



HOUSE OF LORDS

Science and Technology Committee

3rd Report of Session 2007–08

Air Travel and Health Update: Government Response

Report

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Contacts for the Science and Technology Committee

All correspondence should be addressed to:
The Clerk of the Science and Technology Committee
Committee Office
House of Lords
London
SW1A 0PW

The telephone number for general enquiries is 020 7219 6075.
The Committee’s email address is hlscience@parliament.uk.

Air Travel and Health

THE COMMITTEE'S COMMENTARY ON THE GOVERNMENT RESPONSE

1. In December 2007 the Committee published its report *Air Travel and Health: an Update*¹ as a short follow-up to an earlier report *Air Travel and Health*². The Government response to our follow-up report, which we received at the end of February 2008, is published in the Appendix to this report.
2. In many respects, the Government have responded positively to our recommendations, with the Aviation Health Unit (AHU) and the Aviation Health Working Group (AHWG) taking the lead on most initiatives. There are some aspects of the response, however, on which we wish to make some comment.

Recommendation 5.1

3. We recommended that efforts should be made to raise the profile of the AHU. As a result, the Government have announced that they intend to consult colleagues about transferring the chairmanship of the inter-departmental AHWG from the Department for Transport to the Head of the AHU. Whilst we understand why this change is being proposed, we invite the Government to offer some assurance that this will not make scrutinising the activities of the AHU and AHWG more difficult.
4. We recommended also that the AHU should become the body responsible for handling queries and complaints for passengers on health issues. The Government have not accepted this recommendation, taking the view that responsibility should remain with the airlines, especially since some airlines have developed their own medical expertise. This is a lost opportunity. We heard in evidence how passengers had not only failed to have what they regarded as a satisfactory outcome to the handling of their complaints by the airlines, but had also failed to receive such satisfaction from the AHU. We remain of the view that concerns about the effectiveness of the system for the handling of complaints should be addressed by placing responsibility for dealing with complaints with the AHU.

Recommendations 5.4 and 5.7

5. The Government agree in principle to support Phase II of the World Health Organisation Research into Global Hazards of Travel (WRIGHT) Project to investigate flight-related factors which may increase the risk of Venous Thrombo-Embolicism (VTE). We welcome this response and we look forward to the outcome of the project.
6. In our report, however, we expressed some concern about the United Kingdom's own research capacity in aviation health matters, and we noted the evidence of Professor Michael Bagshaw, Aviation Medicine Director at King's College London, about there being insufficient research into aviation

¹ 1st Report (2007–08) (HL Paper 7)

² 5th Report (1999–2000) (HL 121-I)

health in the UK and, in particular, his own university's inability to fund aviation health research. In their response (to recommendation 5.7), the Government list three research projects funded by the Medical Research Council which may have some relevance to aviation health. This falls significantly short of our recommendation that efforts should be made to increase the UK's research capacity. Individual research efforts may all be worthwhile but what is needed is an integrated civilian research capability in aviation health. We urge the Government to think again and give a clear directive by designating a central portal through which funding is directed to aviation medicine.

Recommendation 5.13

6. The Government have not accepted our recommendation to limit to 30 minutes the amount of time that passengers should remain in an aircraft when the ventilation systems are non-operational. The issue of spread of disease by contact with infectious passengers is high in the public's mind. We accept that wide risk of transmission of disease in a fully functioning aircraft is negligible. But the risk of infection increases when closely confined in an aircraft with no effective filtration. If the Government will not accept our recommendation 5.13, we would urge them at the very least to take measures to ensure that having a loaded aircraft with no ventilation for more than 30 minutes is tolerated only in exceptional circumstances. We suggest that a reporting system of occasions on which the 30 minutes is exceeded should be put in place in order to put pressure on the airlines to avoid such circumstances.

Recommendations 5.17 and 5.18

7. With regard to contaminated air events, we are pleased that the Government is committed to filling the knowledge gap in this area and to ensuring that the AHWG-sponsored research to identify the substances produced during a fume event is completed urgently. We look forward to seeing the results of this research. We also welcome the Government's initiative to commission a data analysis project to determine if there is any correlation between operational practices and oil and hydraulic fluid leakages into the aircraft cabin.

APPENDIX: THE GOVERNMENT RESPONSE

Introduction

This paper sets out the Government response to the Committee's update report on Air Travel and Health, published on 12 December 2007.

