CAS-29624-N7S4

Ombudsman's Determination

Applicant	Ms L
Scheme	NHS Injury Benefit Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

1. I do not uphold Ms L's complaint and no further action is required by NHS BSA.

Complaint summary

2. Ms L's complaint is that NHS BSA has declined to award her a Permanent Injury Benefit (**PIB**).

Background information, including submissions from the parties

3. The relevant provisions are 'The National Health Service (Injury Benefits) Regulations 1995' (SI1995/866) (as amended) (**the 1995 Regulations**).

4. The 1995 Regulations apply to a person who sustains an injury, or contracts a disease, before 31 March 2013. Briefly, in order to be considered for a PIB, the injury sustained, or disease contracted, must be deemed wholly or mainly attributable to the person's NHS employment or to the duties of that employment (Regulation 3). If the injury or disease is deemed to be wholly or mainly attributable to the NHS employment, the second eligibility criterion is that the person has suffered a permanent loss of earning ability (**PLOEA**) of more than 10% by reason of the injury or disease (Regulation 4).

5. Extracts from the 1995 Regulations are provided in Appendix 1.

6. Ms L was a part-time (15 hours per week) Haemophilia Research Nurse. In 2015, she left NHS employment and was awarded Tier 1 ill health retirement for a recurrent depressive disorder.

7. In January 2019, NHS BSA received Ms L's application for a PIB. Ms L explained she had suffered a lower back injury in 1993, a recurrent depressive disorder resulting from incidents at work dating back from 2001 and the consequential effects of the stress-related condition: skin and gastrointestinal problems and migraines.

8. First instance decisions are made by the Scheme's medical advisers, Medigold Health (**Medigold**) under delegated authority. An initial decision was given on 1 May 2019 declining Ms L's application. The decision letter quoted the advice provided by a Medigold doctor (**the First MA**) who had reviewed Ms L's case. The First MA gave their opinion that Ms L's claimed injuries were not wholly or mainly attributable to her NHS employment.

9. Ms L appealed invoking the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**).

10. In August 2019, NHS BSA issued a stage one decision declining Ms L's appeal. It quoted from another MA (**the Second MA**) who had reviewed Ms L's case. The Second MA accepted that Ms L had sustained a lower back injury in 1993 which was wholly or mainly attributable to her NHS employment. However, the evidence indicated that injury was temporary and did not give rise to a PLOEA. Regarding Ms L's recurrent depressive disorder and consequential skin and gastrointestinal problems, the MA concluded that the medical evidence did not show that these were wholly or mainly attributable to her NHS employment, rather non-work-related events and an underlying personality trait were more likely (greater than 50%).

11. Ms L remained dissatisfied and further appealed. NHS BSA issued a stage two decision in October 2019. It declined Ms L's appeal and quoted from another MA (**the Third MA**) who had reviewed Ms L's case. The Third MA concurred that Ms L's soft tissue injury to her back had not caused a PLOEA and said any ongoing back pain was likely to be the result of degenerative changes that were not wholly or mainly attributable to Ms L's employment. The MA said Ms L's mental health, gastrointestinal and skin problems were not wholly or mainly attributable to her NHS employment. Regarding Ms L's migraines, the MA accepted that migraine attacks could be precipitated by stress but noted that migraine has a strong genetic component. Based on this the MA gave their view that Ms L's migraines could not be considered wholly or mainly attributable to stress.

12. Summaries of and extracts from the MAs reports are provided in Appendix 2.

Ms L's position

13. Ms L submits:-

- Her claim fulfils the criteria for a PIB award.
- Both her Employer and the Union dismissed their obligations in this matter.
- The facts have been repeatedly twisted to her disadvantage.

NHS BSA's position

14. NHS BSA submits:-

- Ms L sustained a soft tissue injury to her back in 1993 which was wholly or mainly attributable to her NHS employment, however it is not accepted that Ms L suffered a PLOEA of more than 10% by reason of this injury.

- It is not satisfied that Ms L's other claimed injuries; psychological, skin and gastrointestinal medical conditions are wholly or mainly attributable to her NHS employment or wholly or mainly attributable to the duties of her NHS employment.

- It has reached the conclusion that Ms L does not satisfy the legislative requirements for entitlement to PIB having investigated the matter, taken advice from the Scheme's MAs, carefully considered such advice, and accepted that advice. As a result, it has arrived at a decision that it believes is not perverse.

- The Ombudsman will understand that in matters medical, decisions are seldom black or white. A range of opinions may be given from various sources, all of which must be considered and weighed. However, the fact that Ms L does not agree with the conclusions drawn or the weight attached to various pieces of evidence does not mean that any conclusion is necessarily flawed.

Adjudicator's Opinion

15. Ms L's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA. The Adjudicator's findings are set out below in paragraphs 16 to 42.

16. The Adjudicator set aside Ms L's comment that both her Employer and the Union dismissed their obligations in this matter, as the complaint accepted for investigation pertained only to NHS BSA's decision not to award Ms L a PIB.

17. The Adjudicator explained that entitlement to a benefit was determined by the relevant scheme rules or regulations. The scheme rules or regulations set out the circumstances in which a person was eligible for a benefit, the conditions which they must satisfy, and the way in which decisions about benefits should be taken.

18. In Ms L's case, the relevant regulations were Regulations 3 and 4. These provided that an injury benefit was payable if an individual had:

    - sustained an injury, or contracted a disease, in the course of their NHS employment which was wholly or mainly attributable to that employment; or

    - sustained an injury, or contracted a disease, which was wholly or mainly attributable to the duties of their NHS employment; and

    - by reason of the injury or disease, their earning ability was permanently reduced by more than 10%.

19. A qualifying injury (that is an injury or disease determined to be wholly or mainly attributable to the person's NHS employment), as referred to in Regulation 3(2),

excluded the exacerbation of a pre-existing injury or condition to the extent that such an injury or condition was not wholly or mainly attributable to the person's NHS employment. It included the possibility of more than one cause, but the NHS employment must be more than 50% of the cause.

20. One of the specific obligations on decision-makers was to consider all relevant information which was available to them and to ignore all irrelevant information.

