INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid meeting
Wednesday 15 October 2025

Present:

Professor Gillian Leng	IIAC Chair
Dr Chris Stenton	IIAC Vice Chair
Dr Ian Lawson	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 Dan Shears	IIAC
Mr Steve Mitchell	IIAC

In attendance:

Dr Clare Leris	Ministry of Defence observer
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 Nicola Needham	DWP IIDB policy
Ms Georgie Wood	DWP IIDB policy
Ms Roberta Owen	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Professor Richard Heron, Dr Gareth Walters, Professor John Cherrie, 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. The Chair announced that Ms Lucy Darnton (observer from the Health & Safety Executive) was standing down and will be replaced by Yiqun Chen. The Chair thanked Lucy for the many years of advising the Council.

1.4. When asked by the Chair if anyone had any potential conflicts of interest to declare, Ms Lesley Francois indicated 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 was no conflict of interest, and this was previously confirmed by the secretariat.

2. Minutes of the last meeting

2.1. The minutes of the July 2025 meeting and the action point log had been circulated to members to comment on and agree. The minutes were cleared with minor amendments.

2.2. Action points on the log were reviewed and either cleared or carried forward.

3. Understanding IIAC's processes

3.1. The Chair introduced this topic by stating that an early working draft of a paper had been circulated, as a guide for stakeholders, partners and the Council to allow an understanding of IIAC's processes. Over the years, a number of documents have been published which cover certain aspects of IIAC's work, but this document aims to bring them all together and develop a clear process for the future.

3.2. The Chair stated that certain sections of the paper had been highlighted for discussion and members were asked to consider these.

3.3. The Chair explained that since IIAC was established, the world has changed where more data are available, levels of scrutiny are higher and people are more engaged, more keen to challenge, so the draft document aims to address some of these.

3.4. The Chair invited members to consider 'topic selection' as the first item to discuss. The document suggested some criteria which may influence whether or not to proceed with a particular topic:

- The strength and urgency of the issue, including public or political interest
- The number of workers likely to be affected
- Severity of the disease or condition
- Feasibility of conducting a meaningful review including availability and quality of evidence
- Volume and complexity of work required, including resource implications
- Potential impact on workers and the IIDB scheme.

3.5. A member commented that the number of workers may have financial implications, however, with low numbers being apparent for the COVID-19 recommendations, cost doesn't appear to be a factor as these have not yet been accepted.

3.6. A member took up this point and pointed out that IIAC is a practical committee, ensuring benefits go to the right people. When selecting a topic for progression, consideration should be given to topics which would have the most impact, so numbers are an important factor.

3.7. Referring to the suggested criteria, a member's view was that the bullets with most priority were numbers, severity and evidence and the other factors need to be taken into account.

3.8. A member commented that in the past, it has been the tendency to give higher priority to cases which had been raised by prominent stakeholders. They wondered how these cases could be prioritised against the list which the Council may compile. It was noted by a member that requests by MPs/Ministers are almost always actioned and felt that this should continue.

3.9. One train of thought which was discussed was that all IIAC's work could be referred from Ministers, which may ensure they have buy in into that topic. However, this is unlikely to come about.

3.10. A member stated that sometimes referrals to the Council can be dealt with quickly and simply by correspondence if the topic has been covered before. However, if a topic is deemed to be complex and requires a full review, this member was of the opinion that these types of cases shouldn't necessarily take higher priority than the topics already selected by the Council for progression. Another member agreed with this assertion and felt uncomfortable that access to IIAC shouldn't be a deciding factor. They stated that the science, severity and the evidence should the defining factors and that numbers of people affected would unlikely ever be that important.

3.11. It was a general view that IIAC shouldn't be lobbied and IIAC should stick to a process, not necessarily accepting commissions from Ministers.

3.12. The Chair stated that lobbying may be circumvented by asking for the completion of a template requesting a topic be investigated, which was covered in the draft paper under discussion, this would also likely apply to members. Commenting on this, a member felt the Council should continue to be accessible.

3.13. There was more discussion on the process for members to submit topics to progress and it was anticipated that the member should have an awareness of the evidence surround that topic.

3.14. The Chair moved the discussion onto consideration of 'evidence assessment' which was deemed to be key. The Chair indicated that there had been some discussions around the potential to have a collaborating centre, which involves giving a contract (e.g. to a University) for a period of time (e.g. 3 or 5 years) to carry out reviews on an ongoing basis. A member commented that this is the model used by other, similar, committees.

3.15. A member was worried that a collaborating centre may not have the expertise required to carry out the work as some of the topics may be quite niche. A member commented that if a particular topic expertise was missing, the collaborating centre may be able to access that from other sources. Other members thought this approach was good and the collaborating centre could be asked about how they would approach a topic which required different expertise.