The Government welcomes the Committee's continuing interest in this subject. The Government also welcomes the Committee's recognition that much has changed for the better in this area following its previous inquiry in 2000.

The Government's response incorporates contributions provided by the Department for Transport (DfT), HM Treasury (HMT), the Department of Health (DoH), the Civil Aviation Authority (CAA), the Health and Safety Executive (HSE) and the Department for Innovation, Universities and Skills (DIUS). In each case the Committee's recommendation is reproduced followed directly by the Government response.

Regulatory Arrangements

Recommendation 5.1 We welcome the establishment of the AHU within the CAA. However, we recommend that the AHU and the CAA work together with Government departments and the aviation industry in raising the profile of its work so that it becomes the focus for airlines, passengers and health care professionals in their quest for information on aviation health matters. The AHU should become the body responsible for handling queries and complaints from passengers on health issues and should publish guidelines on how those queries will be handled.

Government response

We consider that the Aviation Health Unit (AHU) has made significant strides since its inception. But we agree there is scope to raise its profile. In the course of 2008 we intend to consult colleagues about transferring the chairmanship of the inter-departmental Aviation Health Working Group (AHWG) from the DfT to the Head of the AHU. This means that the AHU would have more visible responsibility for aviation health issues in the UK. The Department would however retain responsibility for the continuing study into the cabin air environment. DfT would also expect to remain fully engaged as the Government Department with statutory responsibility for the health of persons on board aircraft.

The Committee recommended that the AHU should become the body responsible for handling aviation health queries and complaints. In relation to queries, the Government considers it does not make sense to take responsibility away from airlines, especially airlines which have developed medical departments. We should not wish to discourage airlines from maintaining their own expertise and engaging with their own customers. Moreover many queries should start with the passenger's General Practitioner who knows the individual's medical history. The AHU should certainly be a back-up for GPs, hospitals and airlines and an alternative avenue of information for passengers.

In relation to complaints, the Committee heard evidence that few passenger complaints are received about aviation health. Again the Government would not wish to disturb the normal practice that complaints about any aspect of airline

experience should go first to the airline concerned. Nor would we wish to prevent passengers raising aviation health complaints with the Air Transport User's Council (AUC), especially as a passenger may have more than one subject of complaint. The AUC certainly knows it can refer specialist issues to the AHU.

In addition, the AHU reviews any Mandatory Occurrence Reports received by the Safety Regulation Group of CAA which refer to health.

The AHU's web page already gives post, telephone and email contact details. The CAA has ensured that its general enquiry points also have this information to hand. Communication within the CAA has been focussed by presentations from the head of the AHU and the Health and Safety Adviser to ensure that staff are aware of the responsibilities of the Authority in relation to health.

Recommendation 5.2 We agree with the House of Commons Transport Committee that the United Kingdom cannot and must not transfer any further responsibilities from the CAA to EASA until it is clear that EASA is competent to exercise such responsibilities. We recommend that the Government make the strongest possible representations to the European Commission and EASA that the high priority afforded to aviation health in the United Kingdom as a result of the work of the AHWG, the CAA and the AHU must be replicated within EASA.

Government response

The Government supports the development of a comprehensive European regulatory system, centred on an effective European Aviation Safety Agency (EASA), as part of its commitment to establish and maintain a high, uniform level of aviation safety across Europe. The Regulation to extend EASA's competence to air operations and flight crew licensing is expected to be adopted in the next few weeks. The Government, together with the CAA, will continue to work through the Management Board to promote institutional reform within EASA and ensure that the Agency delivers an efficient, high quality safety regime.

Recommendation 5.3 We applaud the Government for having taken the steps necessary to make aviation health a priority. The United Kingdom has always been at the forefront in aviation issues and our regulatory arrangements continue to be seen as a model by other countries. However, we recommend:

- **that the Memorandum of Understanding between the HSE and the CAA, and in particular its Annex 8, should spell out who has specific responsibilities for the health and safety of passengers;**

Government response

The CAA and the HSE have good contacts and meet regularly to look at the arrangements between them. They will consider afresh whether Annex 8 of their Memorandum of Understanding can be given greater clarity with regard to their shared responsibility for the health and safety of air passengers.

