CAS-38314-K9K4

Ombudsman's Determination

Applicant	Ms G
Scheme	NHS Injury Benefit Scheme (the **Scheme**)
Respondent	NHS BSA

Outcome

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

Complaint summary

2. Ms G's complaint is that NHS BSA has declined to award her a permanent injury benefit (**PIB**) on the basis that she has not sustained an injury, or contracted a disease, in the course of her NHS employment which is wholly or mainly attributable to that employment.

Background information, including submissions from the parties

3. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

4. The relevant provisions are The National Health Service (Injury Benefits) Regulations 1995 (SI1995/866) (as amended) (the **1995 Regulations**). The 1995 Regulations apply to a person who sustains an injury, or contracts a disease, before 31 March 2013. Briefly, 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. Relevant extracts from the 1995 Regulations are provided in Appendix 1.

6. Ms G was employed as a part-time Staff Nurse. She worked in a number of treatment suites (clinics) providing services for mental health users. Her employment ended in May/June 2015 on the grounds of ill health.

7. In December 2015, Ms G applied for a PIB. On form AW13, Ms G claimed tenosynovitis in her right arm caused by a vastly increased workload in February to May 2013 when her manager was absent from work.

8. First instance decisions are provided by the Scheme's medical adviser (**MA**) under delegated authority. An initial decision was given on 24 June 2016. The MA declined Ms G's application on the grounds that its doctor had been unable to conclude that she had suffered an injury which was wholly or mainly attributable to the duties of her NHS employment. The decision letter quoted the advice provided by the doctor who had reviewed Ms G's case. A summary of and an extract from this is provided in Appendix 2.

9. In June 2017, Ms G appealed the decision invoking the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**). Ms G said:-

    - She had "stage 3 severe (defused) RSI[1], fatigue and fibromyalgia".
    - She was permanently disabled and currently had a huge reduction in her overall standard and quality of life.
    - There were no further improvements or treatments.
    - She would never be capable of full-time employment.
    - She had been diagnosed with asthma in 2013. She used an inhaler and sometimes was unable to leave her bed due to pain, shortness of breath, fatigue and lack of motivation.
    - She sustained her injury at work through trauma, stress and rapid overuse of her upper limbs.
    - She had been informed that it was not advisable for her to go back to mental health nursing as, if unfortunate circumstances arose, she would not have the strength, agility or reflexes to defend herself.
    - It was clear that the work and pressures she was put through in February 2013, "managing, operating and running 3 clinics", had a debilitating effect on her body.
    - Her illness was aggravated in November 2014, during a phased return to work, using an archaic computer and mouse, despite instructing her employer (**the Trust**) four months earlier that she required an ergonomic assessment. Her manager was aware that she had soft tissue damage. RSI was diagnosed in June 2014.
    - Her records showed she also had other "physical mosquito problems", which all stemmed from the lack of good management by the Trust in February 2013.

[1] Repetitive Strain Injury.

- As well as fibromyalgia and RSI her diagnoses included tenosynovitis, epicondylitis in both elbows (her right elbow had been operated on in 2017 and she was waiting for a date for her left elbow), trigger fingers, De Quervain's disease and Reynaud's syndrome "all caused by rapid overuse and lack of duty of care" by the Trust.

10. Ms G asked that a PIB be paid from 2014 and the evidence she presented be considered for both her PIB and ill health retirement appeals. Ms G submitted a letter from Professor Barton (Honorary Consultant in Rheumatology) dated 15 May 2017 and a letter from Dr Sanders (Consultant Rheumatologist) dated 7 June 2017. Both concern her health at that time.

11. NHS BSA obtained the further opinion of the MA.

12. In September 2017, NHS BSA issued its Stage One IDRP decision not upholding Ms G's appeal. It said:-

    - Having considered Ms G's appeal and the advice from the MA it was not satisfied that the injury for which Ms G had claimed a PIB was wholly or mainly attributable to her NHS employment.

    - The criteria for a PIB award under the Scheme were different to the criteria used by the DWP in determining entitlement to disability benefits or Industrial Injuries Disablement Benefit (**IIDB**).

