Imperial College London
Professor Paul Elliott, MA MBBS MSc PhD MRCP FFPHM
Head, Department of Epidemiology & Public Health
Head, Division of Primary Care & Population Health Studies

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:

2	2	0	2	1	9	9	7

(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

Section 1: Questions on your use of the Airwave radio system. This section includes operations/ control room and direct mode users. If you have never used Airwave, please tick the "No" box in question 1 and go to question 8.

1. Do you currently use or have you ever used 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?

- ☐ 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:)

4. Please provide information on the usual location of your Airwave radio when you are using it in either **Direct Mode Operation (DMO) or Press-to-talk (PTT) or transmit/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 and one tick in the Direct Operation column for each row (a to g).

Approximate amount of time used in this position:

Location of Airwave radio:	**Direct Mode Operation (DMO)**			**Transmit (PTT) mode**			**Mobile phone (PSTN) mode**		
	A lot	Some	None	A lot	Some	None	A lot	Some	None
a) Body mounted radio (covert users)	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
b) Personal radio with earpiece/microphone	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
c) Personal radio without earpiece/microphone	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
d) Desk mounted radio including operation/control room use	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
e) Motorcycle mounted radio	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
f) Car mounted radio	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3
g) Other (please specify:)	☐1	☐2	☐3	☐1	☐2	☐3	☐1	☐2	☐3

5. If you use your Airwave radio in a body-mounted location (i.e. for covert work), where is it usually positioned?

- ☐ 1 Right shoulder harness
- ☐ 2 Left shoulder harness
- ☐ 3 Right leg mounted
- ☐ 4 Left leg mounted
- ☐ 5 Front torso mounted
- ☐ 6 Back torso mounted
- ☐ 7 Front waist mounted
- ☐ 8 Back waist mounted
- ☐ 9 Right Hip mounted
- ☐ 10 Left Hip mounted

6. Please provide:

a. The date you last used your **personal handset Airwave radio or body-mounted Airwave radio at work:**

☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)

b. Please provide the approximate start time and end time (*using the 24-hour clock*) when you used your radio <u>on this date.</u>

☐☐ : ☐☐ (Hr Hr : Min Min) Start time using radio

☐☐ : ☐☐ (Hr Hr : Min Min) End time using radio

c. Please give an **estimate of your <u>talk time</u> using your Airwave radio in each mode on this date (even if minimal). Complete all rows and columns. <u>If talk time is zero or mode not used enter 000.</u>**

	Approximate duration of Radio calls	**Approximate number of Radio calls**
Body mounted radio (covert users)	☐☐☐ (minutes)	☐☐☐
Personal radio	☐☐☐ (minutes)	☐☐☐
Pooled Radio*	☐☐☐ (minutes)	☐☐☐
Vehicle mounted radio	☐☐☐ (minutes)	☐☐☐
Desk mounted radio including operation/ control room use	☐☐☐ (minutes)	☐☐☐
Radio use in direct mode	☐☐☐ (minutes)	☐☐☐

*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. Have you ever used the old analogue radio system?

☐[1] Yes: ***go to question 11*** ☐[2] No: ***go to question 13***

11. Are you still using the analogue radio?

☐[1] Yes ☐[2] No

12. For how many years did you use / have you been using the analogue radio?

☐☐ Years

13. How many **hours per week** do you usually 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%**
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

#

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 **(opticus 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
☐ 1 High blood pressure		☐ 12 Asthma	
☐ 2 Angina		☐ 13 Allergy (eczema, hay fever, rhinitis)	
☐ 3 Heart attack (MI)		☐ 14 Diabetes mellitus	
☐ 4 Other heart conditions		☐ 15 Cataract	
Please specify:		☐ 16 Glaucoma or High eye pressure	
☐ 5 Stroke/Transient Ischaemic Attack		☐ 17 Cancer (please specify type)	
☐ 6 Depression		☐ 18 Arthritis	
☐ 7 Chronic Fatigue Syndrome/ME		☐ 19 Parkinson's disease	
☐ 8 Deafness/partial hearing loss		☐ 20 Chronic liver disease	
☐ 9 Migraine		☐ 21 Thyroid related disorders	
☐ 10 Epilepsy			
☐ 11 COPD (Chronic Obstructive Pulmonary Disease)			

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)*** **Enter 00 if none.**

☐☐ Number

30. At home, about how many **hours per week** are you exposed to other people's tobacco smoke? **Enter 000 if none.**

☐☐☐ Hours

31. Outside of your home, about how many **hours per week** are you exposed to other people's tobacco smoke? **Enter 000 if none.**

☐☐☐ 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*). Enter 00 if none.**

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)***

☐ 1 Financial reasons

☐ 2 Doctor's advice/ ill health

☐ 3 Other reasons ***(please specify below):***

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 <u>comprehensive and confidential feedback</u> please tick the box below:

☐

*

Please fill in your contact information below and the consent section on the next page. All the information you provide will be kept strictly confidential. Each person on the Imperial College Research Team has undergone Home Office security clearance and Research Facilities have been inspected and approved by the NCS/SOCA.

42. Title:

43. First Name:

44. Surname:

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

46. Age in years:

47. Gender: Male Female

48. Home address: Street Number & Name:

Address Line 2:

Town/City:

Postcode:

53. National Insurance (NI) Number:

54. NHS number (if known):

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)**

THANK YOU FOR PARTICIPATING