The context in which that shared responsibility operates is set by the different legal and jurisdictional boundaries of the bodies concerned. The CAA, which has jurisdiction throughout the UK, has responsibilities under the Civil Aviation Act 2006. The HSE, which has jurisdiction in GB (there is a separate HSE for Northern Ireland), has responsibilities under s.3 of the Health and Safety at Work Etc, Act 1974. Neither the HSE nor the CAA can act on health and safety matters

outside UK/GB boundaries, or in relation to passengers or crew on board foreign aircraft. CAA does not yet have enforcement powers for its new statutory function in relation to the health of persons on board aircraft. But it is intended to amend the Air Navigation Order (ANO) to provide these powers.

- **that the HSE and CAA review the interpretation of “occupational health” as it applies to air crew, to ensure that emerging health issues are adequately reflected in regulatory arrangements.**

Government response

All parties, including the Government, the CAA and the HSE share the Committee’s view that emerging health issues should be adequately reflected in regulatory arrangements. All are members of the AHWG which enables good contact with stakeholders in respect of aviation health issues.

CAA and HSE consider the specific duties under the Civil Aviation Act 2006 and the requirements for the maintenance of adequate health and safety protection for crew members, set out in Regulation 6 of the Civil Aviation (Working Time) Regulations 2004, provide an adequate regulatory framework to respond to any current or emerging health issues.

Research

Recommendation 5.4 We recommend that the Government fully support Phase II of the WRIGHT Project including investigations on flight-related factors which may increase the risk of VTE, the relationship between seating and VTE, and effective preventive measures.

Government response

This Government agrees in principle with the Committee’s recommendation to support Phase II of the World Health Organisation Research Into Global Hazards of Travel (WRIGHT) study, aimed at finding how to reduce safely the risk of travel-related venous thrombosis. The researchers wish to study two groups: those at high and intermediate risk. The second group would involve several tens of thousands participants. Any research on such a scale must be considered in the context of air travel as a global phenomenon. The UK was the only individual nation to contribute to Phase I. We believe a European or international collaboration would be appropriate to raise the required funds for Phase II.

Recommendation 5.5 We recommend that the Government bring forward an amendment to Section 23 of the Civil Aviation Act 1982 which regulates the use of information from air crew medical records, so that anonymised data can be extracted and used to carry out epidemiological research projects.

Government response

The Government is sympathetic to the Committee’s view and the CAA’s view that anonymised pilot medical records should be made available for epidemiological research studies. In light of both medical and economic benefits to be achieved from sharing such information, the Government will look into how appropriate changes might be introduced into the Act when a legislative opportunity arises.

Recommendation 5.6 We recommend that jet lag should be studied as a confounding effect of DVT as part of Phase II of the WRIGHT Project.

Other research projects, such as FACE should include jet lag in their studies. We also recommend that the CAA, as the body responsible for the health and safety of air crew while on board an aircraft, commission a study into the possible long-term health effects that jet lag may have on air crew.

Government response

The second phase of the WRIGHT study seeks to investigate effective and safe interventions to reduce the risk of symptomatic thrombosis associated with long travel.

The AHWG will consider, alongside other priorities, whether there is a gap in knowledge about the possible long-term health effects that jet lag may have on air crew and a proven hypothesis to justify further work.

The FACE project (Friendly Aircraft Cabin Environment) completed its work in 2006. It addressed environmental comfort parameters which depend on noise vibration and air quality. The project was co-ordinated by Alenia Aeronautica of Italy. A link is attached.³

Recommendation 5.7 We recommend that in addition to contributing to international research projects, the Government and the Research Councils explore ways to increase the research capacity in aviation health that exists within the United Kingdom. A strong research base in this country is essential if awareness and understanding of aviation health are to be increased across the wider medical profession.

Government response

The Government recognises the importance of a joint approach to aviation research. We agree that there are clear benefits in forging a link between the AHU, the Research Councils and University Departments. This recommendation will be taken forward through the Head of the AHU.

The Department for Innovation, Universities and Skills (DIUS) provides funding to Research Councils through the Science Budget to support the whole range of their activities. Research Councils recognise the need to support a strong research base and will continue to support world class research within and across all disciplines and research areas through their responsive mode funding schemes. In continuing their support across the UK research base, Research Councils must take into account their priorities which have been set for the Comprehensive Spending Review period.

