lesley Francois declared that she had been appointed as a fee paid disability member of the Social Security Tribunal. The member indicated it was their view that there were no conflicts of interest, but the secretariat signalled it will check for any potential conflicts of interest with HM Courts & Tribunals Service.

1.4. The Chair announced that Parisa Rezai-Tabrizi had moved on from the IIDB policy team and her replacement will be Nicola Needham.

1.5. Members and observers online were asked to remain on mute and to use the in-meeting options to raise a point.

2. Minutes of the last meeting

2.1. The minutes of the April 2025 meeting and the action points had been circulated to members to comment on and agree. Action points were cleared or carried forward. The minutes were cleared with minor amendments.

2.2. A member asked for an update on correspondence disclosed at the April meeting where a firm of solicitors had asked to be provided with the written contributions made by Professor Kevin Talbot on the neurodegenerative disease paper on amyotrophic lateral sclerosis (ALS). The secretariat stated that they had reviewed the request along with the Chair and it had been decided that the comments made in the margins of the ALS paper had been adequately reported in the minutes. The Council's position had changed since the draft of the paper had been produced, so releasing that version could have the potential for the Council to be misrepresented.

3. Ministerial feedback on the COVID-19 command papers

3.1. The Chair stated that she had met with Andrew Western MP, Minister for Transformation and Rt Hon Sir Stephen Timms, Minister for Social Security and Disability (MfSSD). A portion of this meeting had been used to convey feedback from MfSSD on the Council's COVID-19 command papers, which was to pause the decision on the recommendations.

3.2. A letter from MfSSD followed and this was circulated to members in meeting papers. The letter posed some additional questions to the Council and covered points which required clarification, some of which were:

- Is prescription required for these conditions in light of existing provisions under the Industrial Accident route?
- Will the recommended prescription cover the intended population as evidence on COVID-19 complications continues to evolve?
- Are revisions to the prescription required in the following areas to:
    - include long COVID for consistency with existing provisions and the NICE definition;
    - include postural tachycardia syndrome as a recognised symptom of long COVID;
    - address the difficulty of distinguishing post intensive care syndrome from broader complications of long COVID;
    - address the challenge of using a definition that requires a date of infection and
    - create a definition of 'developing' a complication of post COVID diagnosis.
- Airborne viral infection;
    - date of infection;
    - proximity

3.3. The Chair invited comments from members. Some noted that under the umbrella term 'long COVID' a number of people will have had the defined complications listed within the command paper recommendations, but it is

likely to be a minority, for example those who have long COVID, only a small number may have had a heart attack or lung fibrosis.

3.4. The Council was clear that the COVID-19 sequelae described in the command papers had sufficiently elevated risks and very clearly defined conditions to recommend prescription. It was felt that reconsidering all aspects of long COVID for inclusion in the prescription was not appropriate.

3.5. There was some discussion around the assertion that there may be some inequity between claims which may be successful through the accident provision of IIDB versus claims through the prescribed disease route if the recommendations were to be accepted. A member felt that if the recommendations were not accepted then this would itself be iniquitous to the potential claimants who would have benefited from the prescription.

3.6. Members reiterated the challenges the Council faced when dealing with a new contagious viral disease and some felt that it was difficult to derive recommendations which would fit within the confines of the legislative requirements of the IIDB scheme.

3.7. The Chair summarised that on the basis of discussions the Council does not think that the fundamental challenge to prescribing for the sequelae as set out is wrong.

3.8. It was felt that the other questions raised were not insurmountable, such as the issue of additional evidence emerging and evolving as the Council would consider this on merit and suggest changes if required.

3.9. The definition of long COVID as set out in the NICE guidelines was discussed and it was not felt this was important as only specified sequelae of COVID-19 were recommended for prescription.

3.10. Postural tachycardia syndrome (PoTS) was considered next and a comment that there were some issues in the literature relating to rigour of diagnosis, where having persistence over 3-6 months is required rather than a single measurement.

3.11. There are also other causes of PoTS such as bacterial and viral infections as well as others including adrenal issues. Also, when this condition is reported as being linked to long COVID, often other causes are not ruled out.

3.12. There was some discussion around the sometimes transient effects of PoTS and how this could be included in the prescription. A member commented that PoTS is well-described after COVID-19 as part of the spectrum of long COVID, but there is diagnostic confusion to what it actually is.

