The Pensions Ombudsman

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Ms B's complaint is that NHS BSA has not assessed her eligibility for a permanent injury benefit (**PIB**) in a proper manner.

Background information, including submissions from the parties

3. The relevant regulations in Ms B's case are Regulation 3(2) and Regulation 4(1) of the NHS (Injury Benefits) Regulations 1995 (as amended) (**the Injury Benefits Regulations**), which are set out in Appendix 1.

4. In childhood, Ms B developed a curvature of her spine (scoliosis) and underwent surgery at age 11. Metalwork was inserted to correct the curvature and support/stabilise her spine.

5. Ms B was employed as a full-time Psychiatric Nurse/Senior Research Assistant from 1 October 1990 to 26 January 2016.

6. On 17 September 2012, during a fire evacuation Ms B experienced severe pain in her back whilst descending flights of stairs (**the index incident**).

7. In April 2016, Ms B applied for a PIB due to exacerbation of symptoms of scoliosis, she believed she had suffered as a result of the index incident. In her application, she said:

   "I began to experience severe pain in my spine, legs and neck. I experienced considerable back pain, numbness and pain in my right leg."

8. First instance decisions relating to a PIB are made by the Scheme's Medical Adviser (**SMA**) under delegated authority. On 17 July 2017, the SMA sent Ms B its decision

letter declining her application. It referred to its medical adviser's (**MA**) opinion (see Appendix 2), who concluded that:-

- Ms B's injury arose directly from the spinal degenerative disease and the arthritis of neck, back and hips was due to this pre-existing condition.
- Her persistent chronic pain was multi-factorial arising from the natural progression of the pre-existing back symptoms and neck symptoms, and a frozen shoulder in addition to soft tissue pain in the low back caused by the evacuation. So, her chronic pain could not be attributed wholly or mainly to the index incident.
- So, there was insufficient evidence that the disease contracted was in the course of her NHS duties and was wholly or mainly due to her duties.

9. In January 2019, Ms B's representative from the Royal College of Nursing (**RCN**) made an appeal under the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**). RCN provided further medical evidence dating from the 1980s and also evidence post-dating the application. It claimed that the index incident had caused Ms B severe chronic pain syndrome (**CPS**) and that this was the reason for her permanent loss of earning ability (**PLOEA**).

10. NHS BSA referred the appeal to the SMA. Another MA for the SMA gave their opinion that it was very clear that Ms B had a highly significant medical condition that impaired her level of functioning. However, the evidence indicated that the index incident was an exacerbating factor of a pre-existing condition that was demonstrating signs of progression and was predicted to have been progressive (see Appendix 2).

11. On 2 April 2019, NHS BSA turned down Ms B's appeal under IDRP stage one.

12. NHS BSA said:

> "The Medical Adviser has stated the evidence indicates the workplace incident was an exacerbation factor of a pre-existing condition. I can see no reason to disagree with the latest Medical Adviser's comprehensive assessment and recommendation and therefore I am satisfied that the claimed injury is not wholly or mainly attributable to Ms B's NHS employment. In this instance there is no entitlement to Permanent Injury Benefit."

13. On 24 September 2019, RCN further appealed under stage two of the IDRP. In its submissions, RCN asserted the exacerbation caused by the index incident was "so catastrophic that the permanent deterioration of her condition was mainly attributable to her NHS employment" and directly led to the development of CPS which was not present prior to the incident.

14. On 29 October 2019, NHS BSA sent Ms B its stage two decision rejecting her final appeal. It quoted the opinion of a third MA (see Appendix 2) and said:-

- It agreed with the MA that the contemporaneous medical evidence demonstrated the pain that was suffered by Ms B related to the spinal surgery that was undertaken for scoliosis at age 11. The contemporaneous medical evidence supported the fact that the pain she suffered was an exacerbation of symptoms of the scoliosis and pain related to the subsequent surgery.

- It did not agree that Ms B had suffered no CPS symptoms until the index incident. GP records showed similar symptomology of chronic pain in 1983, 1984, 1998, 2002, 2007, 2009, and specialist reports and referrals from October 2009, November 2010, reported “flares of pain” in 2010-2012.

- It had no reason to disagree with the MA’s opinion that Ms B experienced a soft tissue injury in September 2012, while carrying out the duties of her NHS employment. On the balance of probabilities this was self-limiting and more than likely within months of it having occurred healed in line with the regular healing pattern of self-limiting soft tissue injuries. The x-rays that were taken in February 2013 showed no change from x-rays taken in 2009 and this confirmed that any soft tissue injury had fully healed.

- The CPS that Ms B suffered from was evidenced to have been present prior to the index incident. Namely: she was being seen by a pain specialist; she had been referred to physiotherapy in August 2012 due to the return of symptoms over the last six months; she had been placed into an adjustment role at work two years prior to the injury and she was taking analgesia for her pain. There was a weight of evidence to support this conclusion. It understood that when a person had CPS their symptoms waxed and waned intermittently, and although certain events might trigger a symptom this was not the same as saying the illness causing the symptoms was wholly or mainly attributable to the trigger event.

- The Injury Benefits Regulations provided that the illness or injury had to be wholly or mainly attributable to the duties of the applicant’s NHS employment. It understood from the medical evidence provided that while the soft tissue injury she suffered might have contributed to the onset of further symptoms of her underlying spinal disease, this ongoing pain was not by reason of the healed soft tissue injury but by reason of the CPS and scoliosis that she suffered from.

- It was relevant that the symptoms that Ms B reported following on from the index incident mirrored the symptoms that she had been reporting prior to it: pain in the back, numbness, and pain in the right leg. It was not accepted that any pain in her neck or shoulder could have been caused by the journey downstairs during the evacuation.