The Medical Research Council (MRC) currently funds a range of research which could be of relevance to aviation health, this includes:

- research into infection and immunity some of which may have relevance to infections acquired or spread during air travel. The MRC Centre for Outbreak Analysis and Modelling at Imperial College London has the mission to understand how best to control epidemics using public health measures, travel restrictions, drugs and vaccines and will look at diseases such as Severe Acute Respiratory Syndrome (SARS) and avian influenza;

³ <http://www.bksv.com/2656.asp>

- providing long-term funding to Professor A J Harmar’s team at the University of Edinburgh for their research on the control of peripheral circadian rhythms. This research will increase our understanding of the mechanisms by which circadian rhythms are controlled and the impact of these rhythms on physiology and metabolism. It may lead to a better understanding of jet-lag, and ways to prevent or treat it;
- co-funding the Clots in Legs Or sTockings after Stroke (CLOTS) Trial—A Randomised Trial to Establish the Effectiveness of Graduated Compression Stockings to Prevent Post Stroke DVT—run by Professor M Dennis’ team at the University of Edinburgh. The results of the trial may have some relevance to DVT in air travellers.

Recommendation 5.8 We find surprising and frustrating the number of EU-led research projects that have not published their reports. We recommend the Government should take an interest in these projects and if possible expedite the publication of their results.

Government response

The Head of the AHU is Medical Chair of the Ideal Cabin Environment project (ICE) sponsored by industry and the European Commission. We remain mindful of the need to maintain confidence in EU-led research projects. This can only be achieved through policies that embrace robust commitments to timely research delivery. Therefore AHU will explore options for engaging with the Commission on the expedient delivery of research where appropriate.

The Cabin Environment

Recommendation 5.9 We recommend that the CAA implement the recommendations of its own research into aircraft seating standards, and increase the regulatory minimum distance between seats to at least 28.2 inches. The Government should also make the strongest possible representations to EASA on this subject when they take over responsibility on this issue.

Government response

The purpose of the research commissioned by the CAA, “Anthropometric Study to Update Minimum Seating Standard”, was to ensure that seating standards are such that passengers would be able to evacuate an aircraft quickly in the event of an emergency.

There is no scientific evidence to determine a proven link between the increase in aircraft seating legroom—and in particular the relatively small increase specified—and the promotion of health. The Committee’s report in 2000 advised against using the concept ‘economy class syndrome’ for DVT, and we agree.

Any move to increase the minimum seat pitch will have to be taken on a European-wide platform by EASA once it assumes responsibilities for regulation of operations. Many long-haul flights already operate above the minimum.

Deep Vein Thrombosis

Recommendation 5.10 We recommend that the Government urgently review the level of air passenger duty levied on “premium economy” seating. We further recommend that they explore ways in which the

airlines can be encouraged to offer extra space to passengers for a modest premium.

Government response

In the final sentence of paragraph 4.2 the report “agrees with BATA that premium economy seating should be taxed at the standard rate of Air Passenger Duty (APD)”; we assume that the Committee means the reduced rate of APD, as premium economy seating currently attracts the standard rate.

The APD liability of premium economy seating was considered by HM Revenue and Customs (HMRC) as part of their consultation ‘Air passenger duty: Consultation on the definition of class of travel’. The outcome of this consultation, which closed on 31 July 2007, was that reducing the APD liability of premium economy travel would add considerable complexity to the system and would lead to an estimated overall revenue loss of £70 million. A summary of the responses to this consultation has been published on HMRC’s website (www.hmrc.gov.uk).

The Chancellor announced, at the 2007 pre-budget report, the Government’s intention to replace APD with a per plane based tax from November 2009, which would remove any distinction between classes of travel. A further consultation document was published on 31 January 2008, and the consultation closes on 24 April.

Recommendation 5.11 We recommend that the Government and the AHU work together with airlines and others in providing consistent travel advice to passengers on the risks associated with self-medicating with the intention of preventing DVT.

Government response

The Government agrees that consistent evidence-based information is essential in providing advice on possible interventions to reduce the risk of DVT. In 2004 the AHWG commissioned Synovate Healthcare to carry out a study aimed at quantifying the extent of aspirin usage amongst UK long-haul aircraft passengers, which appeared to be 20 per cent.

We recognise the importance of consistent and accurate advice on the risks associated with self-medicating, with the intention of preventing DVT. To this end, information covering the relevant Frequently Asked Questions (FAQ) on the AHU website will be modified in accordance with research findings. We shall also raise this at the AHWG in order to promote industry-wide consistency of information to passengers.

