



Imperial College London

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Airwave Health Monitoring Programme

Dear participant,

This is an important letter inviting you to take part in the Airwave Health Monitoring Programme. The goal of the Programme is to investigate any possible health effects associated with Airwave, the Police Communications System.

For further details, please refer to the information leaflet provided with this letter. Updated information is also available on our website at: <http://www.police-health.org.uk>.

On the following pages, you will find the Imperial College Health Monitoring Questionnaire. The questionnaire allows us to monitor your health in the long-term. **Please complete this questionnaire even if you do not currently use Airwave. Your participation is vital.**

You also have the opportunity to receive a **free and confidential health screen**, the results of which will come directly to you, and **only you**.

Please fill in your contact and personal details at the end of the questionnaire as accurately as possible. Without these details we will not be able to keep track of your health in future. **All information collected will be kept strictly confidential. Under no circumstances will the Home Office or Police Force have access to any of your individual data or samples.**

The questionnaire begins on the next page. Please read all questions carefully. Most questions can be answered by putting a cross in the box next to the answer that applies to you, like this:

¹ Yes ² No

Sometimes you have to write a number in a box, for example:

(dd/mm/yyyy)

Please try to complete all questions that apply to you. Where you need to skip a question, we have clearly indicated which question or section to go to next. **Please make no other marks on the questionnaire e.g. do not cross through questions or pages just because they do not apply to you, as this affects the scanning process.**

All information will be kept in strict confidence.

Thank you for your participation.

Professor Paul Elliott
Principal Investigator
Airwave Health Monitoring Programme

QNR-RECRUIT-1.4

Section 1: Questions on your use of the Airwave radio system. This section includes operations/control room and direct mode users. If you don't use Airwave, please tick the "No" box in question 1 and go to question 8.

1. Do you use the Airwave radio system?

- ¹ Yes: **go to question 2**
² No: **go to question 8**

2. Which year did you first start using Airwave radios?

(Year)

3. While **using or shortly after using your Airwave radio in transmit (PTT) or mobile phone (PSTN) mode**, do you experience any symptoms?

- | | |
|--|---|
| <input type="checkbox"/> ¹ No, I do not experience any symptoms | <input type="checkbox"/> ⁷ Deafness/partial hearing loss |
| <input type="checkbox"/> ² Headache | <input type="checkbox"/> ⁸ Burning sensation in ear |
| <input type="checkbox"/> ³ Dizziness | <input type="checkbox"/> ⁹ Tinnitus/ringing sound in ear |
| <input type="checkbox"/> ⁴ Numbness in hands | <input type="checkbox"/> ¹⁰ Any other symptom (please specify: |
| <input type="checkbox"/> ⁵ Nausea | <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> ⁶ Warming sensation on face | |

4. Please provide information on the usual location of your Airwave radio when you are using it in either **Press-to-talk (PTT)/transmit or mobile phone (PSTN) mode**.

Note: Please do not skip any row. There must be one tick in the transmit mode column and one tick in the mobile phone mode column for each row (a, b, c, d, e, f, g).

Approximate amount of time used in this position:

Location of Airwave radio:	Transmit (PTT) mode			Mobile phone (PSTN) mode		
	A lot of the time	Some of the time	None of the time	A lot of the time	Some of the time	None of the time
a) Personal radio with earpiece/microphone	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
b) Personal radio without earpiece/microphone	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
c) Desk mounted radio including operation/control room use	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
d) Motorcycle mounted radio	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
e) Car mounted radio	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
f) Body mounted radio (covert users)	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³
g) Other (please specify:)	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³	<input type="checkbox"/> ¹	<input type="checkbox"/> ²	<input type="checkbox"/> ³

5. Usually while using Airwave Radio what is the position of your handset?

- ¹ Right side of head ² Left side of head ³ Both sides equally ⁴ Not Applicable

6. Please provide:

a. The start date of the last **full shift** when you **used an Airwave radio**:

(dd/mm/yyyy)

b. The start time and end time (using the 24-hour clock) of this shift.

: (Hr Hr : Min Min) : (Hr Hr : Min Min)
 Start time of shift End time of shift

c. Please give an estimate of your **outgoing calls** (even if this is minimal) using your Airwave radio in **transmit (PTT) or mobile phone (PSTN) mode over this shift**:

	Approximate duration of Radio calls	Approximate number of Radio calls
Personal radio	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>
Pooled Radio*	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>
Vehicle mounted radio	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>
Desk mounted radio including operation/ control room use	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>
Body mounted radio (covert users)	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>
Radio use in direct mode	<input type="text"/> <input type="text"/> <input type="text"/> (minutes)	<input type="text"/> <input type="text"/> <input type="text"/>

*A (common) radio handset that is used by you and your colleagues.