3.16. It was agreed that this model would be explored more with the secretariat to get a view on costs – this would need to be done before the start of the next financial year. Commercial inputs would also be required.

3.17. The Chair then moved on to discuss 'sources of evidence' which goes into little detail in the paper – it was noted that members were working on a standard template for data-extraction which could be included in an appendix to the paper.

3.18. The Chair indicated that this section in the paper is high-level at this stage, but doesn't think that it should be too prescriptive, more could be done on what quality-scoring systems could be used.

3.19. A member commented that other international bodies have a pre-amble which shows how decisions have been made and IIAC may wish to have clearly written statements in papers which are published. This could cover the potential for bias, totality of the evidence etc.

3.20. The Chair moved the meeting on to discuss the next section of the paper which was 'decision making' which contained two aspects for further debate, namely reasonable certainty and when IIAC may recommend prescription and the relative-risk point.

3.21. A member commented that reasonable certainty can be interpreted in different ways, but is similar to that used in civil cases which requires proof on the balance of probabilities. The member felt that IIAC is the only body which has interpreted reasonable certainty and it is within its gift to revisit this.

3.22. There was discussion around reasonable certainty, balance of probabilities and beyond reasonable doubt, which requires a higher level of proof. Generally, balance of probabilities equates in percentage terms as 51% and a member felt that, at times, the Council may have been using the beyond reasonable doubt measure. It was noted that IIAC has traditionally relied on a doubling of risk as a measure of reasonable certainty.

3.23. Reference was made to a publication from the HSE Workplace Health Expert Committee (WHEC) Confidence and Uncertainty which lists possible ways of expressing certainty/uncertainty:

- "Almost certain"
- "Probable"
- "Possible/uncertain"
- "Unlikely"
- "Improbable"

3.24. WHEC use similar criteria to those listed in the draft paper. It was noted that confidence intervals (CI) around the relative risk are not always considered and a member felt that the definition of doubling of relative risk, with respect to CI is not clear enough.

3.25. It was also noted that the doubling of risk criterion was adopted by IIAC and is not specified in legislation, so could be modified on a practical basis to be less constrictive. Reference was made to the Dutch system, which is increasingly using presumption more, in favour of the claimant.

3.26. It was suggested that all the prescribed conditions be reviewed to determine what evidence was available to enable those decisions to be made to prescribe.

3.27. A member commented that the volume of evidence is important to consider as IIAC doesn't tend to prescribe on the basis of one piece of evidence, even if this is strong. This member commented that IIAC has to be comfortable that the evidence is sufficient and strong enough to make a decision. Also, that additional future evidence is unlikely to overturn its recommendations. A comment was made that this felt like quite a high bar to overcome and potentially excludes considering new evidence. This point was countered by a comment which alluded to IIAC being convinced it was correct to recommend prescription because of the evidence it had accumulated.

3.28. A member added that it is also important to carefully consider the quality of the evidence, given the level of poor papers being published which could skew the doubling of risks, and also the context of those papers relating to geography.
3.29. It was pointed out that recommendations made by the Council, which are accepted, go into law, so its decisions to prescribe must be robust as overturning these would require a change to legislation, which is something that should be avoided as this can have negative impacts on claimants and the administration of IIDB.
3.30. A member was of the opinion that IIAC has been liberal in its interpretation of the law, with reasonable certainty being a lesser requirement than certainty. There was also some discussion around the balance of probabilities, reasonably likely (above 50%?) and reasonably certain (doubled relative risk?).
3.31. A member commented that setting the bar too high may result in claimants being disadvantaged if the Council decides a particular condition doesn't meet the criteria for prescription.
3.32. Equality and diversity (E&D) was raised by a member who felt that historically, this has not been considered and it was suggested that E&D should form part of the IIAC decision-making process.
3.33. Individual susceptibility was also mentioned where a proportion of a particular study population could be at higher risks because of susceptibility (e.g. sex, genetics, smoking) and a member thought this needed to be considered. However, other members felt this may not be relevant as the Council looks at populations as a whole and individuals which may be more susceptible would be covered.
3.34. A member commented that women's experience of social security benefits often differed to that of men. An example was given of mesothelioma and the most at-risk occupations which were often more geared towards men.
3.35. The Chair agreed that E&D would be considered further for the next draft of this paper.
3.36. The next topic to be discussed was 'reasonable certainty' and the Chair invited members to consider the points listed in the paper.
3.37. The Chair stated they felt that causality was an important factor to include as the Act talks about cause because there may be elements which are mediators and confounders – if these are not taken into account, the decision to prescribe may be flawed.
3.38. A member commented that having an administratively simple way of characterising the risk is key. An example was given where years of exposure to a particular chemical could be framed as working in a particular occupation or an industry which would be easier for an IIDB decision-maker to follow.
3.39. A member commented that prevalence and severity were included in this section which didn't fit with the threshold of reasonable certainty, so it was agreed this would be removed.
3.40. A member raised that civil litigation is increasingly reliant on the use of material risk rather than the doubling of risks, so they felt this is something the

Council should monitor. Another member felt it may be useful for an external party to give members an overview of this concept. Other members were sceptical and it was pointed out that the Council had covered this in its command paper 'Industrial diseases: presumption that a disease is due to the nature of employment: IIAC report'.