21. NHS BSA based its decision largely upon the advice it received from its own MAs. So, it was appropriate to consider this advice in some detail. However, the weight which NHS BSA attached to any of the evidence was for it to decide, including giving some evidence little or no weight[1]. It was entitled to rely upon the advice it received unless there was a cogent reason why it should not do so or should not do so without seeking clarification. The Adjudicator said the kind of things he had in mind were errors or omissions of fact or a misunderstanding of the Regulations on the part of the MA.

22. The Adjudicator noted also that NHS BSA could only review the medical evidence from a lay perspective. It would not be expected to query a medical opinion as such. However, it could be expected to seek an explanation if there was a difference of opinion between its MAs and the claimant's own doctors if one had not been provided. That being said, a difference of opinion between doctors, in and of itself, was not usually sufficient for the Ombudsman to find that a decision had not been made properly.

23. NHS BSA's MAs did not come within the Ombudsman's jurisdiction so far as their medical opinions were concerned. They were answerable to their own professional bodies and the General Medical Council.

24. Ms L's claim for a PIB pertained to a lower back injury, a recurrent mental health disability, skin and gastric problems and migraines.

25. The questions which the First MA said needed to be addressed captured the attribution conditions set out in Regulation 3.

26. The MA accepted that Ms L had suffered acute back pain whilst handling a patient in 1993 (the index incident). But this was a minor soft tissue injury, for which Ms L received a Temporary Injury Award (**TIA**) and was absent from work for nine months. The MA noted that:-

    - In 1993, an x-ray showed the potential for the remnants of a slipped disc, but an MRI scan did not show any disc prolapse or nerve root impingement.

    - In January 2018, an MRI scan showed a loss of disc at L5/S1 with some endplate reactive changes.

[1] *Sampson v Hodgson* [2008] All ER (D) 395 (Apr)

- Mr Singhal (Orthopaedic Surgeon), in his February 2018 report, considered that sciatica could not be explained by the index incident and that the degenerative changes were constitutional and pre-existing and unrelated to the index incident. The back pain was probably aggravated by the index incident but would have settled back to pre-incident levels within six months or so.

27. The MA concluded that Ms L's back pain was not wholly or mainly attributable to her NHS employment.

28. Concerning Ms L's mental health disability, the MA noted that Ms L had a long history of recurrent depressive disorder. While Ms L had experienced workplace stress, her treating specialists had identified this as a trigger for her recurrent depressive disorder that started with PTSD following an ectopic pregnancy in 1998. The MA's view was that stressors in general with regard to Ms L's gynaecological history as well as work were trigger factors in the relapse of her pre-existing depressive disorder which was not wholly or mainly attributable to her employment.

29. Regarding Ms L's skin condition, the MA noted the dermatologist's letter of 30 July 2018. This specified a diagnosis of endogenous pompholyx eczema and commented that stress was a known triggering factor. The MA noted that there was no further evidence of a temporal association with Ms L's work-related stress but the consideration of the meaning of "endogenous" was that Ms L's eczema was not caused or attributable to an external factor.

30. Concerning Mr L's gastrointestinal problem, the MA noted Dr Thomas' (Gastroenterologist) letter of 19 June 2018, which detailed a diagnosis of upper and lower bowel functional disturbance, a hiatus hernia and deformity of the stomach with associated gastroenterological reflux. The MA stated while the functional bowel disorder could be exacerbated by emotional factors in addition to diet, it was not attributable to external factors.

31. The MA concluded that Ms L's eczema and gastrointestinal problems were not wholly or mainly attributable to the duties of her NHS employment.

32. The MA did not comment on Ms L's migraines.

33. The Second MA agreed that the back injury that Ms L sustained at work in 1993 was a soft tissue injury from which she recovered. So, there was no PLOEA.

34. The MA considered that Ms L perceived significant stress arising from events at work and that this perceived stress played a role in triggering her recurrent episodes of depression/anxiety as well as gastrointestinal and skin conditions. But Ms L's mental health conditions and gastrointestinal and skin conditions were not wholly or mainly attributable to her NHS employment. A previous traumatic event and underlying personality trait (likely to be genetically determined), rather than work circumstances, were more likely (greater than 50%).

35. Again, no view was given on Ms L's migraines.

36. The Third MA concurred with the view of the Second MA that Ms L had sustained a soft tissue to her back in 1993. Contemporary records indicated that Ms L had made a full recovery and that any ongoing back pain was likely to be the result of degenerative changes. So, Ms L suffered no PLOEA by reason of the soft tissue injury. The MA added that even if the injury was a disc prolapse, it was unlikely to have been wholly or mainly due to her NHS employment as there was no reason to suppose that any degenerative changes would have been themselves a consequence of her NHS employment.

37. The MA did not doubt Ms L's perception that work had contributed to her impaired mental health. But said given the current understanding of the causation and natural history of recurrent depression and the documented role of non-work factors in the development of Ms L's condition, it was not possible to conclude that her recurrent depressive illness was wholly or mainly attributable to her perception of work events. So, it was unlikely to be attributable to her NHS employment or the duties of her employment.

38. Regarding Ms L's skin and gastrointestinal problems and migraines the MA said:-

- They were unaware of any evidence that endogenous pompholyx eczema was caused by perceived stress and did not regard it as being wholly or mainly attributable to the duties of her employment.

- The evidence was that Ms L had a functional gastrointestinal disorder. The cause of these conditions was unknown, though alteration in part of the nervous system had been reported in persons with irritable bowel syndrome and these abnormalities appeared like those noted in persons with major depression. So, it was plausible that there was a link between Ms L's gastrointestinal symptoms and her impaired mental health. But from this it could not be concluded that Ms L's gastrointestinal symptoms were wholly or mainly the result of her NHS employment or the duties of that employment.

- Stress was cited in the literature as a precipitant for attacks of migraine. However, migraine had a strong genetic component. Given the current understanding of the condition, migraine could not be considered wholly or mainly attributable to stress.

39. Ms L said the facts had been repeatedly twisted to her disadvantage. The Adjudicator did not agree. It was for the MAs to consider the medical evidence and attach weight (if any) to it. The Adjudicator was satisfied that they had done that.