7. What **proportion of your total radio use** is with a pooled radio? (**Please cross one box**)

None All
 0% 10 20 30 40 50 60 70 80 90 100%

8. Have you ever worked in an operations/control room?

- ¹ Yes: **go to question 9** ² No: **go to question 10**

9. Since joining the Police Force what **proportion of your total working time** has been in an operations/control room. (**Please cross one box**)

None All
 0% 10 20 30 40 50 60 70 80 90 100%

10. Did you ever use the old analogue radio system?

- ¹ Yes: **go to question 11** ² No: **go to question 13**

11. For how many years did you use the analogue radio?

 Years

12. Are you still using the analogue radio?

¹ Yes ² No

13. Usually, how many **hours per week** do you work? *Exclude overtime*

 Hours /week

14. How many **hours per week of overtime** (if any) do you work? *Enter 00 if none*

 Hours

**Section 2: Questions about personal or any other mobile phone use
(not including the use of your Airwave radio).**

15. Do you use a mobile phone?

¹ Yes ² No: *go to question 20*

16. When did you start using a mobile phone?

 (Year)

17. Not counting SMS text messaging, please estimate the **total duration** of phone calls you **made and received** on your mobile phone(s) in the **last 24 hours**.

 Minutes

Question 18 a), b) and c) are about your mobile phone use with hands-free equipment or a headset:

18a. Do you use hands-free equipment or a headset with your mobile phone(s)?

¹ Yes ² No: *go to question 19*

b. When did you first start using hands-free equipment or a headset?

 (Year)

c. Please estimate the **proportion of time** you usually spend using hands-free equipment or a headset while talking on your mobile phone(s). *(Please cross one box)*

None											All
0%	10	20	30	40	50	60	70	80	90	100%	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. While using, or shortly after using your mobile phone(s), do you experience any symptoms?

- ¹ No, I do not experience any symptoms
- ² Headache
- ³ Dizziness
- ⁴ Numbness in hands
- ⁵ Nausea
- ⁶ Warming sensation on face
- ⁷ Deafness/partial hearing loss
- ⁸ Burning sensation in ear
- ⁹ Tinnitus/ringing sound in ear
- ¹⁰ Any other symptom (please specify:)

Section 3: Questions about your general health.

20. Have you ever experienced loss of sight or impairment of vision in one eye, accompanied by pain around the eye caused by eye movement (**optic neuritis**)?

- ¹ Yes ² No:

21. Have you ever been **diagnosed by a doctor** with any of the following conditions? Also, mention **the year when you were first diagnosed**. (*Please cross box(es) and write year of diagnosis where appropriate*)

Condition	Year of diagnosis	Condition	Year of diagnosis
<input type="checkbox"/> ¹ High blood pressure	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹² Asthma	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ² Angina	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹³ Allergy (eczema, hay fever, rhinitis)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ³ Heart attack (MI)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹⁴ Diabetes mellitus	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ⁴ Other heart conditions	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹⁵ Cataract	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Please specify:		<input type="checkbox"/> ¹⁶ Glaucoma or high eye pressure	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<div style="border: 1px solid black; height: 35px;"></div>		<input type="checkbox"/> ¹⁷ Cancer (please specify type)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ⁵ Stroke/Transient Ischaemic Attack	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<div style="border: 1px solid black; height: 35px;"></div>	
<input type="checkbox"/> ⁶ Depression	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹⁸ Arthritis	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ⁷ Chronic Fatigue Syndrome/ME	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ¹⁹ Parkinson's disease	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ⁸ Deafness/partial hearing loss	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ²⁰ Chronic liver disease	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ⁹ Migraine	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> ²¹ Thyroid related disorders	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> ¹⁰ Epilepsy	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<input type="checkbox"/> ¹¹ COPD (Chronic Obstructive Pulmonary Disease)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

22. How many days of sickness leave have you taken in the **past year**?

Days

23. How many times have you consulted your GP in the **past year** for any **health problem**?

(*Enter Number*)

Section 4: Questions on lifestyle factors

24. Do you currently smoke cigarettes?

- ¹ Yes: **go to question 25**
² No: **go to question 26**
³ I have never smoked: **please go to question 29**

25. a. About how many cigarettes per day do you smoke?

Cigarettes per day

b. When did you first start smoking?

(Year)

26. If you are not a cigarette smoker now, **did you ever smoke** 5 or more cigarettes a day?

- ¹ Yes: **please complete questions 27 and 28**
² No: **go to question 29**

27. How many cigarettes a day did you usually smoke?

Cigarettes per day

28. How long ago did you quit smoking?

Years ago

29. How many people smoke in the household where you live? (**Please include yourself if you smoke**)

Number

30. **At home**, about how many **hours per week** are you exposed to other people's tobacco smoke?

Hours

31. **Outside of your home**, about how many **hours per week** are you exposed to other people's tobacco smoke?