- It could see nothing in the MA’s analysis, or the evidence on which it was based, that would cause it to disagree with their findings. No did it consider that their conclusion was perverse; that was, one which no reasonable body of people

could have reached based on the same evidence. As such, its decision was that Ms B's entitlement to PIB could not be granted.

Ms B's position

15. Ms B is represented by the Royal College of Nursing (RCN). RCN submits on behalf of Ms B:-

- Ms B does not dispute that she had a pre-existing and long-standing spinal condition or that prior to the index incident she experienced some spinal stiffening and periods of sickness absence related to her back condition.

- However, Ms B does not agree that Dr Logan's opinion is not supported by the evidence or that the evidence indicates that the index incident was an exacerbating factor of a pre-existing condition that was demonstrating signs of progression and was predicted to have been progressive.

- The evidence shows that the exacerbation caused by the index incident was so catastrophic that the resultant severe and permanent deterioration of her condition was, on the balance of probability, "mainly" attributable to the duties of her NHS employment. It directly led to the development of CPS, which was not present prior to the incident, nor could possibly be said to have been present by way of a few comments made by Ms B to Mr Verma some three years earlier and was "wholly and certainly mainly" attributable to her NHS employment.

- NHS BSA's MAs did not properly attribute weight or any weight to the compelling medical evidence, including expert medical evidence, in Ms B's favour and the reasoning for rejecting her application is weak.

- The medical evidence that confirms the exacerbation of her condition was caused by the index incident comprises:-

  - Dr Ahmad's report of 12 December 2012, in which Dr Ahmad said: "I am of the opinion that her symptoms are likely to be mainly attributable to the incident at work on 17.9.12…"

  - Dr Jeffrey's report of 17 January 2013, in which Dr Jeffrey said: "I then did not see her again until 22.11.12 when there was a dramatic deterioration in her symptoms, such that she had been unable to attend due to her lack of mobility as a consequence of the pain…"

  - An undated report from Ms Vink, in which Ms Vink said: "Therefore, although she does have longstanding spinal problems, this marked deterioration is attributable to the incident at work. Prior to this incident [Ms B] was always able to self-manage her chronic pain symptoms surprisingly well…"

  - Dr Logan's report of 29 February 2016, in which Dr Logan said: "it is therefore my opinion that this incident has prompted the development of a career ending chronic pain syndrome on the balance of probability. The development of

significant anxiety and depression as a result of pain has also exacerbated and perpetuated the pain."

- Dr Logan's opinion "should not be departed from lightly or even at all without exceptionally strong reasoning which is not present in the original decision nor the IDRP stage one decision".

- It disagrees that the index incident was not an operative cause of her PLOEA and that the claimed back injury and worsening of her long-standing condition are not wholly or mainly attributable to her NHS employment.

NHS BSA's position

16. NHS BSA submits:-

- While the stage two decision accepted that Ms B did suffer an injury during the index incident, there is no evidence she has suffered a PLOEA by reason of this injury.

- In the overview of Ms B's sickness absence management, there is no mention of a fall but "pain in the back and right leg following climbing downstairs from 11th floor" and "pre-existing condition deteriorated following incident."

- Ms B's GP confirmed in his report of 21 October 2015 that her long-standing back disease causes her incapacity for work.

- In the occupational health report dated 8 April 2015, Dr Dodman said that Ms B: "had developed a good routine for managing her pain and was managing well until 2 weeks ago when she fell down the stairs at home, she attended Accident and Emergency. Such injuries take a number of weeks to settle down."

- Throughout the application process it has been recommended by the MAs that the PLOEA Ms B suffers is not by reason of the injury. She has a long-standing back condition that flares up when it is irritated in such incidents as walking downstairs and falling at home.

- The Department of Health and Social Care has confirmed that exacerbation of symptoms of a pre-existing condition is not considered to be an injury under the Injury Benefits Regulations.

- In summary, it declined Ms B's application for a PIB on the basis that her PLOEA is not by reason of the incident of walking down 11 flights of stairs during the index incident.

- The index incident, more likely than not, caused a soft tissue injury to her back that was wholly or mainly attributable to the duties of her NHS employment. However, this is not an operative cause of any PLOEA suffered.

- It has correctly considered Ms B's PIB application, using the correct test, taking into account relevant evidence and ignoring anything irrelevant. In making the decision, it sought and accepted the advice of its MAs.

Adjudicator's Opinion

17. Ms B'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 18 to 32:-

18. It is not the role of the Pensions Ombudsman (**the PO**) to review the medical evidence and come to a decision of his own as to Ms B's eligibility for a PIB. The PO is primarily concerned with the decision-making process. The issues considered include 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.

19. The weight which is attached to any of the evidence is for NHS BSA to decide (including giving some of it little or no weight). It is open to NHS BSA to prefer evidence from its own advisers; 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 medical adviser. If the decision-making process is found to be flawed, the appropriate course of action is for the decision to be remitted for NHS BSA to reconsider.

20. In Ms B's case, the relevant regulations are Regulations 3 and 4 (see Appendix 1). Briefly, in order to qualify for a PIB, Ms B had to satisfy the following conditions:-

    - she had to have sustained an injury, or contracted a disease, in the course of her NHS employment; or

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

    - by reason of the injury or disease, her earning ability had been permanently reduced by more than 10%.

21. The initial decision as to whether Ms B qualified for a PIB was made by the SMA under a delegated authority. The two appeal decisions were made by NHS BSA.