    - The MA's opinion on Ms G's ongoing symptoms was that they were not attributable to tenosynovitis, but rather to fibromyalgia and ulnar nerve entrapment which were not accepted as being wholly or mainly attributable to her NHS employment.

    - It had no reason to disagree with the MA's comprehensive assessment and recommendation.

13. NHS BSA's decision letter quoted the advice it had received from the MA. A summary of and extracts from the MA's report is provided in Appendix 2.

14. In June 2018, Ms G appealed the Stage One decision. Ms G said:-

    - She had been in receipt of IIDB since 2014 "for loss of faculty, loss of power or function in my forearm, pain restricted movements of the right wrist with pain in right elbow".

    - At the beginning of 2013, she had already been referred to Occupational Health with anaemia, fatigue, fibroids and stress.

    - She had been diagnosed with RSI in June 2014. It was a progressive condition. When NHS BSA made its decision, it failed to consider that it was at stage 3 (severe).

- Her RSI was brought on by the rapid overuse of her arms dealing with an increased workload while her manager was off sick in February to May 2013; and aggravated in October to November 2014 during a phased return to work.
- The pain had not gone away, instead it had developed into fibromyalgia and Sjorgen's syndrome.
- The Trust failed to consider or acknowledge her injuries prior to her dismissal in 2015.
- She was currently receiving Employment Support Allowance (**ESA**).
- She was mentally and physically extremely ill. Raynaud's syndrome, intersection syndrome, diffused RSI, De Quervain's tendonitis, trigger fingers, IBS, fibromyalgia, Sjorgen's syndrome, acute anxiety, depression and a stomach ulcer had been brought on by the overuse of her "physical being and extended emotional distress", while completing her NHS role in February to May 2013.
- Her body was broken down due to trauma, stress and anxiety. She was now without a career and living with chronic pain, fatigue and anxiety every day. The whole situation was unfair and distressing.

15. NHS BSA obtained the further opinion of the MA. In September 2018, NHS BSA turned down Ms G's final appeal. It said:-
    - The MA had considered all the evidence and determined that Ms G's claimed injury was not wholly or mainly attributable to her NHS employment.
    - The MA was not able to conclude that the tenosynovitis / RSI that Ms G claimed to suffer from was wholly or mainly attributable to her NHS employment because the medical evidence showed that she had fibromyalgia. Fibromyalgia was not wholly or mainly attributable to Ms G's NHS employment. There was no evidence to show that Ms G had suffered an injury or developed a disease that was wholly or mainly attributable to the duties of her NHS employment prior to 31 March 2013.
    - It had no reason to disagree with the MA's assessment.
16. NHS BSA's decision letter quoted the advice it had received from the MA. A summary of and extracts from the MA's report is provided in Appendix 2.

Ms G's position

17. Ms G says:-
    - At the time she was struggling with her health and repeatedly asked for support, but inexperienced management led to her injuries.
    - The team's role was risk assessed and allocated for 2.5 qualified staff nurses. She did the role with minimal support for 16 weeks under very high-pressurised circumstances. She was using her limbs constantly with no breaks. She had to

administer injections, draw bloods, write reports, input patient details, pop medication, lift, handle, clean and drive to and from four hospital sites, caring for 104 mentally ill individuals.

- At the time of getting injured she continued working applying Voltarol and whining in pain. It was only after a large lump became visible on her wrist that she realised the damage done.
- She is still under the care of a Pain Clinic and scheduled to have cubital tunnel release on her left elbow. Her right elbow is still recovering from the surgery in 2017.
- She experiences daily pain in her upper limbs.
- DWP decided in November 2021 that her injury sustained on 1 July 2013 continues to be debilitating and that she does not have to attend any further assessments for IIDB.
- When she was off work on reduced pay, she was supposed to get injury benefit, as the Trust had already decided that it would dismiss her on the grounds of ill health.
- This whole episode has left her physically and mentally ill. At the time the Trust took no responsibility for its actions and did not support her.

