

Amendments to the Control of Asbestos at Work Regulations and a new supporting Approved Code of Practice.

Consultative Document CD 176

Comments to reach HSE no later than 19th February 2001.

The aim is to improve protection of people involved with maintenance and modification of buildings which contain asbestos.

The proposal is to introduce a new "duty to manage" by means of identification of location and condition of asbestos, risk assessment, planning, communication and review. A key component would be presumption that materials contain asbestos unless there is strong evidence that they do not.

Who should be the duty holder? The proposal is that they include; the employer of the person at risk of exposure, and others on who by virtue of contract or tenancy, the employer may rely.

Much of the debate is about ownership of duty, information management and type of premises to be included. These are, by and large, not scientific issues but have implications for liability and property insurance.

There is a proposal to remove the due diligence defence. The defence was originally included to account for the acts or omissions of others. The proposal is to remove it from the entire Regulation, not just the new section on "duty to manage".

Technical proposals are that air analysis should be performed to ISO 17025. Analysis labs for assessing bulk materials should be registered with UKAS and should meet criteria similar to those in ISO 17025.

Section 21 refers to health surveillance in the event that exposure exceeds a certain action level.

A relevant doctor is to identify disease or adverse health effect which is considered to be the result of exposure to asbestos. If such disease or adverse health effect is found, a number of actions arise, including, assignment to tasks with lower exposure and, examination of every other employee who has been similarly exposed.

Guidance for the examining doctor is provided in GN MS13 third edition 1999.

Early signs of asbestos disease, it could be argued, include pleural plaques, thickening and pleural effusions. However, their specificity and sensitivity for the detection of asbestos diseases remains uncertain (for example some studies show that 95% of people with pleural plaques remain free of more serious chest disease). Further guidance on this point is needed if the section on surveillance is to be understood and assessed.

MS 13 describes asbestos diseases as being of insidious onset with non-specific manifestation. Diagnosis is made by exclusion of other conditions and, association with asbestos exposure. It should be noted that the presumption of asbestos exposure does not apply to health surveillance, which is mandatory only when exposure is known to have exceeded a threshold level. [Over a 12 week period; 72 fibre-hours/ml of air if chrysotile and, 48 fibre-hours/ml of air if any other form of asbestos/ mixture]. The presumption of asbestos exposure does not apply to the formation of a diagnosis.

There is some uncertainty about whether plaques and thickening are adverse health effects in their own right. Their presence remains largely unnoticed in every day life. Once discovered, their presence may be a cause of worry over the potential for developing a more serious condition. However, the probability of this is very slight.

Comment

Given that latencies may be between 10 and 40 years, it is not clear that detection of suspected asbestos disease or adverse health effect will provide adequate or additional protection for the employee or current co-workers. The value would seem to be more towards the benefit of employees in the future.