22. Both the initial decision and the stage one IDRP decision were that the injury Ms B sustained was not in the course of her NHS employment and was not wholly or mainly attributable to her employment. The stage two IDRP decision was that there was a soft tissue injury sustained in the course of her employment that was wholly or mainly attributable to her employment. But this was not resultant in a PLOEA. In other words, Ms B did not satisfy the requirement of Regulation 4(1).

23. The interpretation of Regulations 3 and 4 has been considered by the Courts on a number of occasions and the SMA, in the initial decision, referred to the relevant cases. The Courts decided that a qualifying injury need not be the operative cause of the person's PLOEA; it was sufficient that it was an operative cause. In other words, it was not a bar to receiving a PIB if the person had other medical conditions which contributed to their PLOEA. Both the SMA and NHS BSA had this in mind when considering Ms B's case.

24. Ms B's position was that, in September 2012, she had sustained an injury to her back and she continued to suffer pain relating to that injury. In other words, Ms B was of the view that the injury she sustained in 2012 was an operative cause of her PLOEA.

25. At stage two of the IDRP the third MA advised that the injury which Ms B sustained in 2012 was a soft tissue injury which "was self-limiting and more than likely within months of it having occurred healed in line with the regular healing pattern of self-limiting soft tissue injuries". In other words, the MA did not agree that the index incident had caused Ms B a PLOEA.

26. Ms B said she had suffered no CPS symptoms until the index incident and that her CPS was mainly caused by the index injury. However, the MA noted that she was being seen by a pain specialist and had been referred to physiotherapy in May 2012 due to the return of pain symptoms over the previous six months. Also, she had been placed into an adjustment role at work two years prior to the injury and she was taking analgesia for her pain. The MA said that when a person had CPS their symptoms "wax and wane" intermittently. Although certain events might trigger a symptom this was not the same as saying the illness causing the symptoms was wholly or mainly attributable to the trigger event.

27. Further, the MA noted that the pain Ms B suffered was related to the spinal surgery that was undertaken for scoliosis at age 11. The scoliosis that led to metal rods being put into Ms B's back at age 11, was not wholly or mainly attributable to the duties of her NHS employment. The available medical evidence showed that the pain she had suffered was an exacerbation of symptoms of the scoliosis and pain related to the subsequent surgery.

28. In *Stewart v NHS Business Services Authority* [2018] EWHC 2285 (Ch), the judge set out five steps which should be gone through in making a decision under Regulation 3(2). The first of these was to identify the injury or disease in question. There was no definition of injury in the Injury Benefits Regulations, but the Courts had said in *Young v NHS Business Services Authority* [2015] EWHC 2686 (Ch), that an injury was a physiological or psychological change for the worse. The Courts had found the injury: "should be kept separate from the loss of faculty or the impairment in the normal power or function of some part or organ of the body that might result from the injury either alone or in conjunction with other causes." Under the Injury Benefits Regulations the "wholly or mainly" test only applies to the connection of the injury to employment.

29. If Ms B had sustained a soft tissue injury during the index incident, the fact that she was more vulnerable to this happening because of scoliosis and surgery when she was 11, would not be relevant. The fact would remain that Ms B had experienced a physiological change for the worse at the time of index incident. The MA would need to separate the injury (soft tissue injury) from the impairment in the normal function of Ms B's spine (scoliosis). The analysis as to the relative contributions from scoliosis and surgery and the index incident did not address the correct question under Regulation 3.

30. However, having considered possible causation for the soft tissue injury, the third MA noted that there was no evidence on imaging of any injury or other pathology which was attributable to the index incident. The soft tissue injury appeared to have settled within months from the index incident.

31. So far as their medical opinions are concerned, MAs do not come within the PO's jurisdiction. They are answerable to their own professional bodies and the General Medical Council. The question for the PO is whether there was any reason why the decision should not have been based on the advice provided by the MAs. The PO has previously acknowledged that a decision-maker can only be expected to review medical advice from a lay perspective; they are not expected to challenge a medical opinion per se. The kind of things the decision-maker can be expected to look out for are errors or omissions of fact, a misunderstanding of the relevant rules or regulations or reference to an irrelevant matter on the part of the MA. The Adjudicator said this was the approach she had taken in her investigation of Ms B's complaint.

32. The Adjudicator said she had not identified any error or omission of fact on the part of the third MA. It was clear that both the MA and NHS BSA had the correct interpretation of Regulations 3 and 4 in mind and had been aware of the Court's view on this. The Adjudicator said she had not seen any evidence that any irrelevant matters were considered and there appeared to be no reason why NHS BSA should not have accepted the advice of the MA. Consequently, it was the Adjudicator's opinion that Ms B's complaint should not be upheld.

33. Ms B did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. I note the additional points raised by RCN, and I agree with the Adjudicator's Opinion.

34. The RCN submits:-

- The Adjudicator's Opinion does not make any reference to the First-Tier Tribunal Social Entitlement Chamber's (**the Tribunal**) decision of 9 December 2020[1].

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[1] The Tribunal set aside the Department for Work and Pensions (**DWP**) decision of 25 September 2019 that Miss B was not entitled to an Industrial Injuries Disablement Benefit (**IIDB**). The Tribunal assessed from 2 October 2019 the extent of Miss B's disablement from the accident on 17 September 2012 (namely impaired Lumbar spine and right leg function) at 40% for life, after offsetting 20% for pre-existing low back pain and medical conditions.

- NHS BSA can only legitimately refer to the Tribunal's findings and not any preceding decisions made by the DWP.

- The Tribunal made findings of fact by assessing the medical evidence which had also been available to NHS BSA. Its findings cannot now be disputed by NHS BSA or the Ombudsman.