40. While both the First MA and the Second MA failed to comment on Ms L's migraines, the Third MA did. Apart from that, the Adjudicator said he had not identified any error or omission of fact on the part of the MAs and he had not seen any evidence that any irrelevant matters were considered.

41. The Adjudicator found no reason why NHS BSA should not have accepted the Third MA's opinion and based its stage two decision on the MA's advice.

42. The Adjudicator's view was that the evidence did not support a finding that NHS BSA's decision that Ms N was not eligible for a PIB was not reached in a proper manner.

43. Ms L did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Ms L provided her further comments which I have considered but they do not change the outcome. I agree with the Adjudicator's Opinion.

Ombudsman's decision

44. As the Adjudicator explained, my role in this matter is not to decide whether Ms L is entitled to a PIB but to look at NHS BSA's decision-making process.

45. Ms L says the conditions and criteria for the Scheme have not been applied accurately, fairly or reasonably throughout. However, I am satisfied that NHS BSA and its MAs have correctly applied Regulations 3 and 4.

46. Ms L says valid professional evidence and accurate information has been disbelieved and discarded. But it was for NHS BSA (and its MAs) to attach weight to the relevant evidence, including giving some evidence little or no weight. I am satisfied that was done.

47. Ms L says inaccurate and unvalidated assumptions were used, numerous points have been utilised or applied wrongly or inaccurately and irrelevant matters have been used to her detriment, unfairly and unreasonably. While I recognise that Ms L disagrees with the advice NHS BSA received from its MAs, a difference of opinion (even between doctors) is not sufficient for me to require a decision to be reviewed. There would have to be some other reason why NHS BSA should not have relied on the advice it received from its MAs in coming to its decision. I have not identified any such reason in the advice from the Third MA, such as an error or omission of fact, irrelevant matters or a misunderstanding of the Injury Benefit Regulations.

48. I find that NHS BSA's decision not to award Ms L a PIB was properly made and there are no grounds on which to remit the matter back to NHS BSA.

49. I do not uphold Ms L's complaint.

Anthony Arter CBE

Deputy Pensions Ombudsman
5 February 2024

Appendix 1

The National Health Service (Injury Benefits) Regulations 1995 (SI1995/866) (as amended)

1. Regulation 3, 'Persons to whom the regulations apply', provides:

> "(1) Subject to paragraph (3), these Regulations apply to any person who, while he -
>
> (a) is in the paid employment of an employing authority … (hereinafter referred to in this regulation as "his employment"), sustains an injury before 31st March 2013, or contracts a disease before that date, to which paragraph (2) applies.
>
> (2) This paragraph applies to an injury which is sustained and to a disease which is contracted in the course of the person's employment and which is wholly or mainly attributable to his employment and also to any other injury sustained and, similarly, to any other disease contracted, if -
>
> (a) it is wholly or mainly attributable to the duties of his employment; …
>
> (3) These Regulations shall not apply to a person –
>
> (a) in relation to any injury or disease wholly or mainly due to, or seriously aggravated by, his own culpable negligence or misconduct;
>
> (b) eligible to participate in a superannuation scheme established under section 1 of the Superannuation Act 1972."

2. Regulation 4, 'Scale of benefits', provides:

> "(1) Benefits in accordance with this regulation shall be payable by the Secretary of State to any person to whom regulation 3(1) applies whose earning ability is permanently reduced by more than 10 per cent by reason of the injury or disease and who makes a claim in accordance with regulation 18A …"

Appendix 2

First MA's report, Original Decision

3. The MA noted Ms L's age, occupation and earnings, Ms L's claim (as stated in sections 8 and 9 of her application (AW13E) and personal statements) and listed the medical evidence considered.

4. Under the heading 'Attribution', the MA stated the questions to be addressed were:

   1. Was there an injury sustained or disease contracted?

   2. Was the injury sustained (or was the disease contracted)

      (a) in the course of the person's employment and

      (b) wholly or mainly attributable to his/her employment?

5. Under the heading 'Rationale' the MA said:

   "Back Pain

   Q1: Yes. No incident report or contemporaneous medical evidence is submitted from 1993. Occupational health reports from December 2007, January 2008 and April 2008 identify that she is unfit for work because of psychological reasons but recognise a past history of back problems, that her back problems "has not really caused any significant problems over the years with regard to her work" and that in April 2008 a recent worsening was reported with her lumbar pain and neurological symptoms affecting her right thigh and as a result her GP had organised an x-ray.

   The handwritten general practice notes identify that on 12 February 1993 [Ms L] took brufen for back strain – lifting at work. The GP notes at the start of March identify that there is right sided sciatica and that she needs a week off work and goes on to give further sick notes. There is improvement with physiotherapy up until June but a flare up at the end of June prompts a referral to orthopaedics. The orthopaedic consultant when he sees [Ms L] in August identifies the back pain sciatica with sensory loss to the toes requests an x-ray which shows the potential for the remnants of a slipped disc and when reviewed in September 1993 the MRI scan did not show any disc prolapse or nerve root impingement. He recommends continuing with physiotherapy. In the orthopaedic surgeon, Mr Singhal's report from February 2018, he identifies the report from a later MRI scan dated 31 January 2018 which showed a loss of disc at the L5/S1 level with some endplate reactive changes. He identifies that the sciatica cannot be explained on the basis of the index accident and that the degenerative changes are constitutional and pre-existing and unrelated to the index accident. He gives an opinion that remains unchanged from his earlier report that the back pain was probably aggravated as a result of the index accident but would have settled back to pre-accident levels within 6 months or so.

Q2a: Yes. There is no reason to consider that [Ms L] is not telling the truth about an acute onset of back pain whilst carrying out patient handling.

Q2b: No. Whilst there is no reason to doubt any association with carrying out patient handling duties, the potential causes of back pain are multiple, but commonly for a person aged 30 in the absence at the time of any neurological symptoms, this would be due to a minor soft tissue injury that would be expected to go through a period of resolution in a number of weeks. Apart from the personal statement and the recording in the occupational health records of the presence of back pain, there is no contemporaneous medical records and consideration of diagnosis and mechanism of injury and therefore I would consider that this does not represent compelling evidence. The applicant has stated that she was in receipt of TIA following the injury and had 9 month's sick leave.