3.41. A member commented that that the downstream elements of IIAC's recommendations should also be covered in the draft paper as the practical implementation of the recommendations needs to be taken into account.

3.42. The Chair then moved on to the final topic 'approach to updating and reviewing prescribed conditions' which has been touched upon at RWG. The Chair proposed that a regular review of all prescriptions be carried out every 5 years. This could be achieved by looking at each prescription and recommendations made to the Council which prescriptions need to be revised. It was pointed out that this may be a large undertaking for the Council.

3.43. A member pointed out that there are around 6 prescriptions which account for 90% of all applicants to IIDB – it was suggested that these would be prime to review every 5 years. Another member felt numbers of claims was an area which could be explored further.

3.44. A member had concerns about so-called outdated prescriptions where numbers may be low, but there may be potential for numbers to increase in the future, especially where long latencies may be apparent. Related to this, a member commented that the needs of a working community are being served properly and new data sets may make it easier to scrutinise IIDB claims data.

3.45. The Chair suggested that the prescriptions should remain current, that outdated occupations be removed, new terminology included and new occupations added. This could be done on a 'light-touch' basis.

3.46. It was pointed out that the Council undertook a full review of all prescriptions (including the evidence) which concluded in 2007 Completion of the review of the scheduled list of prescribed diseases and took 10 years to complete, which resulted in changes to some prescriptions.

3.47. A member felt that some of the terminology used is restrictive and are barriers to claimants, so a review would be beneficial.

3.48. A rolling review programme was discussed which could incorporate checking if there was any new evidence or anything of significance.

3.49. There was some discussion around the devolution of IIDB to Scotland and the approach of the Scottish Government to disability benefits. IIDB is delivered in Scotland by DWP on behalf the Scottish Government (SG). It was felt that having a discussion with the SG about how IIAC is proposing to review prescriptions would be beneficial.

3.50. The Chair drew this item to a close.

4. Work Programme

Neurodegenerative diseases (NDD) in professional sportspeople

4.1. It was noted that the information note on motor neurone disease had been published on the IIAC.gov website.

4.2. A member gave a verbal update on the progress being made by Manchester University (MU), which had been contracted to look at any potential links between professional sports people and dementia and Parkinson's disease.
4.3. Work was progressing satisfactorily and it was noted that a more detailed update would be made to RWG following the next scheduled meeting with MU.

COVID-19 – response to the Ministerial letter

4.4. The Chair introduced the topic by reminding members that the Council received a letter from Rt Hon. Sir Stephen Timms MP, Minister for Social Security and Disability asking it to address concerns about certain elements in the COVID-19 command papers. These concerns were discussed at RWG and further work was carried out to check if postural tachycardia syndrome (POTS), a concern listed in the letter, could be added to the list of recommendations made in the command papers.
4.5. A response to the letter had been drafted which was circulated in meeting papers – members were invited to comment on the response.
4.6. There were some minor edits suggested to the text but was accepted as representative of the Council's views.

Potential future work programme

4.7. The Chair opened the discussion and indicated that there would be new topics to consider taking forward as well as looking at the existing prescriptions.
4.8. The secretariat informed members that, with input from the Chair, bids had been placed to try to secure 2 interns to assist with revising the current list of prescribed diseases (PD). Some debate on student internships followed with members providing suggestions to follow up.
4.9. The discussion moved on to consider potential new topics to evaluate. The Chair reminded members that there were also new suggested criteria to help with prioritisation e.g. severity, evidence, number of workers.
4.10. A list of potential topics was drawn up from a number of sources, which had been circulated in meeting papers. The Chair referred to the public meeting, where attendees would be encouraged to put forward topics for consideration.
4.11. The list was reviewed:

- Respiratory and other diseases of welders
  COPD and cancer were thought to be important to consider. The International Agency for Research on Cancer (IARC) indicated there were slightly elevated risks for cancer in welders, but nowhere near doubled. COPD is implicated, but a member felt there may not be enough robust evidence to show a doubled risk. Ocular melanoma is also linked to welders, but this is a rare disease and the numbers would likely be small. It was agreed to keep this on the list.
- Osteoarthritis and occupation – the Chair felt that this could be a scoping-type project to potentially establish occupations implicated. A member commented that the Council had done a great deal of work on

this in the past where miners, farmers, footballers and carpet fitters had been looked at.