18. Additionally, Ms G has submitted:-

- An email dated 25 February 2013 from the Matron inviting Ms G and colleagues to a treatment suite meeting to discuss his role and how he could support and develop their services.
- Three emails dated 26 February 2013. The first from Ms G to the Matron and colleagues that she was not able to attend the meeting on her day off. Ms G says she is working at a clinic on her own today. She says this is not permitted and "goes beyond all our concerns and discussions with the union and management". She says it is not acceptable and is causing undue stress for the team. The second and third emails are from the Matron. In the second the Matron asks two colleagues if either are available to cover the clinic. The Matron says he has enquired what is being done "to support around staffing" and asks for any other suggestions. In the third, the Matron confirms to Ms G that he has escalated her concern and asks Ms G to provide her contact details to that person.
- Emails sent in July, August and September 2013 pertaining to the team's current work rota and cover.
- Emails dated 16 and 17 September 2015 pertaining to Ms G's sickness absence, return to work and dismissal on grounds of ill health.

- Ms G's email dated 3 January 2016 requesting a colleague to provide a statement about an incident on 25 September 2013.
- A six-week work rota beginning on 19 August 2013 and ending on 23 September 2013.
- Medical reports from Ms G's treating clinicians pertaining to her health in 2019 and 2020.

NHS BSA's position

19. NHS BSA says:-

- It refutes any allegation of injustice borne out of maladministration and submits that it has correctly considered Ms G's PIB application, using the correct test, taking into account relevant evidence and ignoring anything irrelevant.
- In making its decision it has sought and accepted the advice of its MA.
- That it has weighed the evidence differently or drawn a conclusion that differs from Ms G's own opinion of the cause of her ongoing incapacity is unfortunate but is a finding for it to make based on the facts.
- It is satisfied that in reconsidering Ms G's application it has considered Ms G's application in the proper manner, and in keeping with the Edge principles, namely it:
    - asked the right questions;
    - directed itself correctly in law, in particular it adopted a correct construction of the Scheme Regulations;
    - considered all relevant factors, ignoring any irrelevant ones; and
    - avoided a perverse decision, that is a decision which no other reasonable person could arrive at.
- Ms G's application for a PIB has been consistently rejected on the grounds that there is no evidence she suffered an injury or contracted a disease in the course of her NHS employment prior to 31 March 2013.
- Ms G's claim that it has only considered one illegible report dated 8 December 2015[2] is incorrect. It has considered all the submitted evidence, comprising 15 medical reports and her GP records.

[2] Dr Parker's (Occupational Health Physician) completion of Part C of Ms G's ill health application form (AW33E).

- In 2016, the MA noted that no concerns were raised by Ms G with her employer until June 2014. No injury was recorded. The submitted medical evidence shows she first consulted her GP at that time.

- Ms G's symptoms were first considered to be tenosynovitis, but later MRI scans showed no tenosynovitis. The condition has since been diagnosed as fibromyalgia.

- At Stage Two IDRP, Ms G's claim changed to being in respect of RSI, epicondylitis, De Quervain's disease, Raynaud's syndrome and fibromyalgia, No further medical evidence was submitted. The MA's opinion was that Ms G did not present symptoms until June 2014 and there was no causal connection to the claimed injury of February to 31 March 2013. Ms G says she could not visit her GP from 2013 to June 2014 because she was suffering from anaemia. Anaemia is not a work-related condition. There was no evidence of any injury or condition related to her NHS employment prior to 31 March 2013.

- It declined Ms G's PIB application on the basis that the RSI, epicondylitis, De Quervain's disease, Reynaud's syndrome and fibromyalgia are not wholly or mainly attributable to her NHS employment.

Adjudicator's Opinion

20. Ms G'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:-

    - The decision as to whether Ms G is eligible for a PIB was for NHS BSA to make on behalf of the Secretary of State. It had, however, delegated the task of making first instance decisions to the MA.

    - To qualify for a PIB, Ms G must satisfy a two-part test. The first question, under Regulations 3(1) and (2), was whether Ms G had sustained an injury (or contracted a disease) in the course of her NHS employment prior to 31 March 2013, which was wholly or mainly attributable to that employment or the duties of that employment. If that test was satisfied then the next question, under Regulation 4(1), was whether she had, as a consequence, suffered a PLOEA of greater than 10%. In answering either question the decision-maker, be it NHS BSA or the MA, was making a finding of fact.

    - Both NHS BSA and the MA correctly applied the 1995 Regulations.