Ombudsman's decision

35. As the Adjudicator said, it is not my role to review the medical evidence and come to a decision of my own as to Ms B's eligibility for a PIB. My role is to consider the decision-making process undertaken by NHS BSA. If I find that the decision-making process is flawed, the appropriate course of action is for me to remit the matter back to NHS BSA for it to retake its decision.

36. In order for Ms B to qualify for a PIB, she has to satisfy the conditions set out in Regulations 3 and 4 of the Injury Benefits Regulations. In summary, that:

    - she has to have sustained an injury, or contracted a disease, in the course of her NHS employment which is wholly or mainly attributable to that employment (or which was wholly or mainly attributable to the duties of her NHS employment); and

    - by reason of the injury or disease, her earning ability has to have been permanently reduced by more than 10%.

37. In *Stewart,* the judge said that the first step was to identify the injury or disease in question. Ms B argues that the injury, in her case, has caused her CPS. The stage two MA came to a different conclusion. The MA was of the view that the soft tissue injury had healed within months of the index incident. The MA advised that, the fact that Ms B was more vulnerable to this happening was because of scoliosis and surgery when she was 11.

38. In order to determine whether the decision not to award a PIB to Ms B was taken in a proper manner, I have considered whether NHS BSA has: (i) gone about making the decision in the right way; and (ii) made a decision which is supported by the evidence.

39. Regarding making the decision in the right way, NHS BSA is required to apply the relevant regulations correctly, in accordance with the relevant case law, and obtain and consider relevant evidence.

40. I find that NHS BSA and its MAs correctly applied Regulation 3 and 4 when assessing Ms B's eligibility for a PIB and I have not identified any error or omission of fact on the part of the MAs in their review of the available evidence.

41. The RCN refers to the Tribunal's decision of December 2020 which set aside DWP's decision of 25 September 2019 that Miss B was not entitled to an IIDB. It says the findings of the Tribunal cannot now be disputed by NHS BSA or myself.

42. But Ms B's appeal to the Tribunal is for a different benefit, not the PIB provided by the Scheme, and the Tribunal's decision was made after NHS BSA's stage two IDRP decision, so NHS BSA could not have been aware of it. For these reasons, the Tribunal decision does not form a part of my decision making, and nor could it have formed a part of NHS BSA decision making process in this case.

43. At stage two of the IDRP, the third MA advised that Ms B's soft tissue injury was sustained in the course of her employment (incurred while going down the stairway) but the scoliosis and CPS were not. The MA agreed with the first and second MA that Ms B's scoliosis pre-dated her NHS employment and, on the balance of probabilities, her CPS started before the evacuation incident in September 2012.

44. The MA then considered whether the soft tissue injury had caused a PLOEA of more than 10% and advised that there was no medical evidence to support the conclusion that it had resulted in long-term incapacity.

45. In respect of Ms B's CPS, the MA noted Dr Logan's opinion that the CPS was caused by the evacuation incident and his acknowledgment that there may be a spread of medical opinion on the matter. The MA's opinion was that the evidence supported the conclusion that Ms B was experiencing pain and had a regular requirement for analgesia before the September 2012 incident.

46. The difference of medical opinion is not sufficient for me to find that NHS BSA's acceptance of the third MA's opinion means that its stage two IDRP decision was not properly made.

47. As I have found no reason why NHS BSA should not have accepted the third MA's advice, I find that NHS BSA's decision was properly made.

48. I do not uphold Ms B's complaint.

Dominic Harris

Pensions Ombudsman
1 August 2023

Appendix 1

1. The relevant regulations are The National Health Service (Injury Benefits) Regulations 1995 (SI1995/866) (as amended). Regulation 3 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 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.

   …

   (3) This paragraph applies to a person to whom regulation 3(1) applies who -

   (a) ceases to be employed before 31st March 2018 other than by reason of the injury or disease,

   (b) at the date of ceasing that employment has not attained normal benefit age,

(c) having ceased that employment, suffers a permanent reduction in earning ability by reason of that injury or disease, and

(d) has not been paid, other than under paragraph (5) or (5A), any allowance or lump sum under these Regulations in consequence of that injury or disease.

(3A) Where paragraph (3) applies the Secretary of State may pay from the date that the person attains normal benefit age or, as the Secretary of State may in any particular case allow, from the date that person suffers the reduction in earning ability referred to in paragraph (3)(c), an annual allowance of the amount referred to in paragraph (3B).

(3B) That amount is an amount, if any, which when added to the value of any of the pensions and benefits specified in paragraph (6) will provide an income of the percentage of the person's average remuneration shown in whichever column of the table in paragraph (2) is appropriate to that person's service in relation to the degree by which that person's earning ability is permanently reduced at the date referred to in paragraph (3A): for these purposes the value of any such pensions and benefits is to be expressed as an annual amount."

Appendix 2

Medical evidence

1. From the incident reviewing form, dated 17 September 2012

   "Fire alarm sounded at 08:45. As a consequence staff had to leave the building. Staff member with disabilities therefore had to walk down all the stairs from the 11th floor. It was very difficult for her and as a result she experienced considerable back pain, numbness and pain in her right leg. On returning to the reception staff noticed that she looked pale and expressed concern. She felt very faint and had to sit in the reception area until she felt a little better. Staff member went home at lunch time to rest and take painkillers. Has seen GP and has a sick note for 2 weeks."

2. In his report dated 22 November 2012, Specialty Doctor in Occupational Medicine, Dr Ahmad said:

   "She was referred to see us as she has been on sickness absence since 17 September 2012 with symptoms affecting her back. Her GP is treating her condition with medication. She is still symptomatic and has been unfit for work."