Hours

32. Do you currently drink alcohol?

¹ Yes: **go to questions 33**

² No: **go to question 38**

33. How often do you have a drink containing alcohol?

¹ Monthly or less

² Two to four times a month

³ Two or three times a week

⁴ Four or five times a week

⁵ Daily or almost daily

34. In the last seven days how many **drinks** have you had of each of the following? Please remember that a drink poured at home could be equivalent to 2 or 3 pub measures. (**One drink = half a pint of beer, a small glass of wine, or one measure of spirits**). **If none, please indicate 00.**

a. Red wine Glasses

b. White wine/Champagne Glasses

c. Beer or Cider (include Bitter, Lager, Stout, Ale, Guinness) Pints

d. Spirits/Liqueurs (Include Whisky, Gin, Rum, Vodka, Brandy) Pub measures

e. Fortified wine (includes Sherry, Port, and Vermouth) Glasses

35. How often do you have six or more drinks on one occasion?

¹ Monthly or less

² Two to four times a month

³ Two or three times a week

⁴ Four or five times a week

⁵ Daily or almost daily

36. In the last five years have you changed your drinking habits?

¹ Yes

² No (**go to question 41**)

37. If yes, compared to your current habits, do you drink:

- ¹ More nowadays
- ² Less nowadays (*go to question 40*)

For Non-Drinkers and Past drinkers

38. Did you ever drink alcohol?

- ¹ Yes: *Please complete questions 39 and 40*
- ² No: *Please go to question 41*

39. If you ever drank alcohol, when did you stop?

Years ago

40. Why did you reduce/stop drinking alcohol? (*cross one box*)

- | | |
|---|--|
| <input type="checkbox"/> ¹ Financial reasons | <input type="checkbox"/> ⁴ Reduction in stress at home |
| <input type="checkbox"/> ² Doctor's advice/ ill health | <input type="checkbox"/> ⁵ Change of jobs |
| <input type="checkbox"/> ³ Change of lifestyle | <input type="checkbox"/> ⁶ Other reasons (<i>please specify below</i>): |

41. Are there any other issues, which we haven't raised that you think might be important:

If you are interested in having a free Health Screen with comprehensive and confidential feedback please tick the box below:

Please fill in your contact information below and the consent section on page 11. Without these details, we will not be able to monitor your health in the future via medical registers. All information provided will be kept strictly confidential.

42. Title:

43. First Name:

44. Surname:

45. Date of Birth: (dd/mm/yyyy)

46. Age in years:

47. Gender

48. Home address: Street Number & Name

Address Line 2

Town/City

Postcode

49. Home telephone number:

50. Mobile Phone number:

51. Email address:

52. Other Email address:

53. National Insurance (NI) Number:

54. NHS number (if known)

◆

When people leave the Police Force, it often becomes difficult to contact them. In order to help us keep in touch with you, we would appreciate it if you would provide the name and address of **TWO people** who are likely to know where you will be in the future. They should not be resident at the above address.

55. Title:

56. First Name

57. Surname

58. Relationship (e.g. parent, sibling, friend):

59. Telephone number:

60. Home Address:

Street number & Name:

Address line 2:

Town/city:

Postcode:

61. Title:

62. First Name:

63. Surname:

64. Relationship (e.g. parent, sibling, friend):

65. Telephone number:

66. Home Address:

Street number & Name:

Address line 2:

Town/city:

Postcode:

Consent All questionnaire answers will be kept strictly confidential and stored securely on a private computer network at Imperial College London. Under no circumstances will the Home Office or Police Force have access to any of your individual data or samples.

In order to carry out this Programme, we need your consent to allow us to:

- Access your medical files, including GP and hospital records as well as data on cancer and mortality held on National Registers. The information held by the NHS and records maintained by the General Register Office will be used to check your future health.
- Access data contained in your Police personnel files to confirm home contact details, identify job function(s), educational history, ethnicity, change of Police Force, national insurance number, retirement and sickness absence.
- Link your Airwave call data (if you use Airwave now or in the future) to your health records.

We need to confirm your contact details to obtain your NHS number from the NHS Tracing Service and to make sure your health screening results are sent to the correct address. Job function(s), educational history and ethnicity are required to control for occupational or socio-economic factors. We also need to know if you leave or transfer to another Force so that we can correctly link you to your use of Airwave. National insurance number may be necessary to keep in contact with you in the future. Information on sickness absence and early retirement are vital since these data may be related to whether or not you use Airwave.

Please sign below to indicate your consent.

Sign here: Print your name here:

Date: (dd/mm/yyyy)

Current collar number:

Year of joining Police Force:

Force name :

Division/Department:

If you have had **any other Collar Number** in this or other Police Forces during the **last 3 years**, please state below:

1. Collar Number:

Force name:

Division/Department:

2. Collar Number

Force name:

Division/Department:

THANK YOU FOR PARTICIPATION