    - Concerning the initial decision, the MA appeared to have considered the available medical evidence. The MA noted:-

        - Ms G's first sickness absence due to a musculoskeletal condition started between June and October 2014 and she was further absent from December 2014 until her NHS employment ended in 2015.

- The Trust stated that Ms G had not raised her medical problem prior to June 2014 and there was no documentary record of an injury at work.

- An IIDB award was made in July 2015, backdated to late December 2014.

- At Part C of Ms G's ill health application, the Occupational Health Physician (Dr Parker) stated the condition contributing to incapacity was pain in the right hand and forearm since June 2014 and a diagnosis and nerve conduction studies were awaited.

- The GP records showed a first consultation for upper limb problems in June 2014. This stated that Ms G had noticed a slowly growing lump in her right forearm over the past eight months.

- There had been varying diagnosis since mid-2014.

- The GP records did not support the history, later given in 2016, that there were upper limb symptoms from 2013.

- The MA's opinion was that there was no evidence that Ms G's continuing upper limb symptoms had onset, or were attributable to a work injury, prior to 31 March 2013.

- The Stage One and Two IDRP decisions were made by NHS BSA after obtaining the further opinion of the MA.

- At Stage One, the MA said, based on the June 2014 entry in the GP records, it appeared that Ms G first noted her symptoms in late 2013. While Ms G's symptoms on examination were first attributed to tenosynovitis, scans in July 2014 and 2015 showed no sign of the condition, tendonitis or intersection syndrome. It now appeared more likely that Ms G's symptoms were attributable to fibromyalgia and nerve compression at the elbows. It was also possible that Ms G had an underlying connective tissue disorder, albeit there appeared to be differing views on this. There was no evidence that Ms G's fibromyalgia was sustained in the course of her NHS employment. The way fibromyalgia developed was not fully understood. Studies suggested that it had a genetic component. Trauma as a trigger of fibromyalgia was highly contentious. Numerous investigations were available, and the weight of this evidence did not support physical trauma as a significant causative factor in the development of fibromyalgia. Entrapment of the ulnar nerve was common and multiple factors could give rise to it. While work requiring repetitive extension and flexion of the elbow could exacerbate the symptoms of the condition there was no evidence it was causative.

- At Stage Two, the MA noted Ms G's claim that she was referred to Occupational Health in early 2013 with anaemia, fatigue and stress. The doctor said while fatigue

could be related anaemia, anaemia was not work-induced. So, neither were related to fibromyalgia nor ulnar neuropathy. Stress was not known to result in musculoskeletal problems. The MA noted that further investigations in 2015 showed no evidence of tenosynovitis, epicondylitis or De Quervain's disease. The MA agreed that there was no evidence to suggest that Ms G's fibromyalgia and bilateral ulnar neuropathy were sustained during her NHS employment. The MA said the role of trauma as a trigger for fibromyalgia was disputed by the scientific/medical community. The current understanding was that physical trauma was not a significant causative factor in its development. Regarding ulnar nerve entrapment, nothing suggested that Ms G had undertaken unusual activities beyond the normal range of movements of the elbow joint as a nurse resulting in abnormal biomechanics. While repetitive movements of the elbow could exacerbate the condition there was no scientific evidence that it could cause the condition. On Ms G's RSI claim, RSI was a progressive condition, but there was no definitive scientific evidence to suggest that RSI had a strong association with work activity.

- For Ms G to pass the first question (Regulation 3) she had to demonstrate she had sustained an injury/contracted a disease prior to 31 March 2013. The MA's doctors point to the fact that her first GP consultation was in 2014. The evidence she had presented seemed to consist of the emails from February 2013 which did not mention pain; just that she was working on her own. If, as she said, she was using Voltarol and whining in pain, the Adjudicator expected her to have mentioned this.

- There were no grounds for finding that NHS BSA should not have accepted the views of the MA's doctors.

- There did not appear to be a difference of medical opinion between Ms G's treating doctors and the MA, but even if that was not the case, the Adjudicator was of the view that it was not sufficient for the Ombudsman to conclude that NHS BSA's decision was not properly made.

- There was nothing to suggest that any evidence had been ignored by NHS BSA and/or the MA, rather NHS BSA had given greater weight to the advice from the MA which it was entitled to do.