Infectious Diseases

Recommendation 5.12 We recommend that the Government and the airlines advise passengers on the proven benefits of good hand hygiene in the reduction of disease transmission and in particular that passengers clean their hands before eating on board an aircraft. In the event of a disease outbreak that could lead to a pandemic, we recommend that as part of their contingency plans airlines flying from affected regions should provide bactericidal wipes and alcohol gels to limit the spread of disease in-flight.

Government response

The Government takes seriously the public health responsibility it has to encourage behaviours that minimise disease transmission. The DoH advises the general public about the importance of hand and respiratory hygiene. Last year, the Department sponsored public health information campaigns stressing the importance, amongst other things, of hand-washing. The campaigns were targeted at the population as a whole and were not specific to the travelling public. In normal circumstances, eating on board an aircraft is no different to eating elsewhere, and we do not see a particular need for a message to passengers.

Generally, airlines provide aircrew with guidance on how to manage symptomatic passengers (or crew) in flight, in accordance with the World Health Organisation and the International Air Transport Association (WHO/IATA) guidance, and this would be reinforced in the event of a pandemic.

In addition, airlines typically offer passengers the use of a scented hand wipe. An alcohol hand rub would probably be the most effective hand hygiene measure on board flights and can be obtained in miniature dispensers. Whilst it is debatable whether the use of the recommended measure would prevent any contagious disease by someone who is incubating the illness and asymptomatic throughout the flight, we would encourage airlines to consider supplying the hand rub particularly during a disease outbreak that could lead to a pandemic.

Recommendation 5.13 We recommend that the Government and the regulators limit the amount of time that passengers can remain in an aircraft when the ventilation systems are non-operational to 30 minutes.

Government response

Generally, aircraft on the ground are provided with ventilation via either the Auxiliary Power Unit or ground power. However, we do not agree with the recommendation to set a limit of 30 minutes on the time passengers are on-board without ventilation systems. There are a number of reasons that preclude timely departure or arrival times, and each case is dependent on the particular circumstances. Additionally, the wide variations in parameters such as temperature, humidity and airflow (doors open or closed) would make a single time limit impractical. Passengers would not necessarily welcome being evacuated after 30 minutes if the loading and unloading delayed their flight.

Nonetheless, we encourage airlines and airport operators to discuss and explore appropriate options in accordance with their own policies and procedures including the conditions prevailing during such delays. This topic has been discussed at length in the Aviation Occupational Health and Safety Group. The AHWG will remind airlines and airport operators, via their associations, to ensure that they have developed and communicated appropriate policies and procedures. For example, BALPA's *Cabin Operating Temperature—Guidance to Crews*, available from the BALPA Flight Safety Department, is a useful document outlining key issues and possible mitigations of discomfort.

Air Crew Occupational Health

Recommendation 5.14 We are reluctant to recommend the modification of CAP 371 until more evidence is presented. We recommend, however, that the Government together with the CAA (including the AHU), the unions and airlines work together to find a way of ensuring that pilots have appropriate rest periods and to monitor fatigue complaints by pilots. We

also recommend that the CAA, as the body responsible for the health and safety of air crew while on board an aircraft, commission a study into the long-term effects of fatigue in air crew.

Government response

The Government accepts this recommendation. The CAA has, since the inception of CAP 371 *Avoidance of Fatigue in Air Crews* and based on a recommendation in the Bader Report, provided a forum for industry stakeholders to review and advise the CAA on aircrew fatigue issues. The forum consists of experts representing the breadth of activities within the aviation industry, including cargo, short and long haul operations, together with representation from pilot associations, and medical and sleep research experts.

This body reviews data from the Confidential Human factors Incident Reporting Programme (CHIRP), the Mandatory Occurrence Reporting Scheme (MORS) and associated Air Safety Reporting System (ASRS) which provides a means of identifying fatigue related safety issues, for subsequent review and action by the CAA.

In addition, the CAA maintains an open approach in encouraging aircrew to report fatigue related safety issues to flight operations inspectors, and flight standards staff, as a means of obtaining feedback on actual operating conditions.

