

The logo consists of the letters 'I', 'I', 'A', and 'C' in a yellow serif font, each followed by a yellow dot, all set against a solid green rectangular background.

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**The Industrial Injuries
Advisory Council**

**Proceedings of the
9th Public Meeting**

24 June 2010
Manchester

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Foreword

The ninth Public Meeting of the Industrial Injuries Advisory Council (IIAC) was held in Manchester on 24th June 2010. This event built on the success of the Public Meetings held around Great Britain over the past 8 years. We were very pleased to note that the passage of time has increased the popularity of our meetings, and we welcomed the largest ever number of attendees at the Public Meeting this year.

The meeting allows members of the Council to hear from interested members of the public and for the public to get a better understanding of the Council's work. Important issues were raised and discussed, including osteoarthritic conditions and asbestos-related diseases. The ninth IIAC Public Meeting was an informative occasion for the Council and we look forward to the next event. I would like to thank all members of the public who came to the meeting for contributing to the lively discussions which made the occasion so worthwhile.

IIAC is independent of the Department for Work and Pensions (DWP). It is supported by a Secretariat provided by the DWP and endeavours to work cooperatively with departmental officials to provide advice to the Secretary of State about the Industrial Injuries scheme. However, its recommendations are not necessarily consistent with current legislation, and during the Public Meetings members may have expressed personal views which are recorded in this report. The report should not be used as guidance on current legislation, or current policy within the DWP.

Professor Keith Palmer
Chairman IIAC

Agenda

- 09:00 – 09:45 Registration
- 09:45 – 10:30 **Welcoming Remarks**
Chairman of IIAC – Professor Keith Palmer
- Followed by:
- IIAC's approach to scientific decision making**
Chairman of IIAC Research Working Group – Dr Anne Spurgeon and Professor Keith Palmer
- Work of Scientific Advisor – Dr Marianne Shelton
- 10:30 – 11:00 **Discussion and questions**
- 11:00 – 11:30 Break
- Presentations:**
- 11:30 – 12:15 The effect of state benefits on civil claims – Mr Simon Levene
- 12.15 – 13:00 Osteoarthritic conditions – Professor Keith Palmer
- 13:00 – 14:00 Lunch
- Presentation and open forum:**
- 14:00 – 14:45 Asbestos diseases – Professor Mark Britton
- 14:45 – 15:15 **Open forum**
Facilitator – Mrs Diana Kloss
- 15:15 End of public meeting

Welcoming Remarks

Professor Keith Palmer

Chair of IIAC

1. Professor Keith Palmer welcomed everyone to the Manchester Public Meeting and the IIAC members introduced themselves.
2. The Industrial Injuries Scheme provides a non-contributory, no-fault benefit which includes Industrial Injuries Disablement Benefit (IIDB). This is paid to people who become ill as a consequence of a workplace accident or an occupational or 'prescribed' disease. These terms have specific legal meanings and have been decided by case law. A workplace or 'industrial accident' is defined as "an unlooked for occurrence" or "mishap" arising "out of and in the course of employment". A prescribed disease is one that is listed as a disease in the Scheme's regulations that has been linked with an occupational cause. The Scheme compensates employed earners; the self-employed are ineligible to claim IIDB for work-related ill-health. Claimants can receive benefit from ninety days after the accident or onset of the prescribed disease; shorter periods of disablement are not compensated. (For example, IIAC has recently reviewed pneumonia due to exposure to metal fumes but this condition was not eligible for prescription as the effects would not generally last past the 91st day from the start of the illness).
3. The scheme compensates for "loss of faculty" and its resultant "disablement", which is assessed relative to age- and gender-matched peers by medical advisors engaged by the Department. Assessments of disablement are based on functional, not vocational limitations, and are expressed as a percentage. Thresholds for payment are applied, such that in general disablement needs to be greater than 14% (exceptions exist for pneumoconiosis where payment starts at 1% disablement, and occupational deafness where payment starts at 20%). Assessments of disablement for different accidents or diseases can be aggregated for certain prescribed diseases.
4. IIAC is a statutory body, established under the National Insurance (Industrial Injuries) Act 1946, to provide independent scientific advice to the Secretary of State for the DWP and to the Department for Social Development (DSD) in Northern Ireland on matters relating to the IIDB Scheme or its administration. The members of IIAC are appointed by the Secretary of State after open competition, and consist of a Chairman, scientific and legal experts, and an equal number of representatives of employers and employees. Officials from the Health and Safety Executive (HSE) and relevant policy divisions of the DWP, Ministry of Defence and DSD attend IIAC meetings to provide information and advice. There are four meetings of the full Council per year.

5. The majority of IIAC's time is spent providing advice to the Secretary of State on the prescription of occupational diseases. IIAC's other roles are to advise on proposals to amend regulations under the Scheme, to advise on matters referred to it by the Secretary of State, and to advise on general questions relating to the IIDB Scheme. The Council has no involvement in decision-making or individual claims.
6. A permanent sub-committee of the Council, the Research Working Group (RWG), monitors and reviews medical and scientific literature to identify developments in the field of occupational ill-health which are then brought before the Council. This work is supported by a Scientific Adviser. The RWG meets four times a year.
7. IIAC also investigates diseases following referrals from the Secretary of State, correspondence from MPs, medical specialists, trade unions, and others, including topics brought to its attention by its own members and by other stakeholders.
8. IIAC produces several different types of publication. IIAC Command Papers are produced at the 'command' of Her Majesty and are presented to Parliament by the Secretary of State for Work and Pensions, often forming the basis of legislation. Position Papers are published on important subjects that IIAC has considered, but where it does not recommend prescription or where the matter has not been referred by Ministers. Commissioned research reports are usually published once a year, and are instigated at the request of the Council. These reports are carried out by an independent third party, usually by an academic expert, and have direct relevance to the Council's programme of work. Finally, IIAC publishes an annual report and the proceedings from its Public Meetings.
9. IIAC's current and recent work programme includes by way of example reviews of osteoarthritis of the knee, acid mists and laryngeal cancer, coke oven work and lung cancer, lead and infertility, cancer in painters, shift work and cancer or cardiovascular disease, chromium and sino-nasal cancer and presumption/assessments of disablement.

IIAC's approach to scientific decision making

Dr Anne Spurgeon and Professor Keith Palmer

Chair of the IIAC Research Working Group and Chair of IIAC

- 10.** This talk focussed on IIAC's approach to making scientific decisions in the context of the IIDB scheme, with Dr Anne Spurgeon outlining the principles and Professor Keith Palmer illustrating how it works in practice.
- 11.** Dr Spurgeon began by discussing the legal framework within which IIAC works and the process by which it recommends prescription of occupational diseases. The Council is bound by the legal requirements set out in the Social Security Contributions and Benefits Act 1992. The disease must be a risk of the occupation and not a risk common to all persons and attribution of the disease to the occupation in an individual case must be capable of being established or presumed with reasonable certainty.
- 12.** Some occupational diseases are relatively simple to verify in that they have unique clinical features that can be measured and rarely occur outside work. Examples of 'easy' cases are specific poisonings and mesothelioma; also, occupational asthma and contact dermatitis, where challenge with the suspected occupational agent confirms the diagnosis. On the other hand, where a disease is common in the general population and has no clinical features that are unique to occupational cases, it is much more difficult to establish a link between the occupation and the disease. Both back pain and stress are examples of 'tough' cases for verification and attribution of occupational causation and judgements depend on probability rather than more direct tests and criteria.
- 13.** When considering a disease for prescription IIAC has to address the question of attribution, i.e. whether there is a link between the job and the disease that can be presumed with reasonable certainty. For the purposes of the Scheme, IIAC interprets reasonable certainty as meaning 'more likely than not'. Epidemiology is the branch of medicine that deals with the distribution and determinants of disease in human populations and IIAC applies epidemiological principles when considering prescription.
- 14.** In epidemiological terms 'more likely than not' can be represented mathematically as an attributable fraction (i.e. the percentage of cases caused by an occupational exposure). 'More likely than not' means, for those with exposure, an attributable fraction greater than 50%. Imagine we have two groups of equal size, (for example 1000 in each group), an exposed group and a non-exposed group. Imagine there are 100 cases in the exposed group and 50 cases in the non-exposed group. Then it is clear that there is a doubling of risk in the exposed group. Also the total risk in the exposed group can be split into two parts (i) the 50% that is due

to the background risk common to all persons (ii) the 50% excess risk that is due to exposure. So a doubling of risk in the exposed means 'more likely than not due to the exposure'

- 15.** IIAC's task is to determine whether there is good evidence that the risk of a particular disease is doubled or more than doubled in a group with defined occupational exposure. If the answer to this question is yes, then IIAC would recommend that the disease is prescribed with the intention that exposed workers get the benefit of presumption on the basis of the group's probability. .
- 16.** In order to establish whether there is a doubling of risk of a disease attributable to a particular occupation, IIAC looks to scientific research and academic experts for evidence. It is important that the evidence comes from more than one independent, good quality study, ideally several studies of different design, since this reduces the likelihood of methodological problems resulting in error or bias, or of any decisions being overturned by the results of future research.
- 17.** Practically speaking it is also important that the disease and the relevant exposures can be easily verified and that the disease is a cause of significant impairment.
- 18.** The Council has already recommended prescription for several diseases where the process of attribution to occupation has been complex. These diseases include Vibration-induced White Finger (VWF), carpal tunnel syndrome, chronic bronchitis and emphysema and osteoarthritis (OA) of the hip in farmers.
- 19.** Professor Keith Palmer then outlined IIAC's scientific decision making in practise, using OA of the hip in farmers as an example.
- 20.** OA of the hip is common in the general population and has a similar clinical appearance in farmers to other people. An increased incidence of osteoarthritis in farmers was first suspected as this occupational group appeared on hip surgery waiting lists more often than expected given the relative frequency of farming in the population. This observation in itself was not proof that farmers were more at risk of OA of the hip, since the data could have arisen because farmers presented themselves to hospital for treatment more readily (their livelihood depends on their ability to perform physically demanding work). However, this observation was followed by additional research which concluded that the disease was more prevalent in farmers.
- 21.** In one line of inquiry, researchers used X-rays which displayed the hip joints but which had been taken for other diagnostic purposes (e.g. to look for kidney disease). The frequency of farming was considered in those with and without hip OA. Studies from the University of Southampton and research groups in Sweden showed that there was a 2-10 fold increased risk of OA of the hip in farmers. In this research the problem of

'volunteering' bias was limited since the comparisons were made among people who had not been selected on the basis of their care-seeking for hip disease.