- As Ms G's claim did not satisfy the first part of the test for a PIB she could not have suffered a PLOEA in relation to the second part of the test as that question only arose if the first part of the test was passed.

21. Ms G did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. I have noted the additional points raised by Ms G but I agree with the Adjudicator's Opinion.

Ms G's further comments

22. Ms G says:-

- Her injuries were sustained while doing her NHS duties.
- Her injuries were and are still gradual. Their diagnoses took time. She has had two operations.
- It is unreasonable and unfair that she was not awarded a PIB because she did not visit her GP until June 2014. She discussed her injuries with her manager on numerous occasions. At the time she was unaware that a sore wrist and elbows could lead to much more sinister things. She thought she was tired from overwork and had anaemia, so thought nothing of it.
- It is unfair to say that she did not sustain her injuries at work without proof of how NHS BSA decided this. What were the grounds, on what evidence and how did she injure herself if not at work?
- She was left from February to March 2013 to complete the work of 2.5 people in 22 hours per week.
- Her salary was reduced to 50% having been off work due to De Quervain's tenosynovitis.
- She has not been able to work since 2015 and cannot return to her nursing role in mental health.
- She is now classed as permanently disabled.
- While her health has deteriorated over the last eight years, her initial claim was and still stands as De Quervain's tenosynovitis, intersection syndrome, RSI.
- Her fibromyalgia was diagnosed in 2017, long after she applied for a PIB, and should not be used to cast doubt about her claim.

Ombudsman's decision

23. My role in this matter is not to review the medical evidence and come to a decision on Ms G's eligibility for a PIB. I am primarily concerned with the decision-making process. That is, whether the relevant regulations have been correctly applied; whether appropriate evidence has been obtained and considered; and whether the decision is supported by the available relevant evidence. The weight which is attached to any of the evidence is for NHS BSA to decide, and NHS BSA may prefer evidence from its own MA, unless there is a cogent reason why it should not, or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the MA.

24. Ms G's opinion clearly differs from NHS BSA's and its MA. But, as the Adjudicator explained, a difference of medical opinion is not sufficient for me to be able to find that NHS BSA's decision was not properly made.

25. I am satisfied that the relevant regulations have been correctly applied, that appropriate evidence has been obtained and considered and that NHS BSA's decision is supported by the available relevant evidence.

26. I do not uphold Ms G's complaint.

Anthony Arter

Pensions Ombudsman
2 March 2022

Appendix 1

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

27. Regulation 3 provides:

> "3 Persons to whom the regulations apply
>
> (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."

28. Regulation 4 provides:

> "4 Scale of benefits
>
> (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

MA, 24 June 2016

29. The MA's doctor noted:-

- The criteria for a PIB.
- Ms G's age, her former occupation and the date she ceased NHS employment.
- The evidence considered: GP and Occupational Health case records and submissions from Ms G and the Employing Authority.

30. Under 'Rationale' the doctor said:

> "It is noted that with regard to this Permanent Injury Benefit Application there can only be consideration of injury and onset of any related disease prior to 31/3/13.
>
> [Ms G] had first sickness absence stated due to a musculoskeletal condition between 9/6/14 and 30/10/14. There was further absence due to this condition from 2/12/14 until 21/5/15 when her employed [status] ceased on such health grounds. The Employer states that there was no concern raised by [Ms G] about the above medical problem prior to the sickness absence process. She then states that in her opinion her wrist condition might have been caused by her work. There is no documentary record of an injury at work record.
>
> [Ms G] has been accepted in July '15 as meeting the criteria for an injury under the Industrial Injuries Disablement Benefit scheme and has been given an assessment from 26/12/14.
>
> She applied for Ill Health Retirement in October '15. In the Application form the Occupational Physician stated the condition contributing to incapacity was pain in the right hand and forearm since June 2014. It was added that evidence indicated that the cause of the forearm pain and functional problem with grip and dexterity was as yet undiagnosed and nerve conduction studies were awaited.
>
> From the contemporaneous GP consultation records there was no consultation about an upper limb condition until 19/6/14 when it was noted [Ms G] had noticed a slowly growing lump in her right forearm of 8 months' duration with intermittent numbness in her right hand. She was referred to Orthopaedics.
>
> There have been varying diagnosis:
>
> The Consultant Physiotherapist and Osteopath stated in November '15 that [Ms G] had an 18 month history, (dating from mid 2014) of right upper limb problems and that previous investigation had not revealed evidence of

tenosynovitis or intersection syndrome. The opinion was offered that there could be a De Quervain's Tenosynovitis.