- Shift work
  IARC looked at this in relation to cancer, which indicated limited evidence. Other diseases implicated were metabolic disorders, diabetes, cardiovascular, women being impacted. This topic was considered to be a huge amount of work which may not yield an outcome for IIAC to recommend prescription. There was some discussion around precarious work which may be analogous to shift work. It was decided not to take this forward.
- Skin cancer and outdoor work
  It was indicated that non-melanoma skin cancer may not be particularly disabling and there may not be strong evidence to warrant taking forward, so will not be considered this time.
- Cleaning and asthma
  A member indicated that occupational asthma is already a PD, with a catch-all category for sensitizers. It was decided not to progress this topic as it was felt there was already adequate provision.
- COPD risks in construction etc
  This topic emerged from the respiratory disease commissioned review where the silica content of dusts may have been a concern. A member indicated that it may be difficult to acquire sufficient evidence to warrant taking this topic forward and may be a difficult due to the complexities of the exposures.
  There was some discussion around COPD in cleaners and it was agreed to keep this under review for construction and cleaners.
- Styrene / fibreglass and bronchiolitis
  A member described the impact of diacetyl, which causes popcorn lung. It has also been reported in boat builders where fibreglass and resin are used. However, this is a rare disease. A member indicated there were aware of a larger study which may help inform the Council, so it was decided to await the outcome of this study.
- Lung cancer, paint and cement
  This topic came from the respiratory disease commissioned review where chromates were identified as being implicated in lung cancer. It was decided that as this may come under the review of existing prescriptions, this topic will be revisited when that review takes place.
- PTSD
  A member raised this topic as potential for investigation as it impacts a number of different occupations, especially emergency workers. This may test the limits of the IIDB scheme to check it is fit for purpose. It was acknowledged this will be a difficult topic to cover. A member asked if this could be covered by the accident provision - it was reported that accident claims had been submitted to the accident provision from emergency workers. It was commented that, in general terms, some mental health conditions are covered by the accident provision, this can be an

aggregate of other factors in addition to the causative element. There was further debate on PTSD, and it was decided that this topic would be considered further.

4.12. Noise induced hearing loss was also discussed, but this would fall into the category of revision of current prescriptions but is likely to be a lot of work. An observer suggested that they may have information which could help form a view.

5. **Future recruitment to IIAC**

5.1. The Chair introduced the topic by referencing the paper, circulated in meeting papers, showing the outcomes of the skills audit carried out earlier in the year.

5.2. The Chair indicated that the skills audit could be used in the recruitment process and may inform where there are any gaps in knowledge or experience.

5.3. There was some discussion around when some members were to be considered for reappointment and an employer representative would be standing down. There was an explanation of the process which would need to be followed.

5.4. A member felt that future recruitment should involve seeking expertise in physical exposures to cover musculoskeletal issues and another member felt experience of cancer is important. However, due to the widespread nature and different types of cancers, a generic expert may be difficult to find.

5.5. The Chair asked about the importance around having generic skills vs topic specific skills as specific skills are important at certain times and if that particular expertise is not apparent amongst members, this could be brought in.

5.6. A member felt that having generic skills was more important than topic specific.

5.7. Diversity elements were discussed and the Chair thought that a potential member with public health expertise may cover this aspect.

5.8. Employer and employee representative were discussed and how these types of members are recruited by approaching recognised bodies which potential members could belong to. It was decided that recruitment would be mentioned at the public meeting to raise awareness.

5.9. The issue of numbers of employee and employer representatives was raised as it was felt that there was insufficient provision on the Council as on occasions these representatives were absent at meetings where decisions were discussed. It was pointed out that there is no stipulation in the legislation for numbers of employee and employer representatives, just that these need to be equal. Publication of member meeting attendance in the annual report was discussed.

5.10. It was agreed that decisions would not be taken unless there was a representative of both employees and employers in attendance.

5.11. A member raised the possibility of having a member with lived experience of disability, which the Chair thought could be part of a ‘lay person’ member requirement, but it was felt this warranted further discussion when time allowed.

5.12. The Council agreed that additional employee and employer representatives would be sought at the next round of recruitment.

6. **IIAC public meeting 2025**

6.1. The public meeting was scheduled for the following day, and the agenda had been circulated to members. This is a shorter version than previous meetings and to include a round-table discussion. It was proposed that shorter meetings be held annually.

6.2. Arrangements for the round-table discussion were finalised, and it was agreed that attendees would be allocated to tables and copies of the list of prescribed diseases would be provided to enable discussion.

Date of next meetings:

Date of next IIAC Meeting: 15 January 2026
Date of next RWG Meeting: 4 December 2025