- 22.** The consistent demonstration of a greater than doubling of risk in multiple surveys from more than one country and across a range of study types allowed the attribution of OA of the hip in farmers to their occupation on the balance of probabilities.
- 23.** Verification of OA of the hip is straightforward since there are well-defined diagnostic criteria. Dr Palmer showed pictures of X-rays of normal hips and an osteoarthritic hip. An osteoarthritic hip is characterised by a narrowing of the joint space between the socket (acetabulum) and the head of the femur, and roughened joint surfaces. Bony spikes and bone cysts may also be present. Thus the disease can be confirmed, is disabling, and has been shown to be at least twice as common in farmers as in other groups.
- 24.** The Council then had to consider an exact definition of the occupational criteria for exposure – the definition of farming and whether particular types of farming carried special risks. No evidence was found on which to restrict prescription to a defined sub-category of farming activity; evidence was found on the necessary duration of exposure.
- 25.** OA of the hip in farmers fulfilled the criteria necessary to attribute a disease that is common in the general population to a particular occupation. Thus, IAC recommended that OA of the hip be added to the list of prescribed diseases for those a) employed for at least 10 years in aggregate as a farm worker or farm manager and b) having osteoarthritis of the hip* or having had it prior to hip surgery (*as diagnosed by a specialist and based on a painful hip with restricted movement and on a hip joint radiograph).
- 26.** As part of the review, OA of the hip in other occupations, such as those involved in heavy lifting, was also considered, but the weight of evidence was much lower than for farming. IAC regularly monitors emerging scientific literature on this and other issues and reviews the prescription where necessary. Future advances in research may enable the terms of prescription for OA of the hip to be widened. The case of OA in farmers illustrates the nature and level of evidence the Council needs in prescribing for the "tough" cases as defined in paragraph 12.

Work of the scientific advisor

Dr Marianne Shelton

IIAC Secretariat – scientific advisor

- 27.** Dr Marianne Shelton outlined the work of the scientific advisor. The scientific advisor is a member of the IIAC Secretariat, who are DWP staff who support the Council in its work. The scientific advisor provides a range of scientific services.
- 28.** One of the key roles for the scientific advisor is IIAC's meeting work which includes drafting the agenda, recording complex and technical minutes from meetings and following up action points. This involves close liaison with the Chairs of IIAC and the RWG, Council members and other experts.
- 29.** Part of the scientific advisor's role involves undertaking literature searches for the Council. This generally involves using the PubMed research database run by the National Institute of Health in the US. This is a free digital archive of biomedical and life sciences journal literature, containing over 1.5 million reports from over 450 journals published around the world.
- 30.** The main reason literature searches are conducted is to provide evidence of increased risks for occupational diseases and their exposures for IIAC reviews. Searches may be done at the start of a review, to scope out what evidence is available, or to answer specific questions that arise during the course of a review. As a result of the literature search, a review may be expanded if the Council identifies a need beyond the initial terms of inquiry.
- 31.** Literature searches are also undertaken as horizon scanning exercises to see what new research is emerging.
- 32.** Searches are also conducted in the production of the IIAC abstract booklet which is produced every 6 months for Council members. Abstracts are summaries of the research reports. The abstracts booklet is a literature search of occupational diseases in general and those specific to IIAC's interests. This helps members keep up-to-date with the literature relevant to the Industrial Injuries scheme and is a way in which IIAC can identify new evidence on topics it has undertaken to monitor in past reports, e.g. OA hip in occupations other than farming.
- 33.** The scientific advisor also helps in producing IIAC reports, such as Command papers, position papers, the annual report and the proceedings from Public meetings. The support provided can be in the form of obtaining research papers, making calls for evidence, drafting parts of the report and liaising between Council members or external experts.

- 34.** IIAC can apply for funding to commission literature reviews on various topics. The scientific advisor secures funding from the DWP, suggests research topics, helps put together project specifications, manages the submissions of interest, negotiates the contract and liaises with the chosen contractors during the course of the review.
- 35.** Replies to correspondence from members of the public or MPs about scientific queries relating to IIAC's work are also dealt with by the scientific advisor.
- 36.** The scientific advisor plays a key role in the work of the Council by ensuring that members have access to dedicated scientific support solely focussed on the Industrial Injuries scheme. The scientific advisor identifies, manages, and may sometimes commission, relevant scientific, medical or policy information from published research, Departmental statistics or experts. The advisor therefore plays a crucial role in ensuring the Council can focus its time on analysing and reviewing a broad range of occupational health topics in the most efficient, effective and timely way.

Comments, questions and answers from the morning session

- 37.** *Will IAC be looking at the communication of decisions and the rationale behind them during its review of assessments for disablement? Mr Anthony Whitston - Greater Manchester Asbestos Victims Support Group* - IAC's review of assessments will focus on the scientific aspects rather than administrative or operational issues, such as communication of decisions. However, IAC will refer the comments made to the Department.
- 38.** *Assessments for IIDB are based on a person's loss of faculty leading to disablement but Industrial Injuries benefits are treated as income replacement as they are taken into account when considering claims for means tested benefits. What is IAC's view about this? Mr Anthony Whitston - Greater Manchester Asbestos Victims Support Group* - IAC wrote to the previous government highlighting that IIDB was recompense not a cost of living benefit and asked that claimants in receipt of IIDB could passport other benefits. The previous government were not receptive to IAC's suggestions at that time. IAC will raise this matter again with the new Minister.
- 39.** *Annually there are approximately 18k claims and 7k payments for IIDB compared to 68k claims and 23k payments for civil litigation. 77% of IIDB claims are for asbestos-related diseases. Is IIDB a marginal and disappearing scheme? Mr Anthony Whitston - Greater Manchester Asbestos Victims Support Group* - IAC is aware and has analysed the scheme's statistics. Workers may not be aware of the existence of the scheme. Workers may prefer to make a civil claim only, as potentially there are larger sums of money involved (and claw-back limits scope for double compensation). The decrease in numbers of claims partly is due to the nature of the diseases which are currently prescribed which reflect the UK's industrial heritage. Many modern day diseases, such as back pain and stress, are difficult to prescribe. IAC has recently prescribed OA hip and OA knee which are often associated with older age. With an increasingly aging population it is possible that the numbers of claims for the prescribed osteoarthritic conditions may increase, causing an overall rise in the numbers of claims for IIDB, and the Council remains alert to evidence that the Schedule should be extended.
- 40.** *The HSE has recently published a report on asbestos which states that gastric and laryngeal cancers may be caused by asbestos, following the view of the International Agency for Research on Cancer. Why has IAC not recommended prescription for these conditions?* In order to recommend prescribing a condition and its exposure IAC must satisfy certain legislative requirements. To be eligible for prescription there must be a greater than doubled risk of the disease from an occupation compared to a suitable unexposed group. This is the same standard of proof that is required in civil cases for compensation. The cancers in question do not meet this criterion (the Council's position on cancer of the larynx and asbestos exposure is set out in Position Paper Number 22).

The HSE's viewpoint focuses on prevention. The threshold for consideration of evidence relating to prevention is much lower than that considered for compensation.

- 41.** *To qualify for chronic bronchitis and emphysema claimants must have a loss of lung function of 1L capacity. Why is such a severe loss of lung function required? Dr Robin Rudd, a consultant chest physician, has suggested that the prescription for chronic bronchitis and emphysema is based on miners who smoke. Smoking is less likely nowadays and so the prescription should also consider the loss of lung function in non-smokers. Mr David Guy – National Union of Mineworkers –* The evidence considered during the review of chronic bronchitis and emphysema included both smokers and non-smokers. Both smokers and non-smokers demonstrated a greater than doubled risk of chronic bronchitis and emphysema. The prescription is not based upon miners who smoke. A decrease in FEV₁ of 1L was recommended for prescription as this constitutes a disabling loss of lung function. IIAC would welcome any evidence Dr Rudd or the NUM would like to submit on the topic.
- 42.** *Assessments for pleural thickening vary between regions. Is it possible for IIAC to supervise ATOS assessments and results? Mr John Flanagan - Merseyside Asbestos Victims Support Group –* IIAC has no capacity to supervise ATOS assessments. ATOS is extensively audited by the Department. IIAC does have the capacity to review the audit standards for ATOS/DWP and will consider this during its review of assessments for disablement.
- 43.** *Osteoarthritis (OA) of the hip has been prescribed for farmers. IIAC's report discussed walking on uneven ground and carrying heavy loads as possible causes of OA hip in farmers. Miners also walk on uneven ground and carry heavy loads. Has IIAC considered adding miners to the prescription for OA hip? Mr David Guy – National Union of Mineworkers –* During the review of OA hip in farmers the Council undertook a broad search for other occupational categories. This suggested that farmers might qualify for prescription, but no such evidence was found for miners. However, IIAC will update its search and check that findings remain current.
- 44.** *What is IIAC's position on dual pathology for PD A14 (OA knee)? Mr Chris Skidmore – National Union of Mineworkers –* IIAC considers that previous knee injury is not a valid reason for failing a claimant on the presumption rule (i.e. deciding that OA knee does not arise from work as a miner as set out in PDA14). The process of assessing percentage disablement involving two risk factors, occupational and non-occupational acting in concert, is more complex. Therefore, IIAC is reviewing the presumption rule and considering medical assessments. In future reports IIAC will recommend whether and how the presumption rule should apply in the specific case.