Mental Health

Q1: Yes. Dr Jenkins' report of 25 June 2008 states that [Ms L] has a long history of recurrent depressive disorder dating back to 1998. He was not clear of the form of counselling that she had had after a ruptured ectopic pregnancy which was also life threatening but this is clarified in Professor Sullivan's report of July 2016 that she was seen by Professor Jonathan Bisson and had cognitive behavioural therapy for a diagnosis of PTSD. Dr Jenkins goes on to record a second episode of depression in 2000 and then again in 2008 (although I do notice from [Mr Herbert], the clinical psychologist's reports that he had also provided care in 2005) and that a triggering factor was job related factors from moving into the endoscopy unit in 2001. Dr Jenkins provided a formulation of recurrent major depressive disorder. He recommended treatment through psychology. Both factors with failed attempts at IVF and employment contributed to her depression.

Dr Thomas provided a report on 16 July 2014 with a diagnosis of major recurrent depressive disorder stating that the condition had waxed and waned over the years "often precipitated by work related stressors". Dr Thomas was of the opinion that for finite periods of time [Ms L] would be capable of working as a nurse but that because of perfectionist traits in her personality, work related stressors or social stressors she would experience a relapse. Dr Thomas considered that the potential for redeployment is a requirement by an employer however notes that previous changes of job have each ended up with a recurrence of her depression. Also that as she experiences further recurrence a reduced stimulus would be required each time.

Professor Sullivan reports that following her treatment for PTSD in 1998 she returned to work and due to closures and moves of hospital services, found herself on a ward where a lot of patients were being admitted for termination of pregnancy. For this reason, for the reason of being publicly demeaned by a doctor on the ward on a couple of occasions and because she was having ongoing gynaecology treatment she found another post and moved. Professor Sullivan reports that it was at this time that she moved into the post in endoscopy and started to be bullied by the department manager over various issues such as annual leave and sick leave (injury to her

hands, ruptured tendon in her ankle) and trying to take annual leave to undergo continuing IVF treatment. In 2007 she suffered a further miscarriage (three ectopic and other miscarriages were prior to 2000) and following on with long term sick leave she was dismissed but reinstated following appeal. Further jobs followed with a retirement on ill health grounds in March 2015 from mental health issues. Professor Sullivan reviewed her mental health records and identifies that she attended the PTSD clinic following the ectopic in 1998 and was given a course of psychological therapy. The beneficial effects were not sustained from this and in 2000 she was commenced on antidepressant treatment. Psychological treatment as detailed above from Dr Herbert continued from 2001 to July 2002.She was referred back to secondary care mental health services in 2007. Professor Sullivan identifies that within the mental health record it was noted that her working environment may have precipitated her recurrence of depression. Improvement when away from the workplace was then again followed by a recurrence in March 2013 with workplace stressors being identified. Professor Sullivan concurs with the diagnosis of major depressive disorder (recurrent) and identifies the precipitating event as the PTSD following the ruptured ectopic pregnancy in 1998. The further contributing factors are her ongoing gynaecological treatment and workplace stressors.

Q2a: Yes. It is clear from [Ms L's] statements and from the occupational health and mental health evidence that she had recurrences of her depressive disorder during the course of her employment.

Q2b: No. The evidence indicates that [Ms L] has suffered recurrent episodes of her depression and that triggers have included both those associated with her health and attempts at assisted pregnancies and her workplace stressors. These are against the background of a pre-existing PTSD with depression from 1999.

Therefore my consideration is that whilst she has experienced workplace stress, her treating specialists have identified this as a trigger for a recurrence of her depressive disorder that started with her PTSD following her ectopic pregnancy. Stressors in general with regard to her gynaecological history as well as work are trigger factors in the relapse of her pre-existing depressive disorder which is not wholly or mainly attributable to her employment.

The dermatologist's letter dated 30 July 2018 identifies that [Ms L] has a diagnosis of endogenous pompholyx eczema. The dermatologist notes that stress is a known triggering factor. This is generally accepted that flare ups of a pre-existing disorder can be triggered by a number of different stressors. No further evidence is provided to give a temporal association with [Ms L's] work related stress but the consideration would be that the meaning of endogenous is that it is not caused or attributable to an external factor.

Dr Thomas' letter (gastroenterologist) of 19 June 2018 indicates that [Ms L] has a diagnosis of upper and lower bowel functional disturbance. She has other structural considerations such as hiatus hernia and a "cup and spill" type of deformity of the

stomach with associated gastroenterological reflux. However the considerations are that this is a functional disorder and it can be exacerbated by emotional factors in addition to dietary. Again the consideration would be that functional bowel disruption cannot be attributed to external factors but for many people who suffer this there is no doubt that there is a triggering link.

Based on the evidence presented, I conclude that the applicant has **NOT** sustained an injury or contracted a disease wholly or mainly attributable to the duties of the NHS employment prior to 31 March 2013."

Second MA's report, IDRP Stage One

5. The MA noted Ms L's age, occupation, part-time hours of work, earnings to establish PLOEA, last day of service and PIB claim (as detailed in form AW13).

6. The MA summarised the medical evidence considered and noted that Ms L's appeal comprised a twelve-page personal statement but no new medical evidence.

7. The MA detailed the criteria for an injury benefit under the 1995 Regulations.

8. Under 'Rationale' the MA said:

"In having gone through several thousand pages of evidence, I find the following reports to be the most explanatory for the underlying cause of the health problems which have incapacitated [Ms L] and resulted in her early retirement on the grounds of ill health.

The report of Dr Rahman, staff grade psychiatrist, dated 3 October 2001 notes thar [Ms L] was no better than when she was previously seen, three months earlier. Dr Raham noted, "she still complains of depressed mood. She has ongoing problems with her relationship and at work. She does not get on with people. She has no confidence".

