PO-12394

Ombudsman's Determination

Applicant	Dr T
Scheme	NHS Injury Benefit Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

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

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Dr T's complaint arises because NHS BSA rejected his application for Temporary Injury Allowance (**TIA**).

Background information, including submissions from the parties

4. Dr T was a Consultant Paediatric Intensivist at Central Manchester NHS Foundation Trust (**the Trust**). In November 2010, he attended a conference in paediatric critical care. The Trust approved professional leave to enable him to attend. Unfortunately, while he was in India, he developed Dengue Fever and Chikungunya. Dr T spent a total of three weeks in India. The first week was spent at the conference, and the Trust approved professional leave for his attendance. Following the conference, Dr T took two weeks of annual leave, during which he travelled around India.

5. Due to the ill-health caused by the infections, Dr T had several periods of absence from work between December 2010 and December 2013. He submitted a claim for TIA in January 2014. NHS BSA considered the application under regulation 3(2) (a) of the NHS Injury Benefit Regulations 1995 (**the Regulations**), which required the following conditions to be met in order for the benefit to be paid:-

    - Dr T had to have contracted the infections in the course of his NHS employment; and
    - the infections had to be wholly or mainly attributable to his employment with the NHS.

6. A relevant extract from the Regulations is provided in Appendix 1, and extracts from the medical evidence are provided in Appendix 2.

7. NHS BSA obtained the opinion of a medical adviser, who considered that there was insufficient evidence that Dr T developed the infections at the conference. He concluded that, on the balance of probabilities, Dr T contracted the infections during the two weeks of annual leave he spent in India following the conference. Further, NHS BSA judged that the Trust did not require Dr T to attend the conference. Accordingly, NHS BSA determined that Dr T did not acquire the infections in the course of his NHS employment and wrote to him on 14 July 2014 to tell him that it had taken the decision to reject his application for TIA.

8. Dr T wrote to NHS BSA on 3 August 2014 to appeal this decision under stage 1 of the Scheme's internal dispute resolution procedure (**IDRP**), arguing that his contract of employment with the NHS obliged him to maintain his knowledge base and skills. He also said that the Trust had approved professional leave for him to attend the conference. He insisted that he was therefore attending the conference in the course of his NHS employment.

9. Further, Dr T pointed out that NHS BSA's medical adviser had recognised that he probably acquired both infections simultaneously, from the same mosquito bite. Both Dengue Fever and Chikungunya were present in the area of India in which the conference was held, but not in any of the areas to which he travelled during his annual leave. As such, he must have developed the infections at the conference.

10. Dr T also noted that, according to the World Health Organisation, the incubation period for Dengue Fever is approximately four to ten days. He further pointed out that Centre for Disease Control and Prevention guidelines state that, in the case of Chikungunya, the incubation period is typically three to seven days. Dr T said that his symptoms started two days after the end of the conference and therefore, in accordance with this data, he must have acquired the infections at the conference. As a result of these considerations, Dr T submitted that the infections were wholly or mainly attributable to his employment with the Trust.

11. NHS BSA obtained the opinion of a second medical adviser, Dr Simpson, who noted that there was no medical evidence to corroborate Dr T's testimony that his symptoms began two days after the conference ended. NHS BSA wrote to Dr T with its stage 1 IDRP response on 12 October 2015, rejecting his appeal on this basis

12. NHS BSA also noted that the Trust had not required Dr T to attend the conference; rather, it approved professional leave to enable him to attend. As such, Dr T used a benefit of his contract of employment to attend the conference, but was not attending in the course of his NHS employment.

13. Dr T wrote to NHS BSA on 12 November 2015 to appeal this decision under stage 2 of the Scheme's IDRP. He pointed out that the Trust approved his application for professional leave so that he could attend the conference, and that the conference

was directly related to his medical specialism. As such, he attended the conference in the course of his NHS employment.

14. Dr T also argued that, if the Trust had doubted that he would be attending the conference in the course of his NHS employment, it could have rejected his application for professional leave and required him to use some of his annual leave entitlement instead. He further declared that the General Medical Council had advised him that, hypothetically, if a consultant had applied for professional leave to enable them to attend a conference, and they did not go to that conference, this would generally be considered to be a disciplinary matter. Accordingly, Dr T contended that he attended the conference in the course of his NHS employment.