- 45.** *There is much evidence of Post-Traumatic Stress Disorder (PTSD) in the Armed Forces. PTSD due to workplace accidents, such as a colliery explosion, does not seem to be as widely recognised. Is PTSD different from stress? Mr Nicky Wilson – National Union of Mineworkers – PTSD and stress can be distinguished clinically. PTSD has a better defined and well-accepted disease definition in which there is a consensus of expert agreement. In its 2004 report 'Stress at work and PTSD' IIAC clarified what should be accepted as PTSD under the Accident Provisions of the scheme.*
- 46.** *What is the process for those PD A14 claimants who received low assessments prior to October 2009? When will these claimants be notified of the review outcome? Mr Colin Ellis - Rotherham Occupational Health Advice Service – A Departmental official attending the meeting replied that out of 1700 claims, the DWP had identified 200 claimants that had been under-assessed. These claimants are being notified. Claimants who were not under-assessed are not being contacted.*
- 47.** *Why were miners in Sheffield given lower assessments for PD A14 compared to those in Manchester? After looking at anonymised audit data the Department became aware of a geographical discrepancy in assessments for disablement for PD A14. New guidance has been issued and information is being disseminated to trade unions and advisory bodies.*

The effect of state benefits on civil claims

Mr Simon Levene

48. Mr Simon Levene's presentation dealt with the overlap between personal injury law and social security law from his perspective as a personal injury lawyer. The talk covered non-social security benefits, social security benefits, IIDB and personal injury trusts. Definitions were provided for certain legal terms, as follows:

"Damages"	Damages awarded by the Court in a civil claim (or paid if a case is settled before going to Court).
"Claimant"	The plaintiff in a civil claim.
"General damages"	Damages awarded for pain, suffering and loss of amenity, rather than for any financial loss.
"Contributory negligence"	Deduction from the damages where the Claimant was partly to blame for the accident
"Heads of loss"	The components of a claim for damages – e.g. general damages, earnings, care, aids and appliances, housing etc.
The 1992 Act	The Social Security Administration Act 1992

49. Non social security benefits – Double recovery for compensation is not permitted. The courts ensure that a claimant is only compensated once for each heads of loss. The general rule is known as "the rule in **Hodgson v Trapp**¹", such that a claimant must give credit for all benefits received in consequence of his injury against equivalent damages. There are four exceptions to this rule:

- Social Security Benefits (which have their own code)
- Money paid under an insurance policy *whose premiums were paid by the insured person*. This will apply to a work scheme to which an employee contributes. However, if an employer alone contributes to a policy of insurance that pays the employee's wages if the employee is off sick, money from that policy is treated as wages, and is deducted from the claim for loss of earnings.
- Charitable donations (e.g. payment from disaster funds).
- Where the injured person has died, and a claim is brought under the Fatal Accidents Act 1976. Under s.4 of the Act, "In

¹ Lord Bridge said in **Hodgson v Trapp** (1989): "My Lords, it cannot be emphasised too often when considering the assessment of damages for negligence that they are intended to be purely compensatory. Where the damages claimed are essentially financial in character, being the measure on the one hand of the injured claimant's consequential loss of earnings, profits or other gains which he would have made if not injured, or on the other hand, of consequential expenses to which he has been and will be put which, if not injured, he would not have needed to incur, the basic rule is that *it is the net consequential loss and expense which the court must measure*. If, in consequence of the injuries sustained, the claimant has enjoyed receipts to which he would not otherwise have been entitled, prima facie, those receipts are to be set against the aggregate of the claimant's losses and expenses in arriving at the measure of his damages."

assessing damages in respect of a person's death in an action under this Act, benefits which have accrued or will or may accrue to any person from his estate or otherwise as a result of his death shall be disregarded."

50. Benefits are set off "like for like" – e.g. work-related benefits are set off against loss of earnings, but sick pay could not be set off against a claim for the cost of a wheelchair. For the same reason, sums received by way of pension cannot be set off against loss of earnings – though they can be set off against a claim for loss of pension. Where an employer makes any payments to an employee on the understanding that the employee will have to repay them out of his damages, those payments are not deducted.
51. Redundancy payments are deducted from damages awarded for personal injuries if the redundancy was caused by the claimant's injuries. If the claimant would not have been made redundant if he had not been injured, the redundancy payment is deducted from his damages; if he would have been made redundant anyway, the redundancy payment is not deducted. For example, if a claimant was awarded £10k damages as a result of injuries suffered and was awarded £5k from being made redundant due to the injuries suffered, the claimant would have to repay the £5k. If the claimant was awarded £10k in damages and was also made redundant and given £5k where the redundancy was not due to the injury, the claimant would be allowed to keep the £10k in damages and £5k in redundancy payments.
52. Savings made by staying in a public institution are also deducted from compensation awards. Section 5 of the Administration of Justice Act 1982 says that if an injured person makes any saving "which is attributable to his maintenance wholly or partly at public expense in a hospital, nursing home or other institution" that saving "shall be set off against any income lost by him as a result of his injuries."
53. If the Claimant receives a tax rebate as the result of his absence from work due to his injuries, the tax rebate is to be deducted from his lost earnings.
54. Foreign welfare benefits are not deductible if the injured person has to repay them. If he does not have to repay them, they are deducted from his damages.
55. Housing benefit (whether paid before or after the settlement of the claim) must be deducted in full.
56. Recoupment of social security benefits - The Social Security Act 1989 introduced recoupment of benefits from damages. The Act came into force on 6th October 1997. The relevant benefits are listed in the Table below. It is important to note that these benefits can only be set off against compensation awarded in respect of the same loss – i.e. "like for like":

	This benefit...	Is deducted from this...
Work related benefits	Disability working allowance	Damages for lost earnings.
	Disablement pension payable under s.103 of the 1992 Act	
	Incapacity benefit	
	Income support ²	
	Invalidity pension and allowance	
	Jobseeker's allowance	
	Reduced earnings allowance	
	Severe disablement allowance	
	Sickness benefit	
	Statutory sick pay	
	Unemployability supplement	
Unemployment benefit		
Care/mobility related benefits	Attendance allowance	Damages for care (including care provided by family at no cost).
	Care component of disability living allowance	
	Disablement pension increase payable under ss.104 and 105 of the 1992 Act	
	Mobility allowance	Damages for loss of mobility.
	Mobility component of disability living allowance	

57. The person paying compensation tells the Compensation Recovery Unit (the CRU) about the claim, and applies for a Certificate of Recoverable Benefit before settlement (usually known as a "CRU Certificate"). The compensator must repay benefits to the CRU before paying damages to the Claimant. The Claimant is paid his damages net of the amount repaid to the CRU.

58. General damages for pain and suffering and loss of amenities are ring-fenced, and no benefits are deducted under the Act (but see paragraph 63 below). Recoupable damages are deducted in full, even when the injured person only receives a proportion of his damages because the injury was partly his own fault ("contributory negligence")

59. For example, a claimant 'C' was 50% to blame for the accident and lost £3,000 in earnings as a result of her injuries. She has received £2,000 incapacity benefit. She will only be awarded £1,500 damages for loss of earnings, from which the incapacity benefit is deducted in full. C therefore receives nothing for loss of earnings.

60. In the case of an **accident or injury**, benefits are deducted for a period of five years from the date of the accident or injury, or until the claim is finally

² From October 2008 income support paid on incapacity grounds and incapacity benefit were replaced for new claimants by the employment and support allowance (ESA).

settled, whichever is the shorter. In **disease cases**, the relevant period is five years from the date on which the claimant first claimed a listed benefit in consequence of the disease, or the period between that date and the date on which the claim is finally settled, whichever is the shorter. Where the Act applies to a benefit, the rule in **Hodgson v Trapp** does *not* apply – so after the five-year period has expired, or after settlement of a claim (whichever comes sooner) the Claimant is entitled to continue receiving the listed benefits without deduction from his damages.

61. The compensator has to repay the benefits *in full* to the CRU, even if (because of the “like for like” provisions) none of them are to be deducted from the Claimant’s damages. In assessing damages in respect of any accident, injury or disease, the amount of any listed benefits paid or likely to be paid is to be disregarded (s.17 of the Act). No benefits are deducted when the claim is brought under the Fatal Accidents Act 1976.