This has now led the CAA to develop a continuous improvement approach to the management of flight time limitations. As a result, the quality of roster planning and delivery will be improved with lower levels of work cycle disruption, which detracts from crew performance and alertness, both in the short and long term. As part of this process improvement, operators will be required to implement a Fatigue Reporting System, in conjunction with Fatigue Awareness and Countermeasures Training, leading to more sustainable work patterns.

As the industry moves towards a more systematic and objective approach to Fatigue Risk Management, operators will also be able to utilise the SAFE fatigue analysis model, which the CAA has recently developed in conjunction with QinetiQ, allowing objective roster planning and assessment.

With the transfer of legal responsibility for rulemaking in the field of operations to EASA, we consider that any assessment of long-term occupational health associated with aircrew operations should be undertaken as a European research project, in which the CAA (including the AHU) would participate.

Recommendation 5.15 We welcome the fact that the Aviation Occupational Health and Safety Working Group, chaired by the CAA, is looking into noise-induced hearing loss. However, pending the outcome of this work, we recommend that the CAA work with airlines to review the availability of personal protection equipment so that pilots will be better able to protect their hearing.

Government response

The CAA are of the view that the data supplied by a number of airlines provides no objective evidence to cause concern about ambient noise levels on the flight deck or in the cabin, particularly given the benefits of modern aircraft types. Advice from the HSE stresses the need for local data and local analysis to formulate a proper risk assessment of the noise levels within different operations.

It is for the CAA and operators to ensure that all crews are afforded effective hearing protection, on the ground and while operating on the flight deck. However, even when modern noise-attenuating headsets are provided, it is recognised that crews may severely reduce the effectiveness of such devices by using them improperly, for example by leaving one ear uncovered. Nonetheless, the CAA will be inviting operators to submit information on the level of personal protection provided for their crews and the nature of the advice or procedures that they have in place to ensure effective use. Thereafter, the Aviation Occupational Health and Safety Steering Group will determine whether new or additional guidance might be warranted.

Contaminated Air Events

Recommendation 5.16 We recommend that the CAA carries out an awareness campaign aimed at airlines and pilots to highlight the importance of reporting contaminated air events and encourages airlines to follow the spirit as well as the letter of the rules on reporting these events.

Government response

The CAA has regular contact with industry Flight Safety Departments through its monthly MOR Listing. Through this system, the CAA will remind operators of the importance of reporting all contaminated air events that meet the requirements of the MOR Scheme.

A reportable occurrence means any incident which endangers or which, if not corrected, would endanger an aircraft, its occupants or any other person. The CAA's CAP 382 *The Mandatory Occurrence Reporting Scheme*, reflects Directive 2003/42/EC of the European Parliament, and of the Council of 13 June 2003, on occurrence reporting in civil aviation which requires, amongst other items, "events requiring any use of emergency oxygen by any crew member" and "crew incapacitation".

In addition, the air sampling activity on commercial airlines planned for 2008 will raise the profile of the issue with crew.

Recommendation 5.17 We recommend that the AHWG-sponsored research to identify the substances produced during a fume event be completed urgently. It should be followed up by an epidemiological study on pilots to ascertain the incidence and prevalence of ill health in air crew and any association there might be with exposure to the chemicals identified in the AHWG-sponsored study, paying particular attention to the synergistic effect of these chemicals.

Government response

We agree that the AHWG-sponsored research to identify the substances produced during a fume event should be completed urgently. The Government has always made it clear that we would not want anyone to be at risk to their health when flying, and we are working hard to fill the knowledge gap in this area. We have taken the first steps by engaging Cranfield University to oversee functionality tests on equipment which might be capable of capturing substances released during a fume event. We have published the report, following peer review by experts in the UK, Europe and the USA. We have accepted Cranfield's recommendation for further tests, and a Steering Group to oversee the next phase has started work. It is

our view that only after the air sampling data have been obtained can we decide how best to assess any health impacts. We agree that assessment must take account of the synergistic effect of substances.

Recommendation 5.18 We recommend that the Government works with manufacturers, airlines and the regulator to take effective action in preventing oil and hydraulic fluid leakages into the aircraft cabin.

Government response

The Government accepts this recommendation. We share the Committee's view of the importance of preventing oil and hydraulic fluid leakages into the aircraft cabin. No one wants oily or chemical smells in the aircraft cabin, and the conclusions of the COT evidence review into fume events noted the need to reduce fume events irrespective of health impacts.