In January 2016 the Plastic Surgery Doctor referred to a history given of pain and weakness in the right had which began in 2013. It was stated that treatment and investigation in 2015 had not demonstrated synovitis or tenosynovitis. The opinion was that she had intersection syndrome, De Quervain's, triggering of right thumb and lateral epicondylitis.

In March'15 the GP stated that [Ms G] had suffered right forearm pain for almost a year, a resistant tendonitis problem.

There has also been evidence of an ulnar nerve condition.

It is acknowledged that [Ms G] has experienced upper limb symptoms leading to sickness absence from mid 2014. The contemporaneous GP records do not support the history, later given in 2016, that there were symptoms from 2013. The Occupational Physician does not refer to a work related cause for symptoms which had begun in June 2014. The Employer has no record of concerns being raised about an upper limb condition prior to sickness absence and there is no documented injury or incident at work.

It is therefore advised that there is no evidence that the continuing upper limb symptoms had onset, or are attributable to work injury, prior to 31/3/13."

MA, Stage One IDRP

31. The MA's doctor noted the criteria for a PIB and the evidence they had considered. Namely:-

- The referral documents.
- Ms G's personal statement dated 10 June 2017.
- Outcome of IIDB application dated 31 July 2015.
- GP reports dated 20 May and 10 December 2015.
- Print out of GP records.
- Report from Mr Gregory (Consultant Orthopaedic Surgeon) dated 15 July 2014.
- Report to management from Dr Dagens (Consultant Occupational Physician) dated 11 December 2014.
- Physiotherapist's report dated 2 February 2015.
- Report from Dr Kirwadi (Consultant Radiologist) dated 31 July 2015.
- Report from Dr Whitehouse (Consultant Radiologist) dated 31 July 2015.

- Report from Mr Parker (Consultant Occupational Physician) on form AW33E[3] dated 8 December 2015.
- Reports from Professor Suckley dated 10 June and 16 November 2015.
- Report from Ms Hughes (STLAS in Plastic and Hand Surgery) dated 11 January 2016.
- Report from Professor Barton (Consultant Rheumatologist) dated 15 May 2017.
- Reports from Dr Sanders (Consultant Rheumatologist) dated 29 March and 7 June 2017.

32. The doctor said that Ms G had fibromyalgia and bilateral ulnar neuropathy as evidenced by Dr Sanders' report. The medical adviser continued:

> "There is some uncertainty as to when [Ms G's] symptoms began. The various medical reports contain conflicting information about this. The earliest entry in the GP records that appear relevant is an entry from 19 June 2014 when [Ms G] sought advice regarding a forearm swelling that she reported had been present for around 8 months. This would suggest that she first noticed symptoms in late 2013.
>
> It is certainly the case that [Ms G's] symptoms were first attributed to tenosynovitis. Many of the older medical reports refer to this diagnosis. This attribution appears to have been made on clinical grounds, i.e. on the basis of the findings on examination. However, imaging of [Ms G's] forearm did not substantiate this diagnosis. The earliest imaging, an MRI scan of the right forearm undertaken on 23 July 2014, is reported by Dr Whitehouse as showing no tenosynovitis. A subsequent ultrasound scan undertaken in July 2015 and reported by Dr Kirwadi similarly shows no evidence of tenosynovitis, tendonitis or intersection syndrome.
>
> It now appears more likely that [Ms G's] symptoms are attributable to fibromyalgia and bilateral compression of the ulnar nerves at the elbows. The diagnosis of fibromyalgia was not made until this year. The neve compression was diagnosed in early in 2016. It is also possible that [Ms G] has an underlying connective tissue disorder as well that is contributing to her symptoms. However, there appear to be differing views on this. The key point is that there is no objective evidence that [Ms G] has, or has ever had, tenosynovitis."