3. In his report dated 30 January 2013, Consultant Spine Surgeon, Dr Verma said:

   "She works as a psychiatric nurse, however has had to take time off recently because of an acute exacerbation of her symptoms of back and right leg pain. This was following a strenuous fire safety procedure where she had to go up and downstairs.

   …

   Clinically on examination I am unable to demonstrate any neurological deficit in the upper or lower limbs. There is quite a clear suggestion of left frozen shoulder. She is unable to externally rotate her left shoulder as it is painfully restricted which points to the fact that she may have frozen shoulder and at her age I would recommend that she is tested for diabetes and referred for left shoulder physiotherapy to regain her range of movement.

   As far as her cervical spine goes I have arranged for her to have an MRI scan of her cervical spine and repeat CT scan of her lower lumbar spine to look at the foramen and I would also recommend for her neuropathic pain in her right leg that she be put onto Gabapentin 300mg three times a day."

4. In his report dated 6 March 2013, Dr Ahmad said:

   "Based on the information that is available to me, I am of the opinion that her symptoms are likely to be mainly attributed to the incident at work on 17 September 2012 where she states that she had to evacuate down 22 flights of

stairs. Meanwhile, I am unable to confirm whether these symptoms are wholly attributed to the incident at work."

5. In her report dated 17 January 2014, Orthopaedic Physiotherapy Practitioner, Ms Vink said:

   "Her spinal problems are complex and relate to spinal surgery aged 11 for an idiopathic scoliosis. She has had Harrington rods in situ ever since. As a consequence of this she suffers with both cervical and lumbar problems. Recent MRI scans of her lumbar spine have shown foraminal stenosis at the L3 level in the lumbar spine. Spinal surgeons at Hope Hospital have ruled out surgery due to the risk and complexity. As a result, physiotherapy treatment has concentrated mostly on her cervical spine.

   She was referred back to physiotherapy in August 2012 by her GP, as she felt her cervical spine was starting to stiffen up again over the last six months. I assessed her on 30.8.12 and we commenced some cervical mobilisations. She reattended on 6.9.12 feeling much improved, with an increased range of cervical movement. I then did not see her again until 22.11.12 when there was a dramatic deterioration in her symptoms, such that she had been unable to attend due to her lack of mobility as a consequence of the pain. On 17.9.12 there had been a fire alarm at work for which she had to evacuate down 11 flights of stairs.

   On reassessment, [Ms B's] symptoms and mobility had significantly worsened. Her pain level also increased to such a level as to significantly hinder her mobility and function. For somebody with [Ms B's] symptoms, it is unreasonable to expect them to be able to walk down that many stairs. Prior to this event we had managed to control [Ms B's] symptoms such that she had managed to complete 2 years at work without any spinal related sickness. Presently [Ms B] is failing to respond that well to treatment and is suffering increasing back pain with associated numbness in her leg and also neck pain with referred left arm symptoms. I will continue with her treatment."

6. In her report dated 2 March 2015, Consultant in Pain, Dr Makin said:

   "[Ms B] has completed the Intensive Pain Management Programme (PMP) at the Manchester & Salford Pain Centre. The focus of the PMP is on self-management, encouraging patients to address both the physical and emotional impact chronic pain is having on their life."

7. In his report dated 21 October 2015, GP, Dr Jeffrey said:

   "She is currently unable to work and is severely disabled. The cause of her disability is a combination of factors primarily to do with scoliosis of her spine and osteoarthritis. These problems have led to a variety of difficulties including foraminal stenosis and fusion of the vertebrae. She has bilateral hip osteoarthritis. She has nerve entrapment causing paraesthesia and nerve pain

leading to chronic pain syndrome. She suffers from muscle spasms which have been uncontrolled by treatment. This treatment has included referral to the pain clinic, medication and injection therapies. She takes the maximum medication that she can without causing loss of concentration and drowsiness. Her problems have all been exacerbated following injury at work which prompted her period of absence but unfortunately there has been no resolution to her problems.

[Ms B] is significantly affected by these problems although there is some variation from day to day. She is unable to sit or stand for long periods. She suffers from significant muscle spasms and pain in her neck and shoulders whenever she tries to use a computer or do any work which would require being at a desk and despite her best efforts and those of the medical profession she is not going to improve from her current position.

In my opinion she is unable to carry out activities relating to her previous job or indeed any employment now or in the foreseeable future."

8. In his report dated 29 February 2016, Consultant in Pain Management, Dr Logan said:

"In my opinion swiftly going down 22 flights of stairs constituted a major incident for [Ms B] and I think that any such incident would have had a similar long term effect on her. Such incidents are unlikely and therefore on the balance of probabilities but for this incident she would not have her current level of symptoms or prognosis. I also note that there is no radiological evidence of deterioration so I would so not hold the view that her condition would have got worse in any case with me.

Although she has got evidence of substantial pre-existing sickness absence as a result of her condition it appears that she was doing well for nearly 2 years before the incident (and this is stated in one of the GP letters).

It is therefore my opinion that this incident has prompted the development of a career and work ending chronic pain syndrome on the balance of probability. The development of significant anxiety and depression as a result of pain has also exacerbated and perpetuated the pain.

The records and her account suggest the presence of constant severe pain and disability with a severe impact on every aspect of her life.

I do not recommend any further treatment other that physiotherapy and psychological techniques such as CBT or mindfulness. These techniques will help her cope with the pain, anxiety, depression and feelings of lack of purpose though I doubt that she will ever return to work or be free of pain."