3.13. It was suggested by the Chair that, at this point, the Council doesn't have enough information on PoTS to give a considered response, so it was agreed that this condition would be evaluated and a paper produced for RWG to review.

3.14. It was also commented that PoTS can also be caused by immobility and this related back to an earlier comment on diagnostic rigour.

3.15. Another member suggested PoTS was a recognised complication of critical illness so there may be overlap with post-intensive care syndrome (PICS) and may come into the complications of severe pneumonitis. There may also be

some evidence that PoTS is amplified and more persistent in post-critical care.

3.16. The discussion moved onto PICS and a member stated this had been looked at in-depth by the Council at the time. They commented that patients who had undergone ventilatory support on intensive care were subjected to a series of long-term complications, including breathlessness with lung fibrosis and peripheral neuropathy. The member felt the challenge with PICS was that a number of patients experienced PTSD-type issues, hence the recommendations for prescription specified the syndrome rather than the individual components of it. It was felt that introducing a psychiatric disorder to the IIDB scheme would be unworkable. A member commented that there is also a depressive element to PICS and Council considered there was insufficient evidence to support prescription for these psychiatric conditions.

3.17. Referring to the letter, the Chair quoted "...there are concerns that the recommended prescription may cause some claimants to miss out through an inability to be correctly identified..." and asked for views. A member asserted that this would be the same for any prescription and stated that there was a difference between wording in the legislation for a prescribed disease and that contained in the guidance which accompanies it. The member felt that any perceived issues with PICS could be fully clarified in guidance.

3.18. Another member commented that whilst there may be some overlap between PICS and some symptoms of long COVID, this is likely to be small. PICS is a well-defined and recognised condition, so diagnoses are relatively straightforward, which is not the case for long COVID.

3.19. The discussion moved on to cover airborne viral infection and the perceived issue of establishing date of infection. A member stated that a confirmed COVID-19 diagnosis would be required to qualify for the prescription. There would be a date of onset of symptoms and contact with COVID-19 patients would be required within the previous 2 weeks. The member felt that establishing the date of infection would not be any different to the accident provision, where claims for COVID-19 related incidents had already been accepted.

3.20. An official explained that difficulty in determining the date of infection could 'muddy the waters' due to the presumption element of a prescribed disease whereas the accident route asks for a claimant to specify when the infection occurred.

3.21. A member felt that if a claimant presents with a particular condition, the claimant's information should be accepted. A member felt the proposed prescribed route would be easier for claimants as it was more liberal than the accident route. The point was made that discussing wording which might or might not appear in legislation is premature at this point as IIAC would review the wording of a prescription before it went into legislation.

3.22. A member asked how other infectious diseases are assessed such as TB – this was taken away for clarification.

3.23. The Chair stated the discussions had been useful. She felt that further conversations would be required and took up the offer for follow discussions with DWP officials.
3.24. It was decided that an immediate response to MfSSD was not required at this point, but it would be useful to have a draft response available for consideration at the October meeting.
3.25. A member suggested a brief rebuttal to each of the points raised.
3.26. The final point to be discussed was the perceived issue of 'developing' a complication of COVID-19. Members felt that 'developing' could simply be removed from the prescription.
3.27. The Chair summarised by saying a final decision on a response would be taken at the October meeting, with relevant discussions to be held at the next RWG in September. A follow-up meeting with DWP officials would also be considered.

4. Work Programme

Neurodegenerative diseases (NDD) in professional sportspeople

4.1. It was noted that there were 2 items for discussion on this topic:
- The draft amyotrophic lateral sclerosis (ALS) (or motor neurone disease, MND) paper
- Update on the procurement exercise to review Parkinson's disease and cognitive impairment.

The draft ALS paper

4.2. The Chair opened the discussion and handed over to the author of the draft information note which had been circulated in meeting papers.
4.3. The member gave an overview:
- The topic has been discussed at length at a number of meetings.
- The last RWG and full council meetings failed to arrive at a unanimous decision whether or not to recommend prescription.
- At the last RWG meeting, it was decided to consider moving to publishing an information note, as a holding position, summarising the Council's views and to not make a decision on prescription at this time, but to revisit ALS (MND) when further data becomes available.