A report from a consultant psychiatrist, whose name was not provided as the last page of the report appears to have been missing, dated 25 June 2008, from the liaison psychiatry service at University Hospital Wales, noted the following:

"This woman has a long history of recurrent depressive disorder dating back to 1998. In 1998 she had some form of counselling after a ruptured ectopic pregnancy following which she nearly died.
…[Ms L] feels that she has never really recovered properly from that event. The second episode of depression occurred in 2000 and she was treated by my colleague…".

The report then goes on to with aspects of PTSD. Although this was treated her mental health has not fully recovered since. There has been a number of trigger factors including problems with work, multiple miscarriages, problems with her pension/payroll/HMRC and a dispute with a neighbour. Since 1998 she has been under the care of secondary mental health services for significant periods, although

[there] have been periods where her health has been stable in between. The clinic letters included in the application refer to a pattern of increasingly severe episodes over the years.

[Ms L's] back problem has shown a pattern of chronic fairly mild low back pain, with occasional acute exacerbations causing time off work. The exacerbations have been manged with physiotherapy and analgesia…

Having gone through the very extensive documentation, it is clear that [Ms L] suffered a life-threatening event in 1998 [a ruptured ectopic pregnancy], which caused a severe psychological reaction (post-traumatic stress disorder and recurrent depressive illnesses). In addition, she has an underlying personality trait, which causes her to have a cycle of maladaptive coping strategies. The available evidence shows that this has recurred time and again in several contexts at work and also in her personal relationships with her partner, neighbours, trade union and employer.

In my view [Ms L's] previous traumatic medical event and underlying personality trait (which is likely to be genetically determined), are more likely to have caused the permanent break down in her mental health to the extent that she was ill health retired, than the work circumstances, to an extent of greater than 50% on the balance of probabilities.

[Ms L] has noted in her statement a number of incidences in which she believes that work conditions triggered or aggravated her gastrointestinal and skin problems, due to perceived stressful events. In my medical opinion, [Ms L's] mental health fragility and maladaptive responses, due to the above-described conditions, were more likely to have been causative of the stress, which triggered her gastrointestinal and skin problems, to a degree of greater than 50% on the balance of probabilities.

With regards to [Ms L's] lower back problem, although there is reasonable evidence that she did sustain a back injury while undertaking manual handling of a patient in 1993, however, there is also good evidence that she recovered from this injury and that it did not cause a disease, incapacity or permanent loss of earnings.

This medical opinion is supported by the following evidence:

1. An entry in her General Practitioner (GP) records on 6 August 1993, stating that after an orthopaedic referral for four months of low mid-line back pain and right sided sciatica she had responded well to physiotherapy. I interpret this as stating that [Ms L] was recovering from her back pain.

2. The report by Consultant Orthopaedic Surgeon Mr Maheson, dated 6 August 1993, noted clinical signs in keeping with a short-term lower back injury, with no signs of nerve impingement, which would have been indicative of a significant injury. He also reported that the X-ray showed a small osteochondral fragment

on the upper front border of the 5th Lumbar vertebrae. He noted that this fragment could have been due to bony escape from the intervertebral disc nucleus palposis. I interpret this as saying that Mr Matheson what could have been the result of a recent injury. However, there was no sign of this small osteochondral fragment in subsequent lumbar spine X-rays, so it is likely that [it] was resorbed and that the injury did not go on to cause permanent incapacity.

3. A consultant radiologist report by [Dr Thomas] dated 3 April 2008, which notes that her lumbar sacral spine and pelvis x-ray showed no significant degenerative changes affecting the lumbar levels, but did show osteoarthritis changes in both hips. The report also noted loss of normal lordotic curve suggesting pain or muscle spasm.

   This X-ray taken some 15 years after 1993, did not show osteoarthritis of [Ms L's] lumbar spine to a greater extent than expected for her age. If she had had a significant previous injury in 1993, much more extensive osteoarthritis (degenerative changes) would have been evident in my view. The loss of the normal lordotic curve (lumbar lordosis) was likely to be due to a strain or sprain in her lumbar spine muscles in my medical opinion, which could have been due to the lower back injury in 1993. However, these conditions recover fully over a number of months in the vast majority of cases and do not lead to permanent incapacity.

4. In a report from Mr Singhal, consultant orthopaedic surgeon, who provide a medicolegal report, dated 31 January 2018 [,] he noted that the MRI scan of her lumbar spine at that time showed some degenerative changes, but no nerve root impingement. Mr Singhal gave the view that the degenerative changes were constitutional (i.e. genetic).

Hence, in my view, although there is evidence that [Ms L] did sustain a transient injury to her lower back during the patient manual handling episode in 1993, there is insufficient evidence to conclude that she sustained permanent incapacity from this incident. The further degenerative changes found in [Ms L's] lumbar spine in January 2018 were more likely to be due to constitutional (genetic) and age related wear and tear causes in my view at a level greater than 50%

…"

Third MA's report, IDRP Stage Two

9. The MA noted:-

- The evidence submitted was extensive. For brevity, the MA listed the documents they considered the most pertinent.
- Ms L's claim comprised three elements:-

1. Ms L developed a back injury as a result of an incident at work in 1993.
2. She developed impaired mental health at various times during two periods of NHS employment as a result of work events.
3. 1 and 2 had secondary effects on other medical conditions.

- The criteria for a PIB award under the 1995 Regulations.

10. The MA continued:

"In considering the question of attribution I am guided by the judgement of Judge Davies in the case of Dr David Stewart v NHS BSA in the High Court, in particular, paragraph 114 of that judgement where Judge Davies gives his views as to the proper construction and approach to regulation 3(2). Judge Davies indicates that the correct approach is to:

1. Identify the disease in question contracted by the employee.
2. Identify the employee's contractual duties by reference to her contract of employment.
3. To ask whether the disease was contracted in the course of her employment. This involves considering whether the disease was contracted at the time when the claimant was in the process of performance of activities that were part of her contractual duties, including activities reasonably incidental to those contractual duties.
4. If the answer to #3 is yes, then to ask whether the employment was the whole or main cause of the disease being considered.
5. If the answers to #3 and #4 are both no, then to ask whether the duties of employment were the whole or main cause of the disease being contracted.