9. In its initial decision the SMA quoted from the first MA's advice:

"Question 2- Was there an injury sustained or disease contracted? Yes

Explanation:

The evidence indicates that the applicant has a history of spondylosis with right sided radiculopathy at L4. This developed at the age of 11. The ICD 10 Code for this condition is M47.2.

Question 3- Was the injury sustained (or was the disease contracted)

(a) in the course of the person's employment? No

And

Wholly or mainly attributable to his/her employment? No

For attribution to be accepted the answers to Q3(a) and (b) must be YES.

Q3 (a)

Explanation

The Spinal disease developed at the age of 11 and pre-existed both this incident and her employment in the NHS. It cannot be considered to have been contracted in the course of the NHS employment. Chronic pain arises directly from her spinal degenerative disease and arthritis of neck, back and hips due to this pre-existing condition.

Q3(b)

Explanation:

The applicant has a history of back problems which long preceded this event. Her condition is constitutional and cannot be accepted to have arisen in the course of the NHS employment.

Prior to the claimed incident, she complained of pain in the back, numbness and pain in the right leg.

…

Dr Jeffrey has stated that the impact of the incident was to "set off a very bad problem with her back. She has developed further problems with neuropathy running down into her knee and paraesthesia in her lower leg and she has a lot of profound muscle spasms." She has foraminal stenosis and fusion of the vertebrae. Her pain condition is exacerbated by bilateral hip osteoarthritis.

Ms Vink's letter states that she has rods in her spine since her surgery at the age of 11. She has since had both neck and lumbar symptoms, with foraminal stenosis at L3. She is stated to have been referred to her in August 2012 because her neck (not her back) had been "starting to stiffen up again over the last six months." She has improved neck function when reviewed a week later, but her mobility had reduced "dramatically" after the fire alarm event.

Dr Logan's report is consistent with the applicant sustaining "soft tissue injuries" as a result of the index event. He has stated that "this went on to become a long term chronic pain syndrome with pain in her back, down her right leg and also in her neck." He attributes this to the impact of the evacuation "on balance of probabilities". His reason for this is that she was "doing well for nearly 2 years before the incident." Significant anxiety and depression are noted to be exacerbating her pain.

…

There is no indication that her neck was jarred or injured during the evacuation. Her symptoms recorded in the incident record were in the low back. It was noted prior to the incident that her neck had been stiffening up.

It should be noted that an X-ray report dated 25th February 2013 identified no changes to the previous report in 209, indicating that her back condition had not fundamentally changes in structure as a consequence of the evacuation.

[Ms B] went on to develop a frozen shoulder; there is no possibility that this was injured when she walked downstairs, but the impact of this would be to heighten her pain levels further.

…

It is accepted that the event claimed resulted in severe exacerbation of her pain symptoms due to soft tissue injury. However, there was no fundamental change in her pre-existing spinal condition visible on scans as a consequence. She has foraminal stenosis before and after the event. The symptoms she experienced immediately (pain in the back, numbness and pain in the right leg) were all reported prior to this incident. The effort of the evacuation would be expected to cause temporary deterioration in her back and leg pain, but it is evident that her pain has not remitted.

It is not accepted that any change in neck paln or shoulder pain can be linked to the evacuation as the mechanism of injury (walking downstairs) would not be likely to cause such symptoms, and they were not reported immediately afterwards.

It could be said that her persistent deterioration in back pain and development of a chronic pain condition was wholly or mainly attributed to this incident (as Dr Logan has proposed). However, it is also possible to state that the deterioration she experienced overlapped with natural deterioration in pain and disability, which preceded the accident in the neck, shoulder area, low back and leg and which would have continued to progress over time. In support of this conclusion is the evidence from the specialists she saw in the period 2008-2012 including the physiotherapist which states that she had been reporting more symptoms and then stiffening up in the neck prior to the evacuation event. There is no way of determining precisely what would have

been the natural outcome of her spinal disease as time progressed, if this evacuation had not occurred.

It is not appropriate to conclude (as her GP and then Dr Logan have stated) that she had been relatively well before the evacuation because she "was doing well for nearly 2 years before the incident." This is not consistent with the clinical records which identify worsening of her symptoms in 2008, followed by two attendances at A and E, two further surgical opinions, a physiotherapy referral and a further physiotherapy referral in the period until May 2012.

In my opinion, based on all of the evidence presented, I conclude that her persistent increase in pain is multi-factorial, arising from natural progression of the pre-existing back symptoms (evident in 2008, 2009, 2010, 2011 and 2012 prior to the evacuation) and neck symptoms (which was evident prior to the evacuation and no worse immediately after) and a frozen shoulder, in addition to the soft tissue pain in the low back which was caused by the evacuation. Her chronic pain therefore cannot be attributed wholly or mainly to the claimed incident.

It is considered on the balance of probability that there is insufficient evidence to advise that the disease contracted was in the course of the NHS duties and is wholly or mainly due to the applicant's NHS duties.

My advice is that Attribution should not be accepted.

Permanent Loss of Earning Ability:

Question 4- Is the injury (or disease) that formed the basis of the applicant's PIB claim an operative cause of permanent loss of earnings ability for the purpose of Reg. 4(1). No

The injury sustained or disease contracted and which formed the basis of the applicant's claim did not meet the criteria for attribution to NHS employment at regulation 3(2). Therefore, this was not an operative cause of PLOEA for the purposes of regulation 4(1)."

10. In its stage one response, NHS BSA quoted from the second MA's advice:

"Attribution

The questions to be addressed are:

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?