62. IIDB and the 1979 Act - The rule in **Hodgson v Trapp** requires that IIDB be deducted from damages. In **Ballantine v Newalls Insulation Company Ltd**³ the Court of Appeal considered awards under the Pneumoconiosis, etc (Workers’ Compensation) Act 1979 and ruled that such sums had to be set off against all damages in conventional personal injury claims – *i.e.* not Fatal Accident Act 1976 claims. When a worker has died of mesothelioma (or any other condition) and his estate brings a claim, there are usually two parts to that claim:

- A claim under the Fatal Accident Act 1976 on behalf of the Deceased’s dependants; and
- A claim under the Law Reform (Miscellaneous Provisions) Act 1934 on behalf of the Deceased’s estate. Included in this will be any claim that the Deceased would have been able to make on his own behalf had he not died – such as general damages for pain, suffering and loss of amenity, or any loss of earnings between the onset of the disease, and the death⁴.

63. The Court of Appeal did not consider Fatal Accident Act 1976 claims, but the wording of s.4 is quite clear. The Court of Appeal did not consider Fatal Accident Act 1976 claims, but the wording of s.4 is quite clear: “In assessing damages in respect of a person’s death in an action under this Act, benefits which have accrued or will or may accrue to any person from his estate or otherwise as a result of his death shall be disregarded.” However, a claim for general damages can only be brought, not under the Fatal Accident Act 1976, but under the Law Reform (Miscellaneous Provisions) Act 1934. It is a claim on behalf of the Deceased’s estate for damages for losses sustained by the Deceased during his lifetime. If the

³ Court of Appeal, Aldous LJ, Robert Walker LJ, Buxton LJ. Case No: A2/99/1165 15th June 2000.

⁴ For example: C is aged 60 when he is diagnosed as suffering from mesothelioma. His condition forces him to give up work, and he dies two years later, leaving a widow behind him. His estate has a claim under the Law Reform (Miscellaneous Provisions) Act 1934 for the loss of earnings from age 60 to age 62, and his widow has a claim under the Fatal Accident Act 1976 for loss of dependency from age 62 onwards.

Fatal Accident Act does *not* apply, **Ballantine** does, and there must be credit for the payments. The key passages of **Ballantine** come in the following paragraphs:

“This clearly is a payment in respect of the injury. In my judgement it is, and is intended to be, a payment in respect of all aspects of the injury, conspicuously including pain, suffering and loss of amenity, because it is self evident with this disease that someone who suffers it is going to suffer, in the most extreme degree, pain and suffering...”

“Mr Allan [for the Claimant] had a further argument. This was the principle, as he expressed it, that a set off must be on a basis, and only on a basis, of like for like: that is to say, that as a matter of principle and under the application of the **Hodgson v Trapp** principle, one could only set off a payment against a payment for a like aspect of the claim...”

“[But] even if one accepts the “like for like” principle, it does not help in this case. It does not help because it can only be effective if the claimant can say, as has been sought to be said in this case, that the 1979 Act payment cannot be attributed to anything at all. I disagree. Far from not being able to be attributed to anything at all, it is attributable to the whole of the loss. Therefore even if the like for like payment rule is adopted, this case, in deducting the payment from the whole of the loss, squarely fulfils its requirements. In my judgement, therefore, as a matter of principle, and looking at the principle of this case, it is right that the whole of the 1979 Act payment should be deducted from the damages.”

“As a matter of principle, the 1979 Act payment is deductible from the total of damages as a whole. I would, however, go further and say this. Though I would not wish to make any final judgement on this point, it seems to me desirable that the judge should allocate that deduction amongst the various heads of loss that he has identified. In practical terms we were told that a trial judge will identify separate heads of loss, and indeed by section 15 of the 1997 Act he is obliged to identify the award that he makes in respect of those items of damage that are set out in Schedule 2 to that Act. As at present advised, my view is that the fairest way of so allocating is simply to allocate the deduction pro rata amongst the various heads of damages.”

64. Personal Injury Trusts – Mr Levene highlighted that trust law is very technical, and specialised legal advice should **always** be sought in connection with this section. Most Claimants will be given this advice by their solicitors, who should understand trust law. Many injured Claimants will be receiving DWP benefits as well as their damages. They will usually have been receiving their benefits long before their claims have settled. If their benefits are means-tested, the DWP will take their damages into account when assessing their means. Many benefits will therefore be reduced or come to an end when the Claimant receives his damages unless steps are taken to prevent this. There is a legal device – which is approved by the DWP – which takes damages out of means-testing.

65. Damages can be put in a **personal injury trust**; they are then treated as “disregarded assets” by both the DWP and by local authorities. The effect is to preserve means tested benefits. A substantial award of damages will disentitle the claimant to the benefit (when the total household capital is greater than £16,000). Personal injury trusts are approved by the Income Support (General) Regulations 1987 at Sch.10, para.12 (as amended) and

by the National Assistance (Assessment of Resources) Regulations 1987, Sch.4 (as amended). This says that where trust funds come from damages, the value of the trust fund *and any income that the fund generates* are disregarded in the means testing assessment for benefit.

66. The key point of a trust is that *the money is specifically not to be used to fund "normal expenses of daily living" or the "standard rate" of care.* In other words, the Claimant must be able to say to the DWP or local authority "look, I can't touch any of this money to pay for food/housing/care etc."

67. Personal injury trusts are not appropriate for every Claimant. Awards of £3,000 or less do not justify a trust. The drawbacks from a Claimant's point of view include:

- Loss of direct control of the compensation funds,
- The costs of setting up the trust;
- The cost of running the trust;
- They may not be appropriate where the Claimant's medical condition might improve, or he might return to work or cease to need care.

68. A proper written trust deed is essential. There have to be at least two trustees. The claimant is the trust beneficiary. If the deed is a sham, the DWP or local authority may refuse to recognise it. There is a 52-week "period of disregard" so far as means-tested benefits are concerned. This means that the trust *must* be set up within 52 weeks of the date when the Claimant receives his first compensation from the Defendant. This does not just mean the final payout. The following can trigger the 52-week period:

- An interim payment from the Defendant.
- Any kind of insurance payment (medical treatment or lump sum) from the Defendant.
- Any ex-gratia payment made by the employer before settlement.
- *The Claimant's advisors should therefore have trusts in mind from a very early stage, because Defendants are encouraged to make early interim payments.*

69. The disregard relates only to means tested state benefits. It does not apply to local authority provision of care and support. So far as the latter is concerned, a Claimant should be careful to ensure that the trust deed is in place before settlement payment is made. The Defendant should pay the damages directly into the trust. They should not pass through the Claimant's hands.

70. There are no tax savings to be made by putting damages into a trust.

71. The authors of Kemp and Kemp sum up personal injury trusts as follows:

“The potential benefits of a trust cannot be ignored. It should form part of the package of services provided by the personal injury lawyer, even though it relates to a post-compensation environment. Personal injury lawyers should, in all cases of any substance, actively facilitate the access by claimants to specialist advice and assistance. It should be considered before both final and interim payments of damages.

The continuation of means tested benefits can help to bridge the compensation gap in cases of contributory negligence.

Advice should not be restricted to a claimant who is in current receipt of means-tested benefits. An award may usefully be protected from future care-related means testing, long before the need for expensive provision arises.

The creation of a trust can introduce a beneficial “peace of mind” factor for the claimant. Moreover, protection for vulnerable claimants from themselves or others can be secured through the appointment of trustees. A trust may also prove to be a useful administrative vehicle for claimants with no experience of handling large sums of money.

The trust fund can be used flexibly and constructively. It will support payment for all reasonable needs, provided there is no duplication with the need for which the means-tested benefit is intended to pay.

Care costs can be paid from the trust, so long as they are directed to the care provider and not placed in the hands of the claimant. In this way they will not be treated as income. Good practice indicates that appropriate advice should be sought once the likelihood of a personal injury award crystallises.

The professional fees of the specialist adviser should be investigated and considered against the benefits of the trust arrangement. The fees will not be recovered from the defendant in the litigation claim. Again, the ongoing administrative costs of a trust should be investigated and considered against the benefits of the arrangement. The fees and other charges will not be recovered from the defendant. The fees and expenses of a trustee will not be capable of recovery, save perhaps if the claimant does not have full mental capacity”.

Osteoarthritic conditions

Professor Keith Palmer

- 72.** Professor Palmer's presentation focussed on two recent reviews of osteoarthritic conditions – back and neck disorders and knee osteoarthritis.
- 73.** According to the HSE's Self-reported Work-related Illness (SWI) survey, 1 million musculoskeletal disorders are caused or made worse by work, with just under half of those disorders being due to back pain. Back and neck disorders are clearly an important occupational health problem, but one which poses a tough challenge for prescription.
- 74.** Spinal pain is common. The exact frequency of back pain depends on the definition of the condition - where it is felt and how long you feel it for. The prevalence of ever having had low back pain is 60-80%, compared with a prevalence of 17-31% of having current low back pain. For neck pain, the prevalence is greater than 60% for ever having had the condition, with 14% having had greater than a week of neck pain in the past month.
- 75.** For most people spinal pain is episodic. If one considers a cross-section of individuals attending their GP with low back pain, most cases will be new episodes, a small number will be persisting ones and some will have acute and chronic episodes. After three months, the back pain in many individuals will have improved or gone away, but around half will have got worse or remained the same.
- 76.** The traditional concept of back pain is that there is a larger proportion of individuals with acute low back pain ('the mountain') compared to a small proportion of individuals with chronic low back pain ('the molehill'). In practise, low back pain follows a less defined path, with individuals having back pain that fluctuates over time, sometimes being worse, sometimes better along a continuum. This poses a challenge to prescription as back and neck pain are transient problems.
- 77.** Most people with back pain who go off work recover relatively quickly. However, a small fraction develops chronic health problems, remaining off work for a significant period of time. It is a challenge clinically and in compensation to identify those individuals likely to develop long-term problems among the many with more minor illness.
- 78.** There has been an epidemic of back pain disability nationally, with an 8-fold increase in the number of days of sickness and invalidity benefits claimed for back pain in the last 50 years. Paradoxically, the physical demands of work have fallen over this period. The current back pain epidemic cannot be explained by physical risk factors alone, and seems due in part to psychosocial and cultural differences.

