INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid meeting
Thursday 15 January 2026

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
Professor Sharon Stevelink	IIAC
Professor Richard Heron	IIAC
Professor John Cherrie	IIAC
Mr Dan Shears	IIAC
Mr Steve Mitchell	IIAC

In attendance:

Dr Clare Leris	Ministry of Defence observer
Dr Yiqun Chen	HSE 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 Roberta Owen	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Observers from Northern Ireland Department for Communities.

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. When asked by the Chair if anyone had any potential conflicts of interest to declare, Dr Hoyle indicated she had spoken at a joint meeting of the All-Party Parliamentary Group (APPG) on Occupational Safety and Health (OSH) on 3 November 2025.

1.4. The Chair announced that from 31 March, the secretariat would be changing as staff were leaving. How the secretariat will be resourced in the future is under discussion.

2. Minutes of the last meeting

2.1. The minutes of the October 2025 meeting and the action point log had been circulated to members to comment on and agree. The minutes were cleared with minor amendments. It was suggested that future meeting minutes may be refined to a meeting note which provides a summary but doesn't necessarily cover every single item. This was generally supported.

Actions

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

2.3. The Chair was keen that the action referring to developing a collaborating centre model was progressed with officials at DWP and members were invited to share any thoughts they may have.

2.4. An Equality and Diversity Strategy was also mentioned, with reference to new member recruitment and how this topic plays into the agenda item on understanding IIAC's processes. A member suggested that impact assessments be carried out on IIAC's documents, such as reports, before they are published. It was noted that historically this had been the case.

2.5. The secretariat informed members that the applications to acquire internships to assist IIAC with its work had been unsuccessful. Members were invited to submit ideas on how the Council could get access to academic institutions, which provide student placements.

2.6. Future member recruitment was covered and it was stated that the Public Appointments Team was working with the secretariat to finalise reappointments to the Council before a member recruitment campaign would be launched, but plans were in place.

3. Understanding IIAC's processes - The Work of the Industrial Injuries Advisory Council - A guide for stakeholders, partners and the Council.

3.1. The Chair introduced this topic by stating that a second draft of the paper had been circulated with meeting papers, as a guide for stakeholders, partners and the Council to allow an understanding of IIAC's processes.

3.2. The Chair opened the discussion and invited members to comment on the paper. It was proposed to review the main sections, but on a high-level basis, a member stated it should be made clear that IIAC may not have the resources to outsource the scientific aspects, in which case, members would carry out the work. However, scoping of a project would be done in either case.

Evidence assessment

3.3. The Chair noted that a directed acyclic graph (DAG) had been included which may require further explanation.

3.4. Members did not feel the DAG was helpful and may serve to confuse the general public (i.e. a lay person), but in general were supportive of the paper as a whole.

3.5. The Chair agreed that the DAG would be removed from the document in a subsequent version. The Chair raised the question about causality and whether IIAC should routinely consider what the potential confounders and mediators are.

3.6. A member commented that confounders may need further explanation and agreed that causation should be considered but made the points that causation is one of the pieces of information to consider when recommending prescription, but IIAC is able to recommend prescription if the causative mechanism is not known. The member pointed out that potentially important topics could be disregarded if causation was to be used as a stop/go decision where strong associations were apparent but information around causation was not available at that particular time. They felt that over-prioritisation of causation may be detrimental. However, the Chair was not of the same opinion and there was some discussion around the past topic of melanoma in air crew where the mechanism was not understood. There was also discussion around interpretation of the legislation which IIAC has to comply with.

3.7. A member brought up the Bradford Hill criteria where the concept of establishing causation could be made from the epidemiology. In previous IIAC investigations, the epidemiological evidence has taken precedence and where causal pathways/mechanisms have not been established, the evidence determines causation.

3.8. A member indicated they had information on strength and weight of evidence which could be useful. They also indicated that it was very important to consider risk of bias, whether it is quantitative or qualitative, and felt that a prescriptive set of rules would be unhelpful.

3.9. The Chair agreed that flexibility was important but reiterated that routine considerations of potential causal mechanisms was important, even if all the gaps could not be filled. This could become more relevant where IIAC has to consider increasingly complex areas.

3.10. A member referred again to Bradford Hill and felt that the criteria specified could form the basis of conversations around biological plausibility rather than establishing a definitive causal relationship.