I will first consider the question of attribution. I will begin by considering [Ms L's] back injury.

In summary, [Ms L] states that she sustained a back injury while lifting a patient in 1993. The date of this injury is not specified and no contemporaneous documentation from the employer, such as an accident form or accident investigation report have been provided. However, I have no reason to question [Ms L's] account and I will provide advice on the basis that she has provided a reasonable and accurate account of events.

While noting that [Ms L's] GP would be unlikely to have first-hand knowledge of what took place at work and would be dependent upon [Ms L's] account, the GP records do contain an entry dated 12 February 1993 where [Ms L] attended reporting back strain following an incident of lifting at work. [Ms L] attended her GP on a number of subsequent occasions being referred to an

orthopaedic surgeon in August that year because of ongoing symptoms. [Ms L] was seen by Mr Maheson, a senior lecturer in orthopaedics and trauma. Mr Maheson refers to an abnormality on plain x-ray in his report of 6 August 1993. He elected to arrange an MRI scan of [Ms L's] spine in order to exclude a disc prolapse. There are subsequent reports from Mr Maheson dated 10 September 1993 and 1 October 1993. In the first of these reports, Mr Maheson indicates that plain x-rays and MRI scanning do not show any disc prolapse or nerve root impingement. In the second report, he states that the MRI is normal and opines that [Ms L's] symptoms should slowly improve. In his final report of 3 November 1993 Mr Maheson documents that [Ms L] was responding well to physiotherapy and he discharged her from his clinic. Mr Maheson's reports are consistent with the GP records from that time. An entry dated 18 September 1993 documents that the MRI scan was "negative" and that [Ms L] was improving. I note that there are no entries in the GP records relating to back pain between 1993 and 19 May 2003. This appears to be consistent with the report from the employer's occupational physician, Dr Davies, dated 19 May 2003 in which Dr Davies comments that [Ms L] had developed further back pain, apparently following a recent appointment.

The nature of [Ms L's] back injury is not given in the contemporaneous documents. While Dr Davies, writing in July 2003, does refer to [Ms L] developing a prolapsed disc 10 years previously, this comment is at variance with Mr Maheson's contemporaneous reports, where he explicitly states that imaging did not show any disc prolapse. Given that Mr Maheson's opinion is contemporaneous with the injury, that Mr Maheson had the benefit of imaging and given that he is a consultant orthopaedic surgeon, I have given greater weight to Mr Maheson's opinion than that of Dr Davies, who was an occupational physician commenting some 10 years after the event.

Given the negative MRI scan, I think the most likely scenario is that [Ms L] developed a soft tissue injury of her back. This would be consistent with the reported mechanism of injury. The course of [Ms L's] symptoms as documented in the contemporaneous medical records is consistent with a soft tissue injury.

The manual handling of a patient would be part of a nurse's contractual duties. It is therefore my opinion that this soft tissue injury was contracted in the course of [Ms L's] employment.

Given [Ms L's] account, the apparent close temporal relationship between the incident and the development of her symptoms and given the absence of any evidence to suggest that any other events contributed to the injury, it is my opinion that [Ms L's] employment was the whole cause of the soft tissue injury. It follows from this that it is my opinion that the criteria of regulation 3(2) are met in respect of the presumed soft tissue injury.

I am conscious that the outcome of this application will be determined by NHS BSA, not by myself as scheme medical advisor, and that NHS BSA may weigh the evidence differently and prefer the views of Dr Davies when it comes to the nature of [Ms L's] injury, particularly given the abnormality noted on plain x-ray. I will therefore go on to consider whether, if one did regard [Ms L's] injury as being a prolapsed disc, such a prolapsed disc would be wholly or mainly attributable to the incident described.

The intervertebral disc consists of two parts. There is a dense outer ring, called the annulus, which surrounds an inner, softer, part called the nucleus pulposus. Over time, changes occur in the outer layer of the disc causing it to bulge out. There has been a change in our understanding of the aetiology of these changes in recent years. The traditional view is that the factors associated with this process are age, gender, occupation, cigarette smoking and exposure to vehicular vibration. However, there is now increased recognition of the role of genetic factors and it is now believed that the changes I have described above are, to a large degree, dependent upon genetic mechanisms. Studies that have shown a lack of any clear dose-response relationship between physical loading and degenerative disc disease and studies undertaken in monozygotic (i.e. identical) twins support the position that genetic determinants are likely to be more important than environment factors in the development of disc degeneration. The bulges sometimes, but not always, affect the entire perimeter of the disc causing it to bulge outwards. Sometimes, a crack develops in the annulus and parts of the nucleus pulposus protrude through that crack. This is known as disc herniation.

The prolapse or herniation of the disc does not occur unless the annulus is already weakened. The process of herniation can occur in the absence of trauma, though in this instance, an incident did occur which, if one accepts that a disc prolapse did occur, would have been likely to

have contributed to the disc prolapse and may have been the precipitating event.

However, any disc prolapse would have occurred because of a combination of factors; specifically, the weakening of the annulus and the index event. Since the weakening of the annulus is a necessary pre-condition for the disc to bulge or herniate, and in the absence of the weakened annulus the incident described would, in itself, have been insufficient to give rise to a disc prolapse, I would take the view that if Ms Mansell had sustained a disc prolapse, the weakened annulus would have been the main cause of that prolapse.

I accept that one could construct an alternative argument, i.e. that since any disc prolapse would have been unlikely to have occurred at the time it did had the incident not happened, the incident was the main cause of the prolapse. However, since a disc prolapse can occur in the absence of trauma, a

weakened annulus is, in and of itself, a sufficient cause of a disc prolapse. The converse does not apply. Trauma, unless extreme, is not, in and of itself, a sufficient cause of a disc prolapse. It requires the co-existence of a weakened annulus before prolapse occurs. I think the fact that a weakened annulus is in itself a sufficient cause of disc prolapse while trauma, in itself, is not, supports the view that the weakened annulus, not the index event, would have been the main or predominant cause of any disc prolapse.