- 79.** The sensation of pain, or nociception, is felt by the brain. According to Loeser's model of chronic pain, personal factors such as pain behaviour, suffering and the degree of pain all alter the experience of pain.
- 80.** There are personal and cultural predisposing factors to the experience of pain. Personal factors include gender, personality traits, and mental health. Cultural factors include an individual's beliefs about illness, media publicity and the availability of compensation schemes.
- 81.** These influences can be quite strong. A one-year follow-up study looked at the psychosocial predictors of back pain in patients registered with GPs in South West England. The study found that the worse the state of distress observed at the beginning of the study, the greater the risk of new pain or old persistent pain occurring by the end of the study.
- 82.** In the same study, individuals with pessimistic views about the long-term outlook of their back pain were more than twice as likely still to have problems with their backs in 12 months time. The excess risk of persistent back pain remained after the data were adjusted statistically to allow for mental health beliefs and pattern of pain at the start of the study.
- 83.** Psychosocial factors are clearly an important part of the experience of back pain. But spinal pain is multi-factorial and it is well recognised that physical risk factors can also make things worse.
- 84.** The National Institute of Occupational Safety and Health in the USA has reviewed evidence relating to back pain and concluded that there was strong evidence that lifting/forceful movements and whole body vibration were causal risk factors.
- 85.** As outlined in an earlier talk, when considering the case for prescription for any occupational disease, IAC looks for a workable and robust diagnosis, a disease that causes genuine and lasting impairment, exposures that can be verified within the Scheme by lay administrators, and sufficient evidence to make occupational attribution likely in the individual case.
- 86.** The scientific evidence should come from several independent studies. There are numerous studies on spinal pain, and this criterion for prescription is readily satisfied.
- 87.** Although many cases are acute and resolve by themselves, back pain is sometimes a cause of genuine permanent and disabling impairment and so for some people this condition is also met.
- 88.** Certain exposures, such as increased load, repetition and posture, have been associated with increased back pain. It would be difficult for the IADB Scheme decision maker to verify those exposures. However, prescription for back pain could be based on job titles, if there were evidence that any specific jobs were associated with a sufficiently increased risk of back pain, so this criterion might be achievable.

- 89.** For diseases with no unique clinical features and with both occupational and non-occupational causes, IAC seeks epidemiological evidence of a greater than doubled risk that the disease occurs in exposed compared to non-exposed individuals to fulfil the attribution question. However, for very common definitions of the outcome it is difficult to demonstrate a greater than doubled risk. (More than 60% of the general population have experienced back and neck problems by certain definitions. It is not possible to have a greater than doubled risk in a worker subgroup as it is impossible to have 120% affected). For less common outcomes (e.g. very severe back pain), a doubling of risk might be possible; but this consideration sets a limit on the range of outcomes where a 'balance of probabilities' attribution can be made.
- 90.** To fulfil the criteria for prescription back and neck disorders must also be diagnosable. However, back and neck pain are symptoms and not diseases. To corroborate their existence, a patient might be examined by a doctor for local tenderness or painful/restricted movement or asked to undertake a 'functional capacity evaluation' (e.g. shuttle walk test, '1 minute of standing' test) or to fill out a standardised disability questionnaire. But none of these methods provide a truly independent measure of the outcome; they are semi-objective, all requiring the co-operation and input of the claimant.
- 91.** Could X-rays and CT or MRI scans be used to provide independent corroboration for back and neck disorders? In many cases, the amount of pain and disability felt does not correlate well with degenerative changes observed on X-rays and CT or MRI scans. For example, X-rays of several thousand people in Wales showed significant lumbar disease (grade 3-4) in 18% of men and 12% of women, and diseases of any grade in 74% of men and 59% of women. The people recruited for this study were not patients with back pain but ordinary members of the general population. Similar results were observed with X-rays for cervical disease in the general population. After a certain age most people will have some degree of degenerative changes observed by X-rays.
- 92.** MRI scans of patients without back pain also show up a broad range of back conditions and are poor in corroborating the presence of active back problems. Disc bulging, disc protrusion and annular tears are observed in 73%, 50% and 37% respectively of MRI scans of patients *without* back pain at the time of investigation.
- 93.** Objective disease verification would be difficult within the IIDB Scheme. Ongoing research may identify subgroups in which an objective diagnosis can be supported but this lies in the future. Back and neck pain are examples of tough cases for prescription.
- 94.** In July 2007, IAC published its position paper 'Back and neck disorders'. IAC were unable to recommend prescription for back and neck pain due to inherent difficulties with case definition and diagnosis at the time.

- 95.** Professor Palmer went on to discuss the Council's review of knee osteoarthritis (OA) in miners as an example where prescription has proved possible despite some obstacles.
- 96.** Traditionally, mining involves heavy work involving miner's using their knees, e.g. when stooping, crawling and heavy lifting. Former members of the Council asked IIAC to consider evidence relating to OA knee in miners.
- 97.** Diagnosis of OA knee is straightforward using X-rays. In contrast to back pain, there is good correlation between symptoms (knee pain) and the appearance of osteoarthritic changes on an X-ray (such as narrowed joint space, bone spurs). OA knee satisfies the criteria for prescription in that the disease is verifiable within the scheme.
- 98.** OA knee is also a cause of genuine impairment as it can cause significant pain, stiffness, disability. Some patients with severe OA knee require knee joint replacements.
- 99.** There have been only a few high quality studies which have investigated OA knee in miners, all published in the 1950s. Lawrence (1955) showed that miners were 2.5 - 5 times more likely than office workers to have OA knee, and 2.3 times more likely than manual workers. Kellgren and Lawrence (1952) showed that miners were six times more likely to have severe osteoarthritic changes than office or manual workers and twice as likely to have mild changes.
- 100.** Greinemann (1997) published a study of knee OA in miners in Germany. The knee joint is a complex joint composed of several different areas, all of which can be affected by 'wear and tear'. This study showed that OA of the retropatellar part of the knee joint (i.e. behind the knee cap) was 3 times more common in miners compared to non-miners. Arthritis affecting all of the knee joints (panarthrosis) was 9 fold more common in miners compared with non-miners. However there were technical limitations to this study.
- 101.** IIAC concluded that the risks of OA knee were greater than doubled, fulfilling the scientific requirements for prescription. However, IIAC generally seeks evidence of a doubling of risk in a greater number of independent studies than have been conducted. The direct evidence of an association between OA knee and mining is rather limited.
- 102.** IIAC therefore sought indirect evidence to complement the direct evidence, considering research about OA knee due to activities typically undertaken by miners. There was a body of evidence relating to OA knee due to kneeling and squatting under heavy load, most of which shows the risks were greater than doubled in those undertaking both of the activities in question. Coggon (2000) and Cooper (1994) reported a 2.9 fold and 5.4 fold increase respectively in OA knee in those undertaking *both* squatting *and* heavy lifting. The Framingham study (Felson, 1991) showed that the

combination of knee bending and strength demands doubled the risk of developing mild or severe OA knee. Typical exposures common in mining are the kinds of exposures leading to OA knee.

- 103.** A second form of indirect evidence concerned knee cartilage injury in miners. It is well known that injuries to the knee cartilage markedly increase the risk of developing OA knee. One study in North Yorkshire by Sharrad showed that the job title of miner appeared on surgical lists for removal of the knee cartilage four and five times more often than on lists for surgical removal of the appendix. Greinemann showed that miners were four times more likely to have knee cartilage injuries compared with controls.
- 104.** The direct evidence together with the indirect evidence was deemed sufficient in sum to satisfy the scientific requirements for prescription.
- 105.** IAC was aware that mining practises had changed considerably over time, with exposures to kneeling, squatting, and heavy lifting becoming less as mechanisation of the mines progressed. IAC consulted with the HSE Mines Inspectorate, mining unions and various mining experts and mine owners to identify a suitable time period for qualifying exposures.
- 106.** In August 2008, IAC published its Command paper 'Osteoarthritis of the knee in miners' where the Council recommended that OA of the knee be added to the list of prescribed diseases for work for 10 years or more in aggregate as a) an underground coal miner before 1986 and/or b) in certain qualifying jobs (such as a faceworker on a non-mechanised coal face) from 1986. (The Council has since been asked to consider the cut off point of 1986 and the list of qualifying occupations after this date, and this is in the forward workplan).
- 107.** OA of the knee in miners is an example of a tough case for prescription. Prescription was possible in this instance due to the combination of limited but high quality direct evidence and a volume of good quality indirect evidence showing a greater than doubled risk of an association. The use of direct and indirect evidence is a new approach for IAC. IAC's work programme in the future will give consideration to using this new principle, where possible, to widen the prescription of OA of the knee to other occupations, perhaps including construction workers.