3.11. A member commented that causality is complex and when this is considered, the following aspects may have an impact:

- Occupational link
- Confounders
- Bias
- Genetic components
- Other deeper elements not immediately apparent

3.12. A member asked what approach the Independent Medical Expert Group (IMEG), which advises the Minister for Defence Veterans and People on medical and scientific aspects of the Armed Forces Compensation Scheme (AFCS), takes on causality. It was agreed information would be shared, where possible.

Decision-making process

3.13. The Chair was aware that these types of decisions are rarely straightforward, and a number of factors will need to be considered for each topic.

3.14. A member pointed out that IIAC considers additional aspects as well as a 'doubling of risk'. If 'doubling of risk' is apparent, that is helpful, but if it is absent (for many reasons) then the Council may still proceed with a topic and felt the narrative in this paper did not make that clear.
3.15. It was suggested that the IIAC position paper 34 Diseases with multiple known causes and rebuttal be referenced as this report covers many of the points summarised in this draft guide.
3.16. A member commented that a dose-response can add to the weight of evidence, so this could be added to the draft document and added that the totality of the evidence is paramount.
3.17. The discussion moved onto 'Other factors to be considered' where gender & equality (G&E) were raised, also 'Feasibility of diagnosis and attribution' was discussed – members were agreed that a medical diagnosis is acceptable and wouldn't necessarily need to be confirmed by other means (e.g. biopsy).
3.18. The draft document/guide listed many of the protected characteristics when referring to G&E and it was suggested that these may change or time, so a link to this section under the Equality Act 2010 (section 4) could ensure the document is up to date.

Approach to updating and reviewing prescribed conditions

3.19. A member commented that this section should perhaps be more reflective of the fact that IIAC can recommend adding new prescriptions or changes to existing prescriptions rather than focussing on removing elements.

Appendices

3.20. There was discussion around where new topics were considered for potential progression that descriptors be added to the scoring system.
3.21. A member pointed out that a position paper does provide advice to the Secretary of State to not recommend prescription.
3.22. Referring to public meetings, the Chair indicated that it was her preference to hold this annually.
3.23. Drawing the discussions to a close, the Chair thought the next stage would be to share the updated draft document/guide with key stakeholders to ask for feedback – this could also be a focus of a public meeting.

4. Current Work Programme
Neurodegenerative diseases (NDD) in professional sportspeople

A presentation was delivered to members, summarised below:

Cognitive impairment/ dementia

- Numbers: 355 papers were selected for full-text screening (based on manual screening only)
- AI screening was generally considered to be more conservative versus traditional methods.

- Population: mostly professional/elite athletes, retired athletes. Some papers relate to youth athletes - college/university players, National Collegiate Athletic Association (NCAA).
- Sports represented: mostly American football, soccer, rugby. Smaller contributions from boxing, MMA, martial arts, ice hockey.
- Outcomes: Mostly chronic traumatic encephalopathy (CTE), followed by dementia and Alzheimer's disease. Cognitive domains - mostly memory, executive function, attention, processing speed.
- Countries: The evidence base is dominated by US and UK professional sports. Other countries appear only occasionally (Canada, Australia, Finland, Sweden, France, Japan, NZ).

Parkinson's disease (PD), Parkinsonism

- Numbers: 30 papers selected for full-text screening (based on manual screening only) with 16 papers selected for data extraction/quality assessment
- Population: professional or former athletes, including varsity athletes
- Sports represented: American football, soccer, boxing, rugby
- Outcomes: Parkinson's Disease or Parkinsonism
- Countries: Mostly US and UK, followed by Thailand, Spain, France, Sweden, Korea, Australia and New Zealand.

4.1. As the PD project is smaller, it was indicated this would be delivered first.

4.2. Characterisation of exposures was brought up by a member and it was indicated that participation in professional or elite sport was the main element.

4.3. The Chair asked if the papers selected for PD were unique to that disease condition or were they common to the larger number from cognitive impairment/dementia – it was assumed they were unique, but this would be checked.

4.4. There was a short discussion on AI tools in screening for papers.

Potential future work programme

4.5. The Chair opened the discussion and thanked all members for their input into scoping the potential for new topics as agreed at the last IIAC meeting. These topics and the input from individual members were discussed at the last RWG meeting and consequently more information was added in some instances.