In my opinion, on balance or probability, even if one did consider [Ms L's] back injury to be a disc prolapse, such a disc prolapse would have been unlikely to have been wholly or mainly attributable to [Ms L's] employment. There is no reason to suppose that any degenerative changes would have been themselves a consequence of her employment.

I will now consider [Ms L's] impaired mental health. In doing so, I do not think it is necessary for me to consider whether the events described by [Ms L] actually took place in the manner in which she describes them. In reaching this conclusion I am guided by the determination of the Pensions Ombudsman in the case of Gray v CSP, in particular, paragraph 27 of his determination in which he pointed out that if the medical evidence was that Mr Gray's injury was as a result of his perception of events, that fact that Mr Gray's perception was wrong is irrelevant, and a requirement that Mr Gray's reaction must be reasonable was not part of the test in the relevant scheme rule. While the Pensions Ombudsman's determination was not made in respect of an application made under the NHS Injury Benefit Scheme, I note that regulation 3(2) only requires that the injury is contracted in the course of employment and is wholly or mainly attributable to the employment, or to the duties of the employment. As in the Gray case, there is no requirement in regulation 3(2) that the applicant's perception of events is accurate or that their response to those events is reasonable.

The medical reports consistently describe [Ms L's] impaired mental health as being a recurrent depressive disorder. This diagnosis was first made by Dr Hailwood, a consultant psychiatrist, in October 2000. However, in his report of 30 October 2000, Dr Hailwood does allude to [Ms L's] difficulties having their roots in events that had taken place somewhat prior to this, specifically, difficulties in a personal relationship that had ended some 10 years earlier.

[Ms L] also had a period of impaired mental health in 2008. Another consultant psychiatrist, Dr Jenkins, writing in May 2008 opines that [Ms L's] recurrent depressive illness went back to 1998, that she never fully recovered from this, and experienced a second period of depression in 2000. A third psychiatrist, Professor Sullivan, writing in 2016, opined that the period of impaired mental health that occurred in 1998 was post-traumatic stress disorder (PTSD). Professor Sullivan did, however, agree with three previous psychiatrists that [Ms L] had a major recurrent depressive disorder, which Professor Sullivan opined was precipitated by a gynaecological illness in 1998 and the PTSD.

The GP records contain an entry dated 31 July 1998 that referred to PTSD and depression secondary to a significant gynaecological illness.

The overwhelming weight of medical evidence is that [Ms L's] impaired mental health was a recurrent depressive illness. It may be helpful if I now comment on the natural history of a recurrent depressive illness. Depression is one of a group of mental illnesses known as affective or mood disorders. The natural history of these conditions is that they are typically recurrent in nature. An individual who is diagnosed with depression will, most probably, either have already had a previous episode of depression (which may have been unrecognised) or will go on to have a further episode of depression in the future. The fact that [Ms L] was diagnosed with a depressive illness meant that it was more likely than not that she would experience at least one further episode of depression in the future.

On the basis that [Ms L] did have a recurrent depressive disorder, the question then becomes whether this condition was contracted in the course of her employment. To some extent, this would be determined by whether one considers the period of impaired mental health in 1998 to be an episode of depression or not.

If one prefers the GP records, the report of Dr Howarth and the opinion of Dr Jenkins, the depressive illness would not have occurred during the course of [Ms L's] NHS employment as the work events described by [Ms L] did not begin until 2000 (based on entry in the GP records dated 30 October 2000). It is my understanding that a qualifying injury as referred to in regulation 3(2) excludes the exacerbation of a pre-existing injury or condition to the extent that such an injury or condition is not wholly or mainly attributable to NHS employment. Therefore, if one accepts that the illness in 1998 was a manifestation of depression, the relapses of that condition in 2000 and subsequently would fall outside the scope of regulation 3(2) for that reason.

If one prefers the opinion of Professor Sullivan that the illness in 1998 was PTSD and that [Ms L's] depression began around the time of its diagnosis in 2000, then it would not be unreasonable to consider that the depressive illness did occur in the course of [Ms L's] employment as the contemporaneous evidence (Dr Hailwood's report of 30 October 2000 which refers to stress at work caused by understaffing and the GP record entry dated 30 October 2000 which refers to [Ms L] having difficulties with a new job) indicate that [Ms L's] perception of her work circumstances would have been likely to have been a contributory factor to her depressive illness. There are also many subsequent reports written over a period of several years by two GP's (Dr Howarth and Dr Joshi), three psychiatrists (Professor Sullivan, Dr Ratajczak and Dr Thomas), and a psychologist (Dr Herbert) that make reference to the contribution made by [Ms L's] perception of her work circumstances to her depression and the contribution of those work circumstances to relapses of her depressive illness.

If one accepts that [Ms L's] recurrent depressive illness was contracted in the course of her employment, it then becomes necessary to consider whether the illness was the whole or main cause of that recurrent depressive illness. I do not believe this to be the case. There are a number of reasons for this:

Genetic factors play an important role in the development of depression as evidenced by the fact that first degree relatives of individuals with depression are three times more likely to develop depression than the general population. [Ms L] has a family history of depression as evidenced by the reports from Dr Hailwood and Professor Sullivan.

The underlying mechanisms that give rise to depression are not clearly defined. Current evidence points to the role of the relationship between neurotransmitters and their receptors within the brain. Functional neuroimaging studies have shown that depression is associated with changes in metabolic activities in various parts of the brain.

While some form of loss can increase the risk of depression and while psychosocial factors for depression are documented and the presence of negative life events can affect the development and maintenance of depressive symptoms, a major depressive disorder can arise without any precipitating stressor.

Many of the medical reports provided attest to the contribution of non-work factors in the development of [Ms L's] impaired mental health. These reports include Dr Lever's report of 27 March 2013, Professor Sullivan's report of 27 July 2016, Dr Ratajczak's report of 7 September 2015, Dr Thomas' reports of 16 October 2008, 24 January 2012 and 4 September 2012, Dr Herbert's report of 28 August 2008, Dr Hailwood's report of 30 October 2000, Dr Joshi's report of 9 November 2007 and entries in the GP records dated 31 July 1998 and 30 October 2000.