4.4. Since the last IIAC meeting, a meta-analysis (slightly restricted range of papers) of soccer and MND has been published which gave meta odds ratio of 1.4 which is below IIAC's threshold of 2 and above.
4.5. The discussion on the information note was opened and members invited to comment.
4.6. At this point, the Chair commented that it was difficult to keep track if members commented on a paper and recirculated this ahead of the meeting, so asked that comments be kept for the meeting. It was suggested that 'board books' software would be useful where members could comment on a paper 'in situ'.

4.7. A member commented that they found the comments useful as part of an iterative process. Members should all comment on the same version, which board books software would allow.
4.8. The Chair asked members if they had any comments and if members would be willing to accept the paper for publication with the decision that IIAC is not recommending prescription at this time, but will keep the topic under review.
4.9. A member who had a preference to recommend prescription agreed that this was a good solution and asked for the Council to make a stronger commitment to revisit the evidence sooner rather than later.
4.10. There was some debate around the wording of the paper to reflect how soon the Council should reconsider the evidence and the point was made that whilst there was knowledge of some studies, which would likely report within 12 months, there were likely to be others, so the whole of the literature would need to be considered. A member felt there was merit in waiting a little longer (e.g. 2-3 years) to get a better understanding of the evidence.
4.11. A member pointed out that the outcomes of the systematic reviews being carried out by the University of Manchester into Parkinson's disease and cognitive impairment may also help with the Council's views on ALS/MND.
4.12. Members felt that reiterating the fact that this is a very active area of research should be made clear in the paper.
4.13. There was some discussion around the benefits of publishing a position paper versus an information note and it was felt that an information note would be more appropriate as a decision to recommend prescription had not been made and postponed until further evidence was available.
4.14. A member commented that they felt the recent meta-analysis on soccer players would not add value to the information note.
4.15. The legal case, class action, involving professional sportspeople was brought up with a member reminding Council that IIAC's publications would be scrutinised by both sides, so it should be made clear there is a difference between making a prescription and proceeding with a civil claim because of the requirements of the Social Security Act. They also felt it was important to mention that the accident route could be pursued in cases of injury. A member disagreed with the suggestion that the accident route be referred to.
4.16. The Chair felt that, in order to reach a wider audience, the paper could benefit from an introduction and perhaps reframing as high profile. A member suggested that the beginning of the paper have an introductory paragraph explaining it is an information note.
4.17. It was agreed that the paper could be accepted by members, subject to minor edits and did not need to be recirculated.

Update on the procurement exercise to review Parkinson's disease and cognitive impairment

4.18. The Chair stated that the start-up meeting had been held with Manchester University. The 2 reviews will take place concurrently and the final reports for sign-off will be due 31 May 2026.

4.19. The systematic review protocols have been drawn up and could be shared with members if required.

Scoping review into women's occupational health

4.20. The Chair indicated that the final report had been received from the Institute of Occupational Medicine (IOM) and circulated in meeting papers. Accompanying this was a draft foreword which would be used when the IOM report was published on the website.

4.21. A member asked if 'fluoroscopic' was the correct terminology to use in the foreword and it was agreed this would be checked. This member also felt that a footnote, to the foreword, should be included which alludes to the IIDB accident provision can cover PTSD in some instances, e.g. after exposure to violence at work. This was agreed, along with a minor rewording which referred to IIAC's remit around prevalences of violence and sexual harassment amongst health care staff.

4.22. The foreword was accepted by members, subject to minor rewording.

Mesothelioma latency period

4.23. The Chair began by stating DWP IIDB policy officials asked for advice on the latency period for mesothelioma as there was conflicting information in the literature.

4.24. A member took the lead to say that the topic had been discussed at RWG about what the minimum feasible latency period for mesothelioma may be. It was reported that the average latency period could be in the decades (~30-40 years) with few published reports of shorter latency periods (~15 years).

4.25. There are some concerns that reports of recent asbestos exposure which showed a shortened latency period may be due to remote exposures in the past where this could not be recalled (recall bias).

4.26. The member relayed that they had looked at the literature on latency to form a view on whether this had changed. They noted that the lump-sum payment scheme which runs parallel to IIDB specifies a minimum period of 15 years.