4.6. The Chair asked that members consider the topics and agree a small number to take forward for further consideration.

4.7. The list was reviewed:

- **Asbestos exposure and kidney/oesophageal cancer**
  Members considered that there appeared to be little evidence for the involvement of asbestos in kidney cancer but there were several recent studies/meta-analysis of oesophageal cancer, but the evidence did not appear to show risks were doubled. A member suggested that asbestos-related diseases which are not currently prescribed for, such as laryngeal or ovarian cancer, may be worth considering
- **Chromium exposure and lung cancer**

Members indicated there appeared to be good epidemiological evidence that there was at least a doubled risk of lung cancer in certain groups of workers, but these may be legacy occupations which might no longer exist. There is some evidence of a dose-response relationship and IIAC should consider whether this can be demonstrated in current occupations where workers are exposed to chromium, likely to be the hexavalent form. It was observed that current exposures are likely to be much less than those previously reported. A member asked about the lag-phase of disease development and it was thought that chromium is not rapidly cleared from the body, but this would need further consideration. Workers in electroplating were likely to encounter the most exposure, and to a lesser extent, welders potentially when working with stainless steel. Members agreed that the topic of chromium and lung cancer would be worthy of further consideration. It was noted that HSE has done some work on biological monitoring for chromates in collaboration with 'The Institute of Occupational Medicine' (IOM), data may be available.

- **Hearing loss in call centre workers**
  The Chair indicated that there had been correspondence from an MP on this topic. The member who assessed this topic indicated they would classify this as low priority as the epidemiological evidence is sparse. It was suggested instead that cases such as these may be appropriate for the accident provision of IIDB where acoustic shock (e.g. from faulty equipment such as headsets or external deliberate acts such as blowing whistles) could demonstrate hearing loss. It was noted that a number of medico-legal cases had been reported following a high-profile case of a musician. There may also be psychological aspects to this as detailed in the Grindleford criteria [i]. It was concluded that there was insufficient evidence due to a sparsity of epidemiological studies and potential biological implausibility given call/contact centres generally have a background noise of 75dB, less than the accepted criteria for causing hearing loss. It was noted that musicians could be re-evaluated in the future. There was some discussion around whether there could be a call for evidence to be published – the Chair was supportive of calls for evidence but generally only where the evidence would support further investigation of a topic, so not in this instance. A member noted that the Society for Occupational Medicine has a consultation out on priorities for occupational health research and its findings are likely to be reported on 24 March 2026.
- **Pesticide exposure and neurodegenerative diseases**
  A member noted that there was evidence for increased risk of Parkinson's disease (PD) and less evidence for Alzheimer's disease and motor neurone disease (MND). The member stated that occupational pesticide exposure is a very complicated issue to tackle because there is a vast number of compounds which complicates the epidemiology. To obtain sufficient evidence to recommend prescription, each compound

would need to be evaluated individually. A member suggested that an occupational sector be selected for evaluation (e.g. farming) but it was implied that the risks would be low. A member asked if there was any basic scientific information which might support looking at a group of pesticides such as organophosphates – dopamine depletion was suggested. It was noted that there is an existing prescription for organophosphates PD C3. A member noted that there is a HSE pesticide user study and it was suggested that there may be data available – this is a longitudinal study of pesticide applicators where baseline information is collected along with a follow-up i.e. covers pesticide exposure and health outcomes. Mortality and cancer incidence have been published, other ill-health outcomes are self-reported. It was agreed that HSE may be able to provide data on neurodegenerative diseases. A member commented that the PD C3 prescription is for peripheral neuropathy with no particular occupation specified – it was mentioned this prescription was likely to have been based on advice from the Committee on Toxicity (COT). It was agreed that pesticides would not be taken forward at this time, but when the HSE study is published, to potentially reconsider. In the meantime, RWG may discuss further at its next meeting.