Comments, questions and answers

- 108.** *What is IAC's view about previous knee injuries being taken into account to reduce a percentage assessment in medical examinations for PD A14? Durham Miners Association* – IAC and the DWP are aware of the issue. The Department has taken on board claimants' concerns and are taking steps to address the problems. There is a series of steps involved in deciding a claim for IADB:
- i) is/has the claimant been in the prescribed occupation?;

- ii) has the claimant been diagnosed with the prescribed disease in question,
- iii) can the disease be presumed to be due to the occupational exposure (presumption question)? and finally;
- iv) what is the assessed disablement?

Problems of co-existing causes (occupational and non-occupational factors present together in the same individuals) may arise both in relation to the presumption question and to the question of assessed disablement. The Council's view is that where miners with pre-existing knee injury satisfy the terms of prescription, their disease should be presumed as due to their occupation (the presumption question), and that the underlying secondary legislation in this area could be usefully clarified across the whole Scheme. A review is planned, which will also consider the process of assessing percentage disablement (a separate and more complex issue).

- 109.** *Why do underground miners require 20 years exposure to qualify for the prescribed disease chronic bronchitis and emphysema but only 10 years to qualify for OA knee? National Union of Mineworkers* –The qualifying period of exposure recommended in the prescription for chronic bronchitis and emphysema is based upon evidence that at least 20 years exposure is required for the development of disabling loss of lung function, and at least 10 years for the development of OA knee of sufficient severity.
- 110.** *Recently a union member was awarded 20% disablement for his OA knee but it was deemed that 19% was due to a broken leg he had sustained 20 years previously and only 1% was due to his occupation. He was therefore only given 1% disablement for PD A14. Mr Terry Fox – National Association of Colliery Overmen, Deputies and Shottfiringers* - The causation/presumption question is not the same as the disablement question. A claimant can pass the causation test with occupational OA knee and a previous knee injury but the impact of both the occupational and non-occupational causes of the disease are normally taken into account during the assessment for disablement. It is a difficult probability decision for the decision maker and medical adviser to apply, however, and is a topic IAC intends closely to review.
- 111.** *Why are claimants who have won civil claims for vibration white finger (VWF) told they do not qualify for PD A11 (Hand Arm Vibration Syndrome (HAVS)) as they do not have VWF? Mr Chris Skidmore - National Union of Mineworkers* – To qualify for PD A11 the claimant must satisfy the terms of prescription for the prescribed disease, which provides benefit for severe cases of HAVS. A claimant may have VWF as judged by civil claims but not have the prescribed disease VWF (i.e. the qualifying severity and pattern of symptoms). Many qualifying cases of VWF are still assessed at less than 14% and so do not attract payment in the absence of aggregation. Diagnosis of VWF can be difficult as the medical advisers must rely on the customer's patient history as it is rare to witness an attack during an examination.

112. *Why is there only a 20 minute medical assessment for PD A11 compared to the 1.5-2 hour medical examination for the Department for Trade and Industry compensation scheme for VWF? Why is the evidence from the DTI scheme not able to be used to support a claim for PD A11 in the IIDB scheme? National Union of Mineworkers – Dr Ian Lawson was part of the medical reference panel for the DTI scheme. The panel were asked to identify robust objective tests for the vascular (i.e. VWF) and sensorineural components of HAVS which were sensitive and specific. Consequently, a battery of tests was included in the medical examination for the DTI scheme. However it became apparent that these tests were not sufficiently sensitive or specific when tested using large populations and that a good clinical history was the best way to diagnose VWF. Medical advisers for the IIDB scheme rely on obtaining a good clinical history in assessing claimants for PD A11. In considering whether additional evidence can be used to support a claim for IIDB, the Department must consider equality issues and whether there is capacity in the NHS to accommodate diagnostic tests claimants may ask for to support their IIDB case. Additional medical evidence can be used to support a case for IIDB in certain cases.*

Asbestos related diseases

Professor Mark Britton

- 113.** Professor Britton reviewed the Council's work on asbestos-related disease.
- 114.** Asbestos is a naturally occurring fibrous silicate which is separated into two major types, serpentine and amphibole. In the serpentine group is chrysotile or 'white' asbestos, and in the amphibole group are crocidolite ('blue' asbestos), amosite ('brown' asbestos), tremolite and anthophyllite. These materials are mined in a number of countries including Russia, South Africa and Canada.
- 115.** The exposure to asbestos has been quantified for a number of occupational job titles, since exposure will vary between practices. For practical purposes, asbestos exposure is defined as the number of fibres per ml of air (fibres/ml). For example, a person applying asbestos lagging would be exposed to approximately 60 fibres/ml, whereas a person involved in spraying asbestos would be exposed in excess of 50,000 fibres/ml. In addition to this, quantification of cumulative asbestos exposure may be defined which takes into account the number of years of exposure and expressed as an average fibres/ml years.
- 116.** The asbestos fibres can be seen in lung tissue and in sputum. Some fibres may be encapsulated by cells of the body's defence system which try to digest them. These are called asbestos bodies. As such they may be counted. Asbestos body counts are a useful measure to determine exposure but there are some caveats to their interpretation. Some forms of asbestos such as chrysotile, are less likely to become coated which makes them more difficult to detect and count; inter-laboratory differences in counting methodology may give different results; sampling errors may lead to over- or underestimation of the number of fibres and there may be differences in fibre counts between the lobes of the lungs of the same person.
- 117.** There are a number of prescribed diseases which relate to asbestos exposure. These are asbestosis (PD D1), mesothelioma (PD D3), lung cancer (PD D8) and pleural thickening (PD D9). These conditions were the subject of an IIAC review, published as Command Paper 6553, 'Asbestos-Related Diseases' (July 2005) which involved analysis of IIDB and population statistics for asbestos-related diseases, consultations with a variety of experts and DWP officials and reviewing scientific literature.
- 118.** IIAC revisited the topic of pleural plaques in 2009 following a Ministerial request to do so. This was a result of the rulings on pleural plaques in the Scottish courts and the debates that stemmed from that decision.

- 119.** The pleura is a thin membrane consisting of two layers which cover the lungs and chest wall. Fluid produced in the space between the layers facilitates breathing without causing friction. Exposure to asbestos causes pleural diseases such as pleural plaques (calcified pleural and diaphragmatic plaques), benign asbestos pleurisy, diffuse pleural thickening and round atelectasis.
- 120.** Pleural plaques are the most common, but often the only, condition associated with asbestos exposure. Like other asbestos-related conditions, pleural plaques develop many years after asbestos exposure. They occur after low dose, intermittent exposure (similar to mesothelioma). Pleural plaques are areas of hyaline fibrosis, which are usually on the parietal pleura. The apices and costophrenic angles are spared. They tend to follow the line of the ribs and can be found in the paravertebral gutters and over central tendons of the diaphragm. It is not fully understood how fibres cross the pleural space but theories include fibres directly crossing the space, entering through the lymphatics against the normal direction of lymphatic flow or being transferred by mediators.
- 121.** Pleural plaques do not normally cause symptoms but may have a minor effect on lung function which does not result in any disability. They are not pre-malignant, but are an indication of exposure to asbestos which may indicate an increased risk of associated diseases. They do not require treatment but may be a source of anxiety.
- 122.** In IIAC's review of asbestos-related diseases in 2005, the Council recognised that symptomatic pleural plaques can occur but that there was a lack of evidence that they cause impairment of lung function sufficient to result in disability. The 2009 review of pleural plaques extensively considered the evidence available and concluded that the Council's position on pleural plaques had not changed since the 2005 review.
- 123.** Benign asbestos pleurisy is associated with pleuritic pain and breathlessness but which may be symptom free. Effusions are often bloodstained. The condition may resolve but can result in diffuse pleural thickening.
- 124.** Diffuse pleural thickening affects the visceral pleura, the costophrenic angle is often obliterated. The pleura may be several cm thick and the pleural layers may fuse together. This condition may produce a restrictive defect which causes disablement.
- 125.** Prior to 2005 diffuse pleural thickening (PD D9) was prescribed for unilateral cases affecting at least 50% of chest wall or bilateral cases affecting at least 25% each side. To be eligible for prescription there had to be a minimum of 5mm thickness at one point within the pleural area affected, as measured on a plain chest radiograph. After examining the evidence in the 2005 asbestos-related diseases review, the Council recommended amending the prescription to remove the requirement for measurements of pleural thickening and instead introduce the requirement

for involvement of the costophrenic angle on plain chest radiographs. The occupational coverage remained unchanged.

- 126.** The definition and guidance within the ILO system regarding the Costophrenic Angle Obliteration is as follows:

“The lower limit for recording costophrenic angle obliteration is defined by the Standard Radiograph I / I , t / t . If the pleural thickening extends up the lateral chest wall from the obliterated costophrenic angle, the thickening should be classified as diffuse pleural thickening. Costophrenic angle obliteration may occur without diffuse pleural thickening”

- 127.** Progress in diagnosis of early stages of diffuse pleural thickening using computed tomography (CT) scans has been made in recent years. Fibrosis involving the visceral pleura can be focal or diffuse as viewed by CT scanning. When focal, the visceral changes appear as small, pleuro-parenchymal fibrous strands, known as "crow's feet". When extensive, the pleural fibrosis is called "diffuse pleural thickening", usually accompanied by blunting of the costophrenic angles.

