COVID-19 and Occupation: An Interim Report from the IIAC

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On 25 March 2021 the Industrial Injuries Advisory Council ("IIAC") published "*COVID-19 and occupation: position paper 48*" – found here. It will be of interest to disease and personal injury practitioners alike, and a great many other people besides.

On 1 April 2021 the BBC reported that: "*About one in five people have symptoms of long Covid five weeks after an initial infection and one in seven after 12 weeks, an Office of National Statistics (ONS) survey suggests. It estimates that 1.1 million people were affected in the UK in the four weeks from 6 February. About 20% of people said ongoing symptoms limited their day-to-day activities a lot*".

As the Summary to the Position Paper explains, the IIAC: "*considered it timely and necessary to review the evidence for the relationship between occupation and COVID-19 during 2020 whilst acknowledging that, as yet, there may not be sufficient good quality information to make definitive recommendations*".

That last point is important because the IIAC's remit is (i) to make recommendations to update the list of diseases and the occupations that cause them for which Industrial Injuries Disablement Benefit can be paid; and (ii) to draft papers for the Secretary of State for Work and Pensions to present in Parliament, where legislative changes to the Industrial Injuries Scheme are proposed. As those interlocking responsibilities may lead to significant claims on the public purse, a high threshold is applied to causation before recommending prescription, namely a more than 'doubling of the risk'.

As the IIAC routinely states in its reporting:

> "*The requirement for, at least, a doubling of risk is not arbitrary. It follows from the fact that if a hazardous exposure doubles risk, for every 50 cases that would normally occur in an unexposed population, an additional 50 would be expected if the population were exposed to the hazard. Thus, out of every 100 cases that occurred in an exposed population, 50 would do so only as a consequence of their exposure while the other 50 would have been expected to develop the disease, even in the absence of the exposure. Therefore, for any individual case occurring in the exposed population, there would be a 50% chance that the disease resulted from exposure to the hazard, and a 50% chance that it would have occurred even without the exposure. Below the threshold of a doubling of risk only a minority of cases in an exposed population would be caused by the hazard, and individual cases could not be attributed to exposure on the balance of probabilities. The epidemiological evidence required should ideally be drawn from several independent studies, and be sufficiently robust that further research at a later date would be unlikely to overturn it*".

So relatively soon into the pandemic or its wake, "*epidemiological evidence … drawn from several independent studies*" was likely to be lacking as reflected by the opening comment that "*there may not be sufficient good quality information to make definitive recommendations*". Accordingly, it is perhaps of little surprise that, applying the 'doubling of the risk' criterion, the IIAC does not recommend that Covid become a prescribed disease for any given occupations – yet.

That 'yet' is important. The report is self-described as being an "*interim* position paper". This is for the following reasons.

First, it is interim precisely because there are and will be a number of studies ongoing. Presently, there is limited scientific evidence on the exact modes of transmission of COVID-19 in both workplaces and community settings and scarce data on dose, exposure frequency and length of exposure in the workplace. The IIAC is therefore particularly interested in large good quality studies of workers and workplaces and also community-based studies regarding both death and long-term effects of infection with SARS-CoV-2. The common denominator here is the wish to see studies that enable an evaluation to be made of the risks posed in occupational settings relative to (i.e. compared to) those in community settings. This is challenging when assessing causation because the health effects arising from workplace

exposure to SARS-CoV-2 cannot be distinguished from infection transmitted in non-occupational circumstances. The Council thus looks for robust research evidence that the risk of developing the disease is more likely than not to have arisen from occupational exposure i.e. is more than doubled.

Secondly, the IIAC found at least a "clear association" between several occupations and an increased risk of death or serious ongoing injury from COVID-19. In terms of unpacking what is meant by clear association, there is a discussion of various studies as to relative risk ratios for different occupations. Indeed, some will say that the more than doubling of the risk criterion is (close to being) already fulfilled. This is because the summary to the report acknowledges:

> *"Analyses of UK death certificates between March and December 2020 show more than a two-fold risk in several occupations especially for males, including social care, nursing, bus and taxi driving, food processing, retail work, local and national administration and security. The number of occurrences of cases and deaths from COVID-19 reported through RIDDOR (Reporting of Injuries Diseases and Dangerous Regulations) for these occupations mirror the death data; RIDDOR also provides evidence of the relatively high numbers of cases in other occupations such as education."*

It nonetheless seems (at least to the IIAC) that the lack of adjustment for factors, such as deprivation, means that the evidence is currently too limited in quality and quantity to justify prescription at this stage.

Thirdly, although the IIAC has tasked itself to ensure the advice it gives about the Industrial Injuries Scheme is impartial, evidence-based, effective, credible and timely, pressure will grow – in part because of the numbers affected, in part because of schemes elsewhere. For example, Belgium and Norway have already recognised COVID-19 as an occupational disease. The IIAC's 2020/2021 programme includes assessing coronavirus (COVID-19) and its potential occupational impact.

In unusual language for an IIAC report, it speaks of the evidence of a doubling of risk in several occupations as indicating a "*pathway*" to potential prescription. This goes somewhat further than the ordinary take of keeping further research under review.

Wider Context of Health and Safety at Work

Standing back, it is interesting to reflect on how the work of the IIAC is but one part of a complex matrix, including regulatory, that bears on health and safety at work. Take for example the Approved Code of Practice ("ACOP") in relation to COSHH, which goes to the community-transmitted nature of the virus:

> *"The general duties of COSHH apply to incidental exposure to, and deliberate work with, biological agents. However, COSHH does not cover a situation where, for example, one employee catches a respiratory infection from another. This is because regulation 2(2) specifies that COSHH only applies in those circumstances where risks of exposure are work related, and not those where they have no direct connection with the work being done."* (para 18)

Another way in which issues of work-related (as opposed to community-related) risk arises is in the context of guidance on the RIDDOR reporting duties. Thus, for example, the Office of Rail and Road has issued guidance within the rail industry for coronavirus in the following terms:

> *"COSHH does not apply where employees are exposed to a disease which is in general circulation and which may happen to be present in the workplace as well."*

That was based on an assumption that "*with widespread societal spread, very few cases will need to be reported under RIDDOR*". The correctness of that assumption will be revisited as the IIAC travels further along the "*pathway*" it has identified.