Rationale

Q1: Yes…The conclusion from this medical evidence is that [Ms B] has a chronic musculoskeletal condition that in structural terms required no further spinal surgery intervention but in terms of physiotherapy and psychological support she was continuing to require treatments prior to the incident and certainly the incident seems to have exacerbated her existing condition.

Q2a: No. Notwithstanding the clearly reported exacerbation of pain that [Ms B] experienced following the evacuation of the building or [Dr Logan's] Opinion the evidence is clear that [Ms B] had a genetically predisposed and pre-existing musculoskeletal condition from childhood.

Q2b: No. Again notwithstanding [Dr Logan's] opinion given to the Court it is clear that [Ms B] had significant psychological concerns relating to her back pain as detailed by Mr Verma in his letter of October 2009. At this consultation [Ms B] discussed that she was concerned about further degradation and damage to the nerves of her spine and becoming paralysed, ending up in a wheelchair and becoming incontinent. This evidence does not support [Dr Logan's] opinion that her psychological expectations of pain and the development of the chronic pain syndrome is only related to the incident in question.

It is very clear that [Ms B] has a highly significant medical condition that significantly impairs her level of functioning however the evidence indicates that the workplace incident was an exacerbating factor of a pre-existing condition that was demonstrating signs of progression and was predicted to have been progressive."

11. In its stage two response NHS BSA quoted from the third MA's advice:

"The documents provided to me are extensive, amounting to over 2300 pages of scanned documents in total. However, there is a large element of duplication and when this is taken into account, the number of different documents is probably around half of this. I confirm that I have reviewed the full case file. However, for brevity I will only cite those documents that I consider to be material to the issues under consideration.

…

In considering this application, it is necessary to first consider whether [Ms B] satisfies the requirements of regulation 3(2), which relates to the question of whether the injury is attributable to employment and, if so, to then consider whether the injury has given rise to a PLOEA of greater than 10% and, if so, the level of any award, as provided for in regulation 4.

I will begin by considering the question of attribution.

Attribution

In considering the question of attribution I am guided by the judgment of Judge Davis in the case of Dr David Stewart v NHS BSA in the High Court last year, in particular, paragraph 114 of that judgement where Judge Davis gives his views as to the proper construction and approach to regulation 3(2). Judge Davies states 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 consideration of whether the disease was contracted at a 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 answer 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.

[Ms B] has a number of medical conditions:

She developed a curvature of her spine in childhood (an idiopathic scoliosis) and underwent surgery for this at the age of 11. This surgery involved the insertion of metalwork to correct the curvature and support/stabilise [Ms B's] spine. The metalwork remains in situ.

It appears likely that [Ms B] developed a soft tissue injury to her lumbar spine in September 2012 as evidenced by the reports of Dr Logan, dated 27 February 2016 and 22 November 2018. This appears to have also been the opinion of Mr Siddique, as documented by Dr Logan in the first of his reports.

[Ms B] also developed a chronic pain syndrome.

I note the job description provided.

I will now consider whether the above conditions were contracted in the course of [Ms B's] employment.

<u>Scoliosis</u>

With regard to the idiopathic scoliosis, this condition first became manifest when [Ms B] was a child. It therefore clearly pre-dates her NHS employment and so was not contracted in the course of her employment. The duties of [Ms B's] employment would not be the cause of her scoliosis for the same reason.

Soft Tissue Injury

With regard to the soft tissue injury, this appears to me to have been a presumptive diagnosis as there do not appear to be any findings on physical examination or imaging that are documented which provide objective confirmation of this injury. However, two specialists who have personally assessed [Ms B] have reached this conclusion. I think their conclusion is reasonable. The fact that the incident of 17 September 2012 took place is not in question. [Ms B] would have been exiting the building, presumably with some degree of urgency, and I think it is reasonable to anticipate that she would [have] descended the stairs more rapidly than she would have been accustomed to do and, most probably, turned around the corner at the bottom of each flight more rapidly than she would normally have done. I think it is reasonable to assume that in doing so her spinal muscles went through a range of motion and were subjected to forces in excess of that to which they would normally be exposed and that this unaccustomed exertion gave rise to a soft tissue injury.

There is evidence from [Ms B's] account that her symptoms acutely worsened while going down the stairway. There is therefore a clear and close temporal relationship between the incident and the worsening of [Ms B's] symptoms. I think it is likely that the soft tissue injury was sustained at this time. While it is a matter for NHS BSA to determine, I would regard the evacuation as being an activity that was reasonably incidental to [Ms B's] contractual duties and on that basis it would be my opinion that the soft tissue injury was contracted in the course of [Ms B's] employment. As I have indicated, there is a very close temporal relationship between the incident and the worsening of [Ms B's] symptoms and there is no evidence to suggest that any other factors contributed to this injury. In my opinion, on the balance of probability, [Ms B's] employment was the whole or main cause of her presumed soft tissue injury.

Chronic Pain Syndrome

With regard to the chronic pain syndrome, I think there is a weight of evidence supporting the conclusion that [Ms B] was experiencing spinal and lower limb symptoms before the incident in September 2012. I note Dr Jeffrey's comment that [Ms B's] back had been good over the last couple of years. I also note that she was working between February 2011 and the incident. However, it would be inappropriate to extrapolate from these facts that [Ms B] was asymptomatic or that her pre-existing scoliosis and its sequelae were not resulting in a degree of incapacity. [Ms B] had been placed in an adjusted role because of her spinal problems (as evidenced for example by Dr Dodman's report of 12 March 2015). [Ms B] had been experiencing symptoms sufficient to result in her being referred to a specialist in pain management whom she saw in February 2012 and had been experiencing intermittent exacerbations of her symptoms for the previous two years (as evidenced by Dr Lieberman's report of 6 February 2012). [Ms B] was taking analgesia (as evidenced by a

consultation documented in the occupational health records as having taken place on 20 March 2012 and an entry in the GP records dated 31 August 2012. The GP record further document that [Ms B] did not want to stop taking diclofenac (a non-steroidal anti-inflammatory drug) as it was “the only thing that works for her back pain”). In my opinion, on the balance of probability, [Ms B’s] chronic pain syndrome started before the incident in September 2012.