4.27. The member referred to a short paper prepared for the meeting which reviewed the epidemiology and illustrated the numbers where short latency periods had been reported. The member noted that a paper published by GF Frost appeared to show lower latency periods than expected which may have been due to methodological issues.

4.28. The member discussed whether the latency periods for pleural and peritoneal mesothelioma were the same and evidence from the literature indicated peritoneal has a slightly shorter latency. This member also examined whether there was a relationship between the amount of exposure and latency period – the evidence was very mixed, so no conclusion could be drawn.

4.29. To comply with the request from IIDB policy for advice, a member had drafted a statement which had been circulated in meeting papers and comments were invited.

4.30. A member reviewed the question being asked in the request for advice and offered their opinion:

- If there were 2 exposures, it was likely that the first exposure would be the cause of their mesothelioma – this could be important if a claimant was originally from a different country, so the initial exposure may not have occurred in the UK. However, there was some concern that there are rare cases where the latency period was much shorter, which may be due to genetic factors and if a shorter latency period was not accepted, these claimants could be disadvantaged.

4.31. There was some further debate around the wording of the statement which had been drafted and a member felt that the mutation in BAP1 gene, which is widely being accepted as a diagnostic tool, should be taken into consideration. This could infer the latency period would be reduced and patients could live longer than expected. The Chair indicated this could be taken into account when the advice is provided.

4.32. A member commented that it is likely that the numbers of patients with short latency periods would be very small and felt that recall bias would become more prevalent over time as people may be less aware of their asbestos exposure (e.g. the construction industry).

4.33. A member commented that the discussions had centred around an average or median latencies whereas the question asked was about an acceptable minimum latency period. They felt this needed to be addressed and suggested that the 15-year period expressed in the guidance for the lump-sum payment scheme which runs parallel to IIDB be amended accordingly.

4.34. This was picked up by a member who stated that they felt there should not be a minimum latency period expressed if a claimant could demonstrate non-trivial asbestos exposure in the UK. Another member felt that the circumstances of each claim would need to be carefully considered and be done on a case-by-case basis as a shortened latency period, whilst very rare, is still possible.

4.35. Having a cut-off latency period was not favoured by a member as they had successfully progressed claims which had around 10 years latency.

4.36. An official commented that the discussion had been useful but would like more clarity around whether very short latency periods could be possible (e.g. 6 months after exposure) and was there any evidence in the literature to support this.

4.37. The Chair felt that the draft statement covered most aspects and asked if factors which could influence shorter latency periods should be listed. However, she felt that the statement drafted, subject to the amendments as discussed, was probably the best advice the Council could offer.

4.38. It was agreed the statement/advice would be amended off-line and the Chair would sign this off when ready.

Potential future work

4.39. The Chair indicated that the Council needs to decide on which topics to take forward for further consideration and felt this could be covered in more detail at the IIAC October meeting.

4.40. The Chair asked that members give some thought on what to take forward and she was also keen to have defined criteria on how the Council decides what to take on. The Chair also indicated that she would like to see suggestions for future work from a wider range of stakeholders (e.g. from networks).

5. Terms of reference (ToR)

5.1. The Chair introduced the topic by referencing a flow-chart, which had been drawn up by a member and the secretariat, which showed how a topic can progress from inception to completion – this included interactions between RWG and full Council.

5.2. A flow chart indicating the processes which happen after IIAC has made recommendations for prescription was also referenced. The Chair commented that she wanted to be clear that IIAC was sufficiently involved to ensure a smooth progression through the stages listed.

5.3. During the break it was suggested that the Faculty of Occupational Medicine, or other professional bodies such as the Occupational Medicine Section at the Royal Society of Medicine could be consulted to get professional insight into which topics IIAC may wish to investigate. Referring to topic selection, the Chair referred to a box on the flow chart which covered that element. There was some discussion around how this could be achieved.

5.4. A member noted that in previous meetings, it had been suggested that 'quick-wins' could be taken on board, such as reviewing certain prescriptions where outdated terminology was used or where the occupational element was no longer relevant. This approach would require command papers to be drafted, but may not necessitate an in-depth scientific review/investigation.

5.5. A member brought up stakeholder pressure and high-profile topics which had influenced the Council's decisions to take topics further. It was also pointed out that on occasions IIAC is formally requested to look at a topic (e.g. Firefighters and cancer). A member commented that they felt the lack of diversity and a certain social demographic on the Council may influence which topics progress.

