# Asthma

## An Approved Code of Practice for Occupational Asthma.

The Health and Safety Commission are consulting on a proposed Approved Code of Practice and a complex plan of action intended to reduce the incidence of occupational asthma. Consultation Document CD 164.

### Basic Facts

HSC has relied on the following factors in deciding to take these measures.

- Sensitisation to specific chemicals is unpredictable.
- Safe exposure levels cannot be accurately defined.
- Asthma attacks occur at much lower levels of exposure than those required for inducing the specific sensitisation
- Sensitisation is generally irreversible.
- If exposure is not initially controlled following sensitisation, asthma continues in the absence of causative agent.
- Asthma may be prevented if exposure is reduced as soon as symptoms of sensitisation are first noted.

These facts create a strong case for action following the development of initial symptoms. Health surveillance and personal diligence should monitor these symptoms. This would complement current reliance on Official exposure levels as the primary method of risk management.

As such, surveillance as a means for revising risk assessments is not a new duty. Production of an ACoP is intended to clarify existing duties. It is more unusual for HSE to promote such a pivotal role for health surveillance in risk management. In our view, given the uncertainties of primary prevention, this is a pragmatic step and one that may be repeated for other hazards.

A list of known sensitisers is kept up to date by HSE in an Asthmagen Compendium. Supply of such sensitisers must be accompanied by the risk phrase R42 “may cause sensitisation by inhalation”.

### Other Points to note

LPC Centre staff became aware of this issue in February 2000 and have assisted in the development of this CD. The early draft raised considerable uncertainty over the need to distinguish the meaning of ‘caused or made worse’, from ‘made more symptomatic’. The latter would include any source of irritation at work that might lead to an attack of asthma. The initial suggestion from HSE was that any asthma attack should be considered a potential indicator of occupational sensitisation. Given the prevalence of asthma in the general population, and the very wide range of triggers including changes in humidity, air temperature, other forms of ill health and so on, we felt that such a general trigger of duty was not reasonable and should not be imposed by means of an ACoP.

The distinction between ‘caused or made worse’, and ‘made more symptomatic’, seems to have been accepted, draft ACoP paragraph 1. This principle could prove valuable in discussion of other duties in areas, such as upper limb disorders and passive smoking. The distinction is relevant to foreseeability and causation.

HSE use the term ‘incidence of asthma’ to indicate that a person who was previously not asthmatic, now is. Adult acquired asthma is relatively unusual and should be regarded as a warning sign. However the casual reader of the ACoP might mistake the use of this term, ‘incidence of asthma’, to mean that any asthma attack should be taken as a warning of an occupational cause. Such an interpretation sets a very high standard for the duty of care and reasonable foreseeability and is probably not sufficiently accurate in terms of causation. The language could be clearer. Advice to policyholders should carefully consider the difference between incidence and incident.

The key duties now clarified in the draft ACoP are:

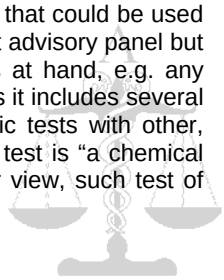
“13 The employer should set out procedures for responding to a confirmed new case of asthma. These should include measures to:

- Protect the person(s) while the cause of the symptoms is investigated;
- Review the assessment and control measures;
- Report the case to the enforcing authority if a doctor has notified the employer of it in writing. This is required by RIDDOR”

In our view, these clarifications are reasonable and should have the effect of mitigating harm following initial sensitisation. [It is likely that the final bullet point should have been qualified to indicate that a RIDDOR report is required once the occupational cause is established, and not before.]

A summary box on levels of health surveillance (paragraph 49) is also a little surprising. Here it says that "high level health surveillance is needed where … it is not possible to conclude that there is insignificant or no risk in the circumstances of the work". This is at first sight surprising, as the usual standard of risk management is that of 'reasonably practicable'. It would not generally be possible to conclude that **any** workplace has **no** risk. As it stands it seems that a very high duty of care is being prescribed.

A final point on this excellent CD relates to foreseeability. Annex 1 lists the evidence that could be used to indicate a risk of sensitisation. Such a list is probably intended for use by an expert advisory panel but employers could be expected to use these guidelines if they have sufficient skills at hand, e.g. any workplace employing a chemistry graduate. In our view, the list may be misleading as it includes several evidential tests that in isolation are non-specific. Combination of these non-specific tests with other, more specific indicators would be more reasonable. An example of a non-specific test is "a chemical structure related to substances known to cause respiratory hypersensitivity". In our view, such test of foreseeability is not reasonable.



Closing date for comments to HSE, 16th February 2001.