- 128.** Rounded atelectasis is also known as folded lung or Blesovsky's syndrome. It is a pseudo-tumour and a consequence of retractile visceral diffuse pleural thickening/fibrosis.

- 129.** Asbestosis has been defined as “fibrosis of the lungs caused by asbestos dusts which may or may not be associated with fibrosis of the parietal or pulmonary layer of the pleura” (Acheson ED, et al. Asbestos: Final report of the Advisory Committee. Vol 2: The ill effects of asbestos on health. HMSO, London 1979). Asbestosis can be defined clinically, radiologically, physiologically and histologically by a history of substantial asbestos exposure, clubbing, crackles, radiological changes on plain X-ray, restrictive defect with reduced KCO (transfer coefficient for carbon dioxide), HRCT (high resolution chest computed tomography) abnormalities and asbestos bodies seen in tissue sections.

- 130.** The CT features of asbestosis involving the lung tissue include curvilinear sub-pleural lines, parenchymal bands, thickened interlobular (septal) and intralobular (core) lines and honeycombing. These CT features are non-specific as they may also be observed in pulmonary fibrosis due to other causes.

- 131.** For asbestosis, PD D1 (pneumoconiosis), diagnosis is made based on a clinical and radiological diagnosis. Histological proof is not necessary. In ILO's 2005 review of asbestos-related diseases it recommended that:

- Diagnosis of asbestosis should be based on clinical evidence of interstitial lung fibrosis and a history of substantial occupational exposure

- Absence or low numbers of asbestos bodies or asbestos fibres in the lungs should not exclude a diagnosis of asbestosis in claimants with a history of substantial occupational asbestos exposure.
- The list of occupational exposures in the terms of prescription should remain unchanged

132. The association between asbestos exposure and lung cancer has been suspected since the 1930s and was clarified in 1955. The involvement of fibrosis in the development of asbestos-related lung cancer has been the subject of much debate. There are two hypotheses. First that asbestosis must be present because the fibrosis itself is necessary to increase the risk of cancer. The second hypothesis is that the asbestos “dose” necessary to produce cancer is at least equal to the dose necessary to produce asbestosis, but asbestosis need not be present. It is also unclear whether there is a threshold dose of exposure to asbestos necessary for the causation of lung cancer, or whether exposure and the risk of the disease proceed along a linear continuum.

133. Increased knowledge of the biology of carcinogenesis makes the hypothesis that fibrosis is a pre-requisite to developing lung cancer unlikely. There is also good evidence that there is an increased risk of lung cancer in the absence of asbestosis. The levels of exposure that are estimated to cause a doubling of risk are 25-100 fibres/ml years. These factors are also affected but not wholly explained by exposure to different fibre types.

134. The risk of lung cancer increases with exposure to asbestos but there is a smaller relative risk than for contracting mesothelioma. For example, a person subject to ‘heavy’ asbestos exposure has a 1000-fold risk for contracting mesothelioma but only has a 5-fold risk for developing lung cancer. A worker subject to ‘light’ asbestos exposure has a substantial increase in risk for mesothelioma but no significant increase in risk for lung cancer.

135. Different asbestos fibre types produce different risks of mortality from lung cancer, such that exposure to amphiboles doubles the risk of dying from lung cancer compared with exposure to chrysotile.

136. A meeting of experts, representing 8 countries which do not manufacture asbestos, was held in Helsinki in 1997 to discuss the attribution of lung cancer to asbestos. The Helsinki Criteria were derived from the discussion held at the meeting and were published as a consensus document in the ‘Scandinavian Journal of Work and Environmental Health’ (23: 311, 1997). The main criteria for attribution of lung cancer to asbestos exposure are:

- i) radiological or pathological diagnosis of asbestosis.
- ii) fibre count in asbestosis range in same laboratory.
- iii) 5,000-15,000 asbestos bodies/gram of dry lung.

- iv) more than 5 million fibres with more than 1 µm long per gram of dry lung, or more than 2 million fibres longer than 5 µm long as determined by electron microscopy.
- v) Occupational history indicating exposure above 25 fibre/ml years.
- vi) One year of heavy exposure, e.g. lagging, or 5-10 years of moderate exposure, e.g. shipbuilding, construction.

137. The outcome of the Helsinki meeting was considered carefully by IIAC. The Council's view was that after consulting the experts and the scientific literature that there was insufficient evidence on which to base prescription on the criteria of 25 fibre/ml years.

138. With regard to the IIDB scheme, there was a good case for prescription of lung cancer on the basis of a cumulative asbestos exposure sufficient to give rise to risk of asbestosis. Therefore, IIAC recommended that primary carcinoma of the lung should be prescribed in relation to asbestosis. Despite lung cancer being common in the general population the evidence showed a 4-5-fold risk of the disease in the presence of asbestosis. The question that IIAC considered was whether the risk for lung cancer was at least doubled in those who have substantial exposure to asbestos without asbestosis.

139. The recommendations for prescription of primary carcinoma of the lung were made in the 'Asbestos-Related Diseases' report. These recommendations are:

- i) Lung cancer should remain prescribed in relation to asbestosis and that no changes should be made to the occupational categories for asbestosis.
- ii) Lung cancer in those without asbestosis but who have a history of substantial exposure to asbestos should be prescribed:
Exposure for at least 5 years before 1975 and 10 years after 1975 in the following occupations:
 - a) Asbestos textile manufacture.
 - b) Asbestos sprayers.
 - c) Asbestos insulation work.
 - d) Asbestos workers in shipbuilding, including those applying and removing asbestos containing materials.
- iii) Claimants eligible for PD D8 should be assessed at 100%.
- iv) Reference to pleural thickening should be removed from terms of prescription.

140. Malignant mesothelioma is a cancer of the pleura or peritoneum (the membranous lining of the abdomen) caused by asbestos exposure. In recent years we have seen an epidemic of mesothelioma deaths. Peto *et al.* (1995) estimated that the peak of the UK epidemic of mesothelioma

caused by asbestos exposure will not be reached until 2020, with two thirds of the cases yet to occur. This is due to the long latency period of the disease, with most cases presenting 40 years after initial exposure to asbestos. It is unusual for the disease to present within 20 years of exposure. Different asbestos fibre types (amosite, crocidilite, etc.) produce different risk estimates for mesothelioma. Most occupational exposures were to mixed fibre types. Risks are also dose-dependent and time-dependent. The amphibole asbestos fibre types are associated with the highest risk of developing this disease. According to national death data published by HSE in 2006 there were almost 1,800 male and 300 female deaths due to mesothelioma.

- 141.** Unlike asbestosis and lung cancer, low doses of exposure are causative but the risk increases with increased exposure. Nowadays patients include people employed as carpenters, electricians and plumbers who have low dose exposure. In the past most cases of mesothelioma occurred in heavily exposed workers, such as ladders and shipyard workers
- 142.** Mesothelioma presents with clinical symptoms, such as chest pain and breathlessness. The chest X-ray and the CT scan show either a pleural effusion or irregular pleural thickening, possibly resulting in a reduction in thoracic volume. Diagnosis is confirmed by biopsy often obtained by thoracoscopy; however diagnosis can be difficult and the recent availability of PET (positive emission tomography) scans has helped increase positive biopsy rates.
- 143.** Mesothelioma (PD D3) first became a prescribed disease in 1966. In 1997, IAC recommended amending the prescription by broadening occupational coverage to 'exposure to asbestos, asbestos dust or any admixture of asbestos at a level above that commonly found in the environment at large'. The 90 day waiting period was also removed due to the short life expectancy of mesothelioma sufferers. The prescription was amended further in 2002 so that all mesothelioma assessments were automatically awarded 100% disablement. A fast-tracking process for claims for terminally-ill claimants was also introduced to IIDB district offices with medical assessments no longer being necessary.
- 144.** The review of mesothelioma, as part of the 2005 review of asbestos-related diseases, focused on examining why there was an apparent discrepancy between the number of people gaining benefit for IIDB and the number of mesothelioma deaths. Following analysis of the data, the discrepancy was found not to be due to claimants being refused benefit but because potential claims were not being made. It was surmised that the reasons for mesothelioma sufferers not claiming IIDB could be that people were too ill to claim, sufferers were self-employed or non-occupationally exposed and were aware of the scheme's exclusions, claimants had a belief that the DWP required medical assessments and extensive corroborative evidence for the claim to be successful or that there was a lack of awareness of the scheme. IAC recommended that the

Department highlight the availability of the PD D3 mesothelioma IIDB provisions to potential claimants. The Department consulted with claimants groups, the British Lung Foundation and lung cancer nurses and updated the Departmental website for doctors.