- **Trauma and post-traumatic stress disorder (PTSD)**
  A member commented that it was initially suggested that this topic could be applied to emergency workers, but felt that it may be more relevant to prison officers. It was recognised that mental health may be challenging to evaluate, but in this instance, there is a relatively large population of workers potentially affected, the condition is diagnosable and it has a significant impact. There was some discussion around the potential use of the accident provision to cover PTSD as claims for IIDB under this route had been accepted. There was further discussion around when a disease could be caused by an accident or as a result of longer-term exposure. The Chair indicated that this was a topic for discussion later on in the agenda.
  The evidence available to members might indicate it was insufficient to proceed further, but it was agreed that scoping out the evidence for prison officers may be pertinent when the prescribed disease route versus the accident route has been explored further in a wider context of IIDB.
- **Silica exposure and sarcoidosis**
  A member indicated that, at the moment, this topic could likely be a lower priority but studies are ongoing which will report in 2-3 years. The condition is uncommon and there is a biological model (gene/environment interaction) but this does not appear to have been explored within the epidemiology. Some published studies could have been subject to bias or low quality of reporting with conflicting information around a dose-response. Based on the discussion, it was decided not to move forward with this topic, but to keep a watchful eye on the emerging literature.

- **Welders and ocular melanoma**
  A member stated there was a fair body of evidence around the association of this very rare disease and welding. The epidemiology is difficult because the disease is so rare with a big range of risks being reported. It was suggested that claimant numbers would be very low if this topic went forward for prescription due the rarity of the disease. However, a member indicated that there was a large study ongoing which is assessing the link between ocular melanoma and occupational exposure to UV light (sunlight). It was agreed that this topic would not progress further at the moment, but the outcomes of the study mentioned would be considered when available.
- **Review of PD A10 – occupational deafness**
  A member suggested that the PD A10 should be re-evaluated due to the occupational exposure, disability assessment and hearing loss requirement of 50 dB. The member acknowledged that this is not a new topic to consider, but another member commented they felt there may be anomalies to address. The member leading the discussion opined that the potential to change the prescription revolved around:
    - Aggregation – cannot aggregate as with other PDs
    - The level of disability to qualify for IIDB is set at 20% whereas for most other PDs it is 14%
    - Higher bar on exposure criteria
    - It is difficult to provide new evidence to cover potential additions to occupations which are affected

  A member commented that age is a factor in deafness and exposure to will be a contributory factor and it can be difficult to separate these out. An observer indicated they would be interested in IIAC's views on the disability associated with hearing loss and whether this has changed. The 2017 IIAC position paper 38 was brought up and whilst little has probably changed, the member leading the discussion felt that it could be interpreted in a different way. It was suggested that Council invite a recognised expert in occupational deafness to a meeting before agreeing to commit resources to this topic. A member suggested a colleague and epidemiologist from St Georges who may be a suitable expert to advise the Council.

4.8. The Chair summarised the discussion on the future work programme:

- Chromium exposure/lung cancer to be taken forward, work to be commissioned – RWG to take forward
- Further discussion on hearing loss with input from an independent expert
- Prisoners/PTSD to be discussed further, scoping document to be produced

4.9. The Chair thanked members for their input.

5. Updates on previously published command papers

5.1. The Chair alluded to discussions around the COVID-19 papers. The Chair also informed members that DWP officials had written to her to suggest a series of workshops (or appropriate number) be held with members to discuss the differences between the IIDB accident route and prescribed disease route.
5.2. The Chair invited DWP IIDB officials to update the Council on the status of the command papers which had yet to be evaluated.
5.3. An official indicated the command papers are awaiting impacting, but the main focus has been on COVID-19. Further updates may be available at the next IIAC after considerations have been given to what resources may be available.
5.4. A member offered to share their views to help with potential guidance for the proposed revision to PD A11, hand-arm vibration syndrome, as set out in the command paper 'Hand-arm vibration syndrome and assessment of vibration exposure'.

6. **AOB**

6.1. DWP clinical officials raised a number of issues which may require advice from the Council:
- COPD
- CPFE (combined pulmonary fibrosis and emphysema)

6.2. It was agreed that IIDB officials would provide a written summary of the issues and detail what they consider IIAC can advise on.
6.3. The Chair thanked members of the secretariat, who would be leaving DWP, for their support and wished them well.

Date of next meetings:

Date of next IIAC Meeting: 16 April 2026
Date of next RWG Meeting: 12 March 2026

[i] "The Application of the Grindleford Criteria for Diagnosing Acoustic Shock Claims" Author: Nicholas Robinson Published: 29 May 2025 Source: Ropewalk Chambers Blog
URL: https://ropewalk.co.uk/blog/the-application-of-the-grindleford-criteria-for-diagnosing-acoustic-shock-claims/