5.6. There was some discussion on the level of funding which IIAC could access to provide further scientific support. Horizon scanning was also discussed and how this might fit into the Council's thoughts for topic selection. It was also noted that a list of topics should be created where the Council has not made recommendations for prescription but indicated it would keep the topic under review. There was a suggestion that a review be carried out to remove prescriptions which may no longer be applicable. It was felt that DWP IIDB policy would need to be consulted before embarking on this.

5.7. The meeting then moved on to discuss the draft terms of reference (ToR) for IIAC and RWG which had been circulated in meeting papers. There was no formal terms of reference document for RWG, and the Chair felt it was important to formalise its role compared to that of IIAC.

5.8. The issue of a quorum was brought up by the Chair as this is not specified in legislation. The Chair was clear that where decisions are expected to be made a minimum number of members in attendance should be required, to include

representatives of employees and employers. It was suggested 50% attendance may be appropriate.

5.9. A member felt that the point about IIAC having a role in ensuring the IIDB scheme is functioning correctly should be included in the ToR for IIAC (e.g. ensuring the intents of prescriptions were being correctly applied by DWP).

5.10. A member commented that they felt assurance was needed that members were attending meetings and how this could be reflected in the ToR. The secretariat indicated that members terms & conditions upon appointment specified attendance at meetings, but did not specify the minimum number of meetings which should be attended. It was agreed to revisit the member terms & conditions. The Chair suggested that a table be included in the annual report which showed members meetings attendance.

5.11. The Chair advised that she had asked Dr Chris Stenton (RWG chair) to be vice-chair of IIAC, which was accepted.

5.12. The IIAC ToR were accepted, subject to minor amendments and the RWG ToR were accepted as drafted.

6. **Skills audit**

6.1. The Chair felt it was important to review the skills of the Council as this will inform the next round of recruitment where identified gaps could be targeted.

6.2. Members felt that skills in musculoskeletal could be bolstered and experience in toxicology was lacking. The Chair felt that where certain specific skills were absent from the Council, external expertise could be sourced. A member felt having a statistician would be beneficial. This member also felt that experience was lacking on the Council for women's occupational health issues (e.g. reproductive health).

6.3. A member thought skills could be broken down into 3 main categories:

- Exposures – physical, biological, chemical, psycho-social
- Effects of exposures – respiratory, musculoskeletal
- Functional – epidemiological, statistical

6.4. The Chair indicated she would consider the requirements and draw up a list of what skills she felt would be appropriate for Council members.

6.5. A member brought up the issue of diversity on the Council – this is covered by the public appointments team, but this has been considered to be an issue in general. This is also covered by the annual assurance process which IIAC is subject to and the risks associated with this issue are generally amber rated.

6.6. Skills will be revisited at the October meeting.

7. **IIAC public meeting 2025**

7.1. The Chair stated that agreement had been secured to hold the public meeting in London in October.

7.2. The last public meeting was in Cardiff 2023 and a number of members attended in person.

7.3. The Cardiff agenda was reviewed and the Chair asked if members felt the timelines were appropriate to be applied to the October meeting or could the

time be shortened. It was suggested that the time allocated for specific topics be condensed and perhaps a longer, more focussed open forum be considered.

7.4. There was some discussion around this suggestion with members in support of the suggestions.

7.5. A member commented that many of the questions put to IIAC often involved the administration of the scheme and they felt the Council should embrace this or defer the questions to DWP. The Chair felt this could be part of the meeting and how this could be covered could be considered, with having round-table discussions in a work-shop type approach.

7.6. A member felt there was a great deal of good work to cover, but there will always be attendees who will have their own agenda and how that is managed is important. The Chair stated that she would like to broaden the scope and focus on inviting suggestions for future work as well as receiving feedback on current or completed investigations.

7.7. It was suggested that a small working group be formed to discuss an agenda – members were asked to consider contributing to the agenda.

8. **AOB**

8.1. An observer from the IIDB policy team introduced their intern, Grace.

Date of next meetings:

Date of next IIAC Meeting: 15 October 2025 (pm)
Date of public meeting: 16 October
Date of next RWG Meeting: 4 September 2025