It should be noted that airlines and the CAA have already made considerable efforts to minimise fume events. Good engineering maintenance practice is clearly an important part of this. But we are also interested in the extent to which operational practices may or may not have an effect on the likelihood of an event. DfT has commissioned a short data analysis project to try to determine if there is any correlation with operational practice. The AHWG remains our principal forum for addressing health concerns with aviation stakeholders, and it is through that body that discussions between Government, airlines and the CAA take place. Manufacturers, represented through the Society of British Aerospace Companies (SBAC) were invited to join the AHWG in 2007 and accepted.

Recommendation 5.19 We recommend that a protocol should be made available to health professionals, in particular Authorised Medical Examiners, on how to deal with air crew who suffer contaminated air events. We recommend that airlines, the regulators and the Government work together to improve the support given to pilots claiming to suffer ill health following a contaminated air event.

Government response

The Government considers that any protocol must be based on an understanding of the substances found during a fume event and the link to ill health in crew. The AHWG has already discussed this at length and found it impossible to draw up a genuinely useful protocol at this stage of the debate. Of course, pilots should receive appropriate medical management and support according to their symptoms.

Information and Education

Recommendation 5.20 We recommend that the Government and the regulators review the manner in which information on fitness to fly is offered, giving due consideration to their target audience. As the authoritative provider of information for passengers on air travel and health, the Government must ensure that information is available to all, not just people who have Internet access.

Government response

The Government accepts this recommendation. The AHU works closely with airlines and other key stakeholders, to disseminate consistent travel advice. Those

without access to the internet can request information by telephone, and relevant documentation can be printed and posted.

The Head of the AHU has written a number of articles for medical journals, and further articles are planned, targeted at the GP audience, in order that they may disseminate appropriate information to their patients. In addition, from March 2008, a section of the AHU website will have professional medical information that can be downloaded.

The CAA publication *Travelling Safely* is currently being redesigned. This offers a unique opportunity to address health issues, and highlight the AHU and other sources of pertinent information. This will be of value to those who do not have Internet access.

Recommendation 5.21 We recommend that the general practitioner postgraduate curriculum should include a basic overview of aviation medicine. Continuing professional development in the form of specialised courses should be made available for healthcare professionals with an interest in this area.

Government response

The responsibility for specifying the content of the general practitioner training curriculum rests with the Postgraduate Medical Education and Training Board (PMETB), the competent authority for postgraduate medical training in the UK. PMETB is an independent professional body. The Government will draw the Committee's recommendation to the attention of the Board.

The post-registration training needs of NHS professionals are decided by local NHS organisations against regulatory requirements, local NHS priorities, through appraisal processes and training needs analyses informed by Local Delivery Plans, and the needs of the service. Funding for continuing professional development is included as part of the baseline allocation made by the DoH to Strategic Health Authorities. It is for each Strategic Health Authority to decide its own priorities for investment and to focus training resources where they are most needed.

Recommendation 5.22 We further recommend that various specialties such as cardiology, orthopaedics and psychiatry follow the lead of the British Thoracic Society in producing guidelines on fitness to fly with the intention of informing GPs and other healthcare professionals; and that these publications should be made available in electronic form and hard copy to all GPs. In the course of time the collection of these guidelines would form a valuable (paper) reference manual.

Government response

We agree with this recommendation. It is a function of the medical Royal Colleges and Faculties to work to improve clinical standards. These professional bodies are therefore best placed to consider how the Committee's recommendation could most appropriately be implemented on the basis of coherent and soundly-based guidelines. DfT through the AHU recently consulted the Royal College of Obstetricians and Gynaecologists on introducing guidelines to assist airlines in managing new legislation arising from the new Gender Directive which has an impact on travel during pregnancy.



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6th Report Ageing: Scientific Aspects—Follow-up

7th Report Energy: Meeting with Malcolm Wicks MP

8th Report Water Management

9th Report Science and Heritage

10th Report Science Teaching in Schools

Session 2006–07

1st Report Ageing: Scientific Aspects—Second Follow-up Report

2nd Report Water Management Follow-Up Report

3rd Report Annual Report for 2006

4th Report Radioactive Waste Management: an Update

5th Report Personal Internet Security

6th Report Allergy

7th Report Science Teaching in Schools: follow-up

8th Report Science and Heritage: an update

Session 2007–08

1st Report Air Travel and Health : an Update

2nd Report Radioactive Waste Management Update: Government Response