33. The doctor said there was no evidence that Ms G's fibromyalgia was sustained in the course of her NHS employment. The doctor continued:

> "Fibromyalgia is currently understood to be a disorder of central pain processing. The way in which it develops is not fully understood. It appears

[3] Part C of Ms G's Ill health retirement application.

likely that there is a genetic component as suggested by family studies. The role of trauma as a trigger for fibromyalgia has been highly contentious. However, numerous controlled investigations on this issue are now available. It is my understanding that the weight of this evidence does not support physical trauma as a significant causative factor in the development of fibromyalgia. Entrapment of the ulnar nerve is common. There are multiple factors that can give rise to it. Occupational activities that require repetitive extension and flexion of the elbow can exacerbate the symptoms of this condition. However, I am aware of no evidence that they actually cause it.

In summary, [Ms G's] upper limb symptoms were originally attributed to tenosynovitis, which is the likely reason she was awarded IIDB for this condition. However, there does not appear to be a close temporal relationship between the reported work activity and the onset of [Ms G's] symptoms and, in any event, with benefit of hindsight it is now considered more likely that her symptoms were actually the result of fibromyalgia and ulnar nerve entrapment.

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."

MA, Stage Two IDRP

34. In their report the MA's doctor noted:-

- Ms G's age, former NHS occupation, earnings and last day of service.
- The initial consideration of Ms G's application and Stage One IDRP request.
- Ms G's Stage Two IDRP application and that no further medical evidence in support of her claim had been submitted.
- The medical evidence considered[4]

35. The doctor noted Dr Sanders' diagnosis that Ms G had fibromyalgia and bilateral ulnar neuropathy. The doctor continued:

"[Ms G] claims that she was referred to occupational health with anaemia, fatigue and stress at the commencement of 2013. Her fatigue could be related to anaemia. Anaemia is not work-induced. Therefore they are not related to fibromyalgia or ulnar neuropathy. I note that she has indicated that she has suffered from stress. Although stress can manifest as physical symptoms [such as] palpitations, headaches, it is not known to result in musculoskeletal symptoms.

[Ms G's] symptoms were first attributed to tenosynovitis. The attribution appears to have been made on the findings of clinical examination.

[4] As listed in paragraph 41 above.

> Investigations undertaken have not substantiated the diagnosis. An MRI scan of the right forearm undertaken on 23 July 2014 did not identify any inflammation of the tendons. A further investigation undertaken (ultrasound scan) during July 2015, and reported by Dr Kirwadi shows no evidence of tenosynovitis, epicondylitis or De Quervain's disease.
>
> Based on the review of the medical evidence, there is nothing to suggest that [Ms G] has had tenosynovitis or a work-related musculoskeletal disorder."

36. The doctor said there was no evidence to suggest that Ms G's fibromyalgia and bilateral ulnar neuropathy were sustained in the course of her NHS employment. The doctor then said:

> "As regards to entrapment of ulnar nerve, there is nothing to suggest that she undertook unusual activities beyond the normal range of movements of elbow joint as a nursing sister resulting in abnormal biomechanics. There is no scientific evidence to suggest that repetitive movements of the elbow can result/cause ulnar nerve entrapment. Although repetitive extension and flexion (bending and straightening) of the elbow can exacerbate symptoms of the above condition.
>
> She has fibromyalgia. This condition is a disorder of pain processing. The role of trauma as a trigger for fibromyalgia is disputed by the scientific /medical community. The current understanding is that physical trauma is not a significant causative factor in the development of fibromyalgia.
>
> And regards to her claim that RSI is a progressive condition, the existence of a condition with no physical findings is unique in medicine, and RSI fits in the above definition. There is no definitive scientific evidence to suggest that the RSI (non-specific upper limb pain) has strong association with work activity. The causation has not been proven by acceptable scientific methods, there is a lack of the strength of association (i.e. workers everywhere should get similar symptoms irrespective of their place of work/sector worked/country), and the length of symptoms after eliminating suspected trigger (work). Non-specific upper limb pain should respond to appropriate pain management, and therefore cannot be considered as progressive.
>
> Based on the evidence presented to me, 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."