- 145.** As a consequence of this information IIAC recommended that the awareness of the scheme should be promoted. The British Lung Foundation has addressed this need by raising awareness of the IIDB scheme among lung cancer nurses in hospitals.
- 146.** The 2005 review found that the occupational coverage for mesothelioma was broad and no amendments were recommended.
- 147.** IIAC raised the problem of poor life expectancy in mesothelioma claimants who would receive a fraction of the total amount payable to those with less severe prescribed diseases who lived longer. IIAC also highlighted the problem of patients with no knowledge of any asbestos exposure or where the exposure was non-occupational.
- 148.** In March 2005 the British Lung Foundation organised a Mesothelioma Summit to bring together healthcare professionals, policymakers and other interested stakeholders. The outcome of this summit was the production of a Mesothelioma Charter for patients, a Mesothelioma Framework produced by the government's cancer Tsar, published in November 2006, and the launch of a Mesothelioma Action Day, held every year at the end of February.
- 149.** Other government initiatives have since been launched. The DWP in conjunction with the NHS released a leaflet to provide help and advice to mesothelioma sufferers about benefits available to them. These benefits include IIDB, the Pneumoconiosis, Byssinosis and Miscellaneous Benefit Scheme, Worker's Compensation (Supplementation) Act 1948 and the Pneumoconiosis (Worker's Compensation) 1979 Act. Mesothelioma patients in receipt of IIDB may also qualify for constant attendance allowance, exceptionally severe disablement allowance and reduced earnings allowance.
- 150.** New mesothelioma provisions have been introduced since October 2008 in the Child Maintenance and Other Payments Act. Under this scheme (separate from IIDB) a mesothelioma sufferer can obtain a single lump sum payment for asbestos exposures that do not have to be occupational. In the first 6 months of operation of the scheme there were 318 claims, with average lump sum payments of £16,000 each.
- 151.** Professor Britton went on to discuss asbestos and retroperitoneal fibrosis (RPF) which was the subject of an IIAC review in 2007. The cause of RPF is currently unknown but a number of possible risk factors have been identified. There was limited evidence suggesting that some cases of RPF may arise as part of an asbestos-induced fibrotic process. The Council concluded that the current evidence was insufficient to support a

case for prescription. However, IIAC strongly encourages further high quality research in this area and will continue to closely monitor new research reports.

Open Forum

Facilitator: Mrs Diana Kloss

- 152.** The members of IIAC thanked the attendees for their participation in the Public Meeting.
- 153.** *There seems to be confusion about involvement of the costophrenic angle for some claims. The medical advisers do not seem to read the X-rays themselves, but instead rely on the radiographer's report. On occasion this has not specified that the costophrenic angle has been obliterated and the claim has been disallowed. However according to a consultant physician the costophrenic angle is clearly obliterated on the X-ray despite not being recorded as such on the radiographer's notes. Should the medical advisers always read the X-rays themselves to diagnose diffuse pleural thickening? Mr Anthony Whitston – Greater Manchester Asbestos Victims Support Group.* For diffuse pleural thickening there is a correlation between the percentage disablement and obliteration of the costophrenic angle. The terms of prescription rely on a radiological definition of the disease and ideally medical advisers should make their diagnoses based on analysis of a claimant's X-ray records. The Council will highlight this issue with the Department.
- 154.** *Public and Commercial Services Union – Mr Mark Hibell – Do any of the IIAC members see functional differences between impairment and disability? Impairment and disability have very different meanings in legal terms and the Department has set definitions of these words. Impairment is a loss of function due to a health condition. Disability is the effect of the impairment on function. IIAC is supportive of disability rights.*
- 155.** IIAC Secretariat – Mr Gareth Roach commented on IIAC's work in general. *IIAC is undertaking a review of presumption and medical assessments and would welcome any attendee with concerns about this aspect of the Scheme to raise these with the Council. IIAC is unable to influence specific cases but can look at general issues and audit processes. IIAC make recommendations to Ministers and it is for Ministers to make any final decisions on implementation of IIAC's recommendations. IIAC is dependent on research being undertaken as it does not have a research budget itself. It is unable to make recommendations if the research is not there to support the decision. In previous years IIAC has had access to a small budget to commission secondary data analysis or literature searches. However, IIAC has not been given funding for this work for 2010/11 due to Departmental financial constraints.*
- 156.** Professor Keith Palmer thanked all those attending for their input to a highly constructive and useful meeting.

List of delegates

Surname	First Name	Organisation
Aldcroft	Richie	Chairman, Regional Health and Safety Committee – PCS NW England
Anderson	David	Knowledge Group Leader, Environmental Chemistry Environment Department, Corus RD&T Swindon Technology Centre
Aspin	Alan	UNITE
Ault	David	Branch President GMB Union
Baker	Kay	Registered Nurse Barrow Asbestos Related Disease Support, Hospice of St Mary Of Furness
Ball	Peter	Judge, Manchester Tribunals Service (Social Security and Child Support) North West Region
Barnes	Sheila	Professional Officer, Voice Care Services
Bartlett	Simon	National Industrial Injuries Disablement Benefit Manager Llanelli BDC
Bennett	Alex	National Union of Mineworkers
Bramhall	John	Deputy Chief Executive, Professional Footballers' Association
Britton	Mark	Industrial Injuries Advisory Council
Burns	Kay	Barrow Industrial Injuries Disablement Benefit Office
Caine	Allison	Occupational Health Business Management
Claughan	Lawrence	Executive Member, Durham Miners Association
Combs	Diana	Team member JCP Products and transformation Division
Cooper	Steve	National Union of Mineworkers
Cooper	Angela	Business support manager, JCP Merthyr Tydfil
Culley	Jennifer	Registered Nurse Barrow Asbestos Related Disease Support, Hospice of St Mary Of Furness
Cullinan	Paul	Industrial Injuries Advisory Council

Cummings	Alan	Executive Member, Durham Miners Association
Darnton	Andrew	Health and Safety Executive
Dellaway	Brian	Cheshire Asbestos Victims Support Group
Ellis	Colin	Workplace Health Advisor Rotherham Occupational Health Advice Service
Exell	Richard	Industrial Injuries Advisory Council
Faupel	Paul	Industrial Injuries Advisory Council
Fisher	Neil	Solicitor, John Pickering and Partners LLP, Liverpool
Fitzpatrick	Rob	National Union of Mineworkers
Flanagan	John	Merseyside Asbestos Victims Support Group
Fox	Terry	President NACODS
Gadd	Robert	Medical Advisor, Atos Healthcare
Gill	Ian	Social Insurance Officer, Union of Democratic Mineworkers
Griggs	Russel	Industrial Injuries Advisory Council
Grogan	Paul	Supply chain project leader Unilever Foods
Guy	David	National Union of Mineworkers
Hadfield	Dave	National Union of Mineworkers
Hadley	Nigel	Occupational Physician, Capita Health Solutions
Hajee	Zarina	IIAC Secretariat
Hardman	Kath	Hartlepool Industrial Injuries Disablement Benefit Office
Harris	Nick	National Union of Mineworkers
Hegarty	Catherine	IIAC Secretariat
Hibell	Mark	Assistant Branch Secretary/Equality & Diversity Officer/Health and Safety Representative PCS NW England Branch
Hopper	David	National Union of Mineworkers
Johnson	Kevin	Solicitor, John Pickering and Partners LLP, Liverpool
Johnson	Alan	Executive Member, Durham Miners Association
Kermode	Diane	Specialist Practitioner in Occupational Health, Kellogg Company of Great Britain Ltd.
Kidger	Paul	NUM
Kitchen	Chris	Secretary, National Union of Mineworkers
Kloss	Diana	Industrial Injuries Advisory Council

Lamb	Keith	Trustee, Durham Mechanics Trust
Lawson	Ian	Industrial Injuries Advisory Council
Leris	Clare	Health Work and Wellbeing Directorate
Levene	Simon	Industrial Injuries Advisory Council
McCowliff	Jack	Executive Member, Durham Miners Association
McElvenny	Damien	Industrial Injuries Advisory Council
McNulty	Joan	Health and Safety Officer, UNISON, Stockport
Mills	Tommy	National Union of Mineworkers
O'Neill	Fergus	Tribunal Worker, East Durham Citizens Advice Bureau
Palmer	Hilda	Co-ordinator, Greater Manchester Hazards Centre
Palmer	Keith	Chairman Industrial Injuries Advisory Council
Parker	Susan	Occupational Compensation Scheme, Health Work and Wellbeing Directorate
Porter	Andrew	Jobcentre Plus Products and Transformation Division
Ray	Duncan	Director, Raydar Safety Ltd., Health Safety and Environmental Solutions
Renshaw	Adrian	Health and Safety Rep, UNISON, Stockport
Roach	Gareth	IIAC Secretariat
Robinson	Dave	Branch Secretary, Unilever Foods
Sale	Sue	Health and safety rep, Springfields Fuels Ltd - Preston
Shackleton	David	Specialist in Occupational Medicine Occupational Health Solutions
Shears	Daniel	GMB National Health and Safety Officer
Shelton	Marianne	IIAC Secretariat
Skidmore	Chris	President, National Union of Mineworkers
Skirrey	Vaughan	Health and Safety Representative, UNISON
Smith	Pete	National Union of Mineworkers
Spurgeon	Anne	Industrial Injuries Advisory Council
Sullivan	Claire	Industrial Injuries Advisory Council
Thomas	Wayne	National Union of Mineworkers
Towers	Bobby	Occupational Compensation Scheme, Health Work and Wellbeing Directorate

Trickett	Andy	National Union of Mineworkers
Turner	Andrew	Industrial Injuries Advisory Council
Ward	Rob	Jobcentre Plus Products and Transformation Division
Watkin	Terry	Durham Mechanics Trust
Whitston	Anthony	Greater Manchester Asbestos Victims Support Group
Whitty	Fergus	Industrial Injuries Advisory Council
Williams	Deirdre	Health and safety rep, Springfields Fuels Ltd - Preston
Wilson	Nicky	National Union of Mineworkers
Wood	Jeffrey	President, Union of Democratic Mineworkers
Woodward	Natalie	Macmillan Development Worker, Derbyshire Asbestos Support Team