While I note Dr Logan’s opinion that the chronic pain syndrome was caused by the evacuation incident and I would agree with Mr Hickman’s observation that there is no contradictory report from a similar qualified consultant in pain management, I would draw your attention to paragraphs 8.11-8.13 of Dr Logan’s report of 27 February 2016. In that part of his report, Dr Logan acknowledges that there may be a spread of medical opinion on this matter. Dr Logan accepts that it is evident from [Ms B’s] work record that she had multiple and long absences from work due to pain as a result of her spinal condition and that it could be argued that she already had a pain syndrome. Dr Logan acknowledged that [Ms B] had seen a pain specialist before the incident and was already fearful of movement and worried that this might exacerbate or cause spinal damage. Dr Logan went on to state that it would be reasonable for a pain expert to state that the injury exacerbated the pain for 24 months, as opined by Mr Siddique, and thereafter her symptoms were a continuation of her previous disorder. I have reflected on this matter at some length. In my opinion, the evidence supports the conclusion that [Ms B] was experiencing pain and had a regular requirement for analgesia before the incident in September 2012. On that basis, it is my opinion that, on the balance of probability, [Ms B] did have a chronic pain syndrome before the events of 17 September 2012 and that, in consequence, her chronic pain syndrome was not contracted in the course of her employment. For the same reasons, it is also my opinion that the duties of [Ms B’s] employment were not the whole or main cause of her chronic pain syndrome.

I do not doubt that [Ms B] experienced an increase in symptoms as a result of the incident. However, it is my understanding that an exacerbation of a pre-existing medical condition falls outside the scope of regulation 3(2).

In summary therefore:

Q1: Was there an injury sustained or a disease contracted? Yes. [Ms B] had idiopathic scoliosis, a presumed soft tissue spinal injury and a chronic pain syndrome.

Q2a: Was the injury sustained (or was the disease contracted) in the course of the person’s employment? The presumed soft tissue injury was sustained in the course of [Ms B’s] employment. The idiopathic scoliosis and the chronic pain syndrome were not sustained in the course of her employment.

Q2b: Was the injury sustained (or was the disease contracted) wholly or mainly attributable to her employment? [Ms B’s] employment was not the whole or main cause of her idiopathic scoliosis or her chronic pain syndrome. The duties of [Ms B’s] employment were not the whole or main cause of her idiopathic scoliosis or her chronic pain syndrome.

Based on the evidence presented, I conclude that the applicant sustained an injury or contracted a disease wholly or mainly attributable to their NHS employment prior to 31 March 2013.

Since it is my opinion that [Ms B’s] soft tissue injury is wholly or mainly attributable to her employment, I will now go on to consider whether this injury has given rise to a PLOEA of greater than 10%.

Permanent Loss Of Earnings Ability

Q3: Whether the applicant has suffered a PLOEA of more than 10% by reason of the injury or disease? No.

Rationale

Soft tissue injuries generally resolve completely in a relatively short period of time without giving rise to any long term adverse consequences. There is no imaging that shows any features in [Ms B’s] spine that developed as a consequence of the incident in September 2012 (as evidenced by Mr Verma’s report of 4 June 2013 in which he states that a recent CT scan of [Ms B’s] whole spine showed no changes when compared to imaging undertaken in 2009). I would also like to draw your attention to paragraph 8.13 of Dr Logan’s report of 27 February 2016 in which Dr Logan appears to accept that those of [Ms B’s] symptoms that persisted for longer than 24 months following the incident were a continuation of her pre-existing spinal pathology.

I do not think there is any medical evidence to support the conclusion that [Ms B’s] soft tissue injury has resulted in any long term incapacity. Most probably, she has made a full recovery from the soft tissue injury. In my opinion, on the balance of probability, [Ms B] has not suffered a PLOEA of more than 10% by reason of her presumed soft tissue injury.

I think the most likely scenario in this case is that [Ms B] was experiencing musculoskeletal symptoms arising from her spine that were the result of her previous spinal pathology, subsequent surgery and associated changes with the passage of time. These symptoms were present before the index event. These symptoms became worse as a result of the evacuation, during which she probably also sustained a soft tissue injury that contributed to her symptoms, but which resolved over time. I have no doubt that [Ms B] has significant ongoing spinal symptoms. She has my sympathies. However, I think these ongoing symptoms are the result of her pre-existing spinal pathology and pain syndrome and that these conditions are not the result of

her employment. In my opinion, the presumed soft tissue injury is not an operative cause of any PLOEA.

I note that my advice that [Ms B] has sustained a qualifying injury is at variance with the opinions of the previous scheme medical advisor and also my colleague. However, I do think that the weight of evidence does support the conclusion that [Ms B] did sustain a soft tissue injury that was wholly or mainly attributable to her employment during the index event. I agree with the previous scheme medical advisor and also my colleague that [Ms B's] spinal pathology and pain syndrome are not qualifying injuries as defined in regulation 3(2). I also agree with them that [Ms B's] ongoing symptoms are most probably the result of her pre-existing conditions."