As pointed out by Barth, Kertay and Steinberg, writing in the chapter on mental illness in the American Medical Association Guide to the Evaluation of Disease and Injury Causation, second edition published in 2014, it is pertinent to consider what the normal human response to adverse circumstances is. Barth, Kertay and Steinberg comment that one of the strongest arguments against the premise that adult life experience causes psychopathology is the number of scientific findings that have addressed the normal human response to challenging experiences. These findings have reliably and consistently demonstrated that the normal response to such experiences is positive psychological change. They cite the earlier contribution by Janoff-Bulman in the Handbook of Post-traumatic Growth, edited by Calhoun and Tedeschi and published in 2006 indicating that this phenomenon is reported by over 75% of survivors of a traumatic experience. This phenomenon has been observed in a wide range of situations including combat veterans, chronic and life threatening illness, victims of violence and survivors of disasters. This should

not be taken as negating the significance of the distress that trauma can precipitate. However, as Barth, Kertay and Steinberg point out, distress is not synonymous with mental illness.

A criteria often considered when assessing whether there is a causal relationship between an exposure and the subsequent development of a disease is whether there is a dose-response relationship. In other words, is there a relationship between the level of exposure and the severity or frequency of the disease? A study by Tucker and colleagues published in the American Journal of Orthopsychiatry in 2002 looked at depressive symptoms in workers handling bodies following a terrorist incident and found no reliable dose-response gradient. This provides evidence against a causative role for stressful experiences.

In contrast, a study by Elder and Clipp published in 1989 provides evidence that the phenomenon of post-traumatic growth that I referred to above does exhibit a dose-response relationship.

As part of their working in preparing the chapter on mental illness that I have referred to above, Barth, Kertay and Steinberg undertook a literature search and were unable to identify any published project that actually involved the design that, in their opinion, credibly addressed the aetiology of any mental illness. As they point out, in order to be credible, any claim that adult experience has resulted in psychopathology must explain why and how the claimed cause has overwhelmed the normal human tendency towards post traumatic growth and caused the mental illness instead. They concluded that there was insufficient evidence of a causative relationship between depressive disorder and work.

The current position as regards the aetiology (causation) of major depressive illness is that the specific cause is simply not known. Most probably, the clinical picture that is described as depression is a multi-factorial group of disorders that involve both genetic and environment factors. I do not doubt that [Ms L's] perception of her work circumstances has contributed to her impaired mental health. However, this in itself is insufficient to demonstrate that the test in regulation 3(2) is met. Given our current understanding of the causation and natural history of recurrent depression and the documented role of non-work factors in the development of [Ms L's] condition, I do not think it is possible, even on the balance of probability, to conclude that [Ms L's] recurrent depressive illness is wholly or mainly attributable to her perception of work events. In my opinion, on balance of probability, [Ms L's] depressive illness is unlikely to be wholly or mainly attributable to her employment. It is also unlikely to be wholly or mainly attributable to the duties of her employment for the same reasons.

With regards to [Ms L's] request that her other listed conditions are taken into account I would advise as follows:

The evidence is that [Ms L] does have endogenous pompholyx eczema (sometimes referred to as dyshidrotic eczema) as diagnosed by Dr El-Dars. There are multiple potential causes of pompholyx eczema reported in the literature. These include relationship with atopy (50% of individuals with pompholyx eczema have a personal or family history of atopic illness), various agents known to cause contact dermatitis and at least two different genetic factors. There are reports that emotional stress can exacerbate pompholyx eczema and many patients with this condition do report recurrences of it during stressful periods. I agree with Dr El-Dars' opinion. However, I am unaware of any evidence that this condition is actually caused by perceived stress and I do not think it can be regarded as being wholly or mainly attributable to Ms Mansell's employment or to the duties of her employment.

The evidence is that [Ms L] does have a functional gastrointestinal disorder. The cause of these conditions is currently not known, though alteration in part of the nervous system known as the limbic system have been reported in individuals with irritable bowel syndrome and these abnormalities appear similar to those noted in individuals with major depression. It is therefore plausible that there may be some link between [Ms L's] gastrointestinal symptoms and her impaired mental health. However, I would not conclude from this that her gastrointestinal symptoms are wholly or mainly the result of her employment or the duties of her employment.

Stress is cited in the literature as a precipitant for attacks of migraine. However, migraine undoubtedly has a strong genetic component as evidenced by the fact that 70% of individuals with migraine have a first degree relative with the condition and that relatives of an individual who has migraine with aura have a four-fold higher risk of developing migraine themselves when compared to the general population. While I would accept that attacks of migraine can be precipitated by stress I do not think that migraine can be considered to be wholly or mainly attributable to stress given our current understanding of this condition.

Since it is my opinion that [Ms L's] soft tissue back injury is likely to satisfy the test of attribution, I will now go on to consider whether this condition has given rise to any PLOEA.

As I have indicated above, the most likely scenario is that the index event in 1993 gave rise to a soft tissue back injury. Such injuries would be normally expected to resolve without giving rise to any long term adverse consequences. The contemporaneous medical evidence from 1993, in particular the entry in the GP records dated 18 September 1993 and Mr Maheson's report of 3 November 1993 indicate that [Ms L's] condition was improving. This is further supported by the lack of any attendances at the GP practice due to back problems between 1993 and 2003 as well as Dr Brew's report of 23 November 1996. In that report, Dr Brew states that [Ms L] does not appear to have had a recurrence of the back problem and that the episode

in 1993 was an isolated incident. The medical evidence therefore supports the conclusion that [Ms L] made a full recovery from the soft tissue injury sustained in 1993 and that it has not given rise to any PLOEA. This conclusion is supported by the MRI imaging from 1993 and the more recent imaging in January 2018 commented upon by Mr Singhal, neither of which demonstrated any abnormality that was attributable to the 1993 incident. The scan in 2018 demonstrated only degenerative changes that Mr Singhal clearly opines are constitutional in nature. While I do not doubt that [Ms L] has ongoing symptoms attributable to her back, these symptoms are more likely to be attributable to the degenerative changes than to any soft tissue injury sustained in 1993."