15. NHS BSA wrote to Dr T on 5 February 2016 with its stage 2 IDRP response, maintaining that the Trust did not require him to attend the conference; he was invited independently of the Trust and took a free decision to accept that invitation. As such, the trip to India was not undertaken in the course of his NHS employment.

16. NHS BSA also argued that the fact Dr T had to submit a request for professional leave to the Trust in order to attend the conference demonstrates that such leave did not constitute part of his NHS employment duties. NHS BSA accepted that professional leave was a right afforded to Dr T by way of his contract of employment with the Trust. However, it considered the fact that the Trust authorised such leave does not indicate that he was discharging the duties of his NHS employment when benefiting from that right.

17. Turning to Dr T's argument that it is likely he would have been subject to disciplinary action if he had taken professional leave but not attended the conference; NHS BSA suggested that such action would be taken due to the misuse of professional leave and not because of a failure to attend the conference. NHS BSA explained that the Trust had advised that, if he had decided not to travel to India and shown up for work, he would not have been subject to disciplinary proceedings. NHS BSA considered that this underlines that the Trust did not consider Dr T's attendance at the conference to constitute part of his NHS duties.

18. Dissatisfied, Dr T referred the complaint to us. Amongst other things, he referred to the Employment Appeal Tribunal case of Edwards & Morgan v Encirc [2015] IRLR 528 (**the Edwards judgment**) in order to demonstrate that he attended the conference in the course of his NHS employment. In summary, the Edwards judgment ruled that time spent working outside of everyday employment duties, but which was beneficial to the employer (in that case, attendance at Trade Union meetings) amounted to being at the employer's disposal.

Adjudicator's Opinion

19. Dr T'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 summarised briefly below:-

    - Dr T chose to spend the two weeks of annual leave following the end of the conference in India and so any infection acquired during this period cannot reasonably be said to be related to his NHS employment. He therefore considered whether the available medical evidence supports the conclusion that it is more likely than not that Dr T picked up the infections at the conference.

    - The Adjudicator acknowledged Dr T's point that there was an outbreak of both infections in the area of India in which the conference took place. He also recognised Dr T's argument that the type of mosquito known to transmit both infections simultaneously was present in that region, but not in the areas he travelled to during the period of his annual leave following the conference. However, he noted that Dr T had not provided any evidence of his itinerary during the period of his annual leave and explained that, as such, he could not give substantial weight to this aspect of his testimony.

    - The Adjudicator observed that Dr Simpson noted that Dr T did not seek medical attention while he was in India, and so there is no contemporaneous medical evidence to corroborate his account of when his symptoms started. He also pointed out that Dr T had not provided any medical evidence relating to his treatment in the UK, following his return from India, giving a professional opinion on when he is likely to have contracted the infections.

    - The Adjudicator noted that Dr T's application was considered by two medical advisers, both of whom had reached the conclusion that the available medical evidence did not establish that, on balance, he acquired the infections at the conference. Dr Simpson covered all of the points made by Dr T in his stage 2 IDRP appeal. In the absence of any conflicting medical evidence, the Adjudicator saw no reason NHS BSA should have departed from Dr Simpson's advice. Accordingly, he was satisfied that NHS BSA had considered Dr T's application properly.

20. Dr T did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Dr T provided further comments which do not change the outcome. I agree with the Adjudicator's Opinion, summarised above, and I will therefore only respond to the key points made by Dr T for completeness. In summary, these are:-

- Whilst Dr Simpson mentioned that he had not provided any contemporaneous medical evidence relating to when the symptoms of the infections started, he acknowledged his testimony that they had begun two days after the conference ended. Dr Simpson commented that, if this is the case, then it is likely, on balance, that he sustained the infections during the conference, bearing in mind their incubation periods.

- Dr T obtained a report dated 24 April 2017 from his treating consultant, Dr Vilar, which indicated that the acute phase of the infections had ended more than two weeks before hospital tests were carried out on 23 November 2010 – i.e. around 9 November 2010. As such, the acute phase must have occurred over the preceding week (i.e. from around 2 November 2010), during the conference.

Ombudsman's decision

21. At the outset, it is essential to note that regulation 3(2) (a) of the Regulations says that TIA can only be awarded where the injury is sustained in the course of the member's NHS employment. Accordingly, the medical evidence only becomes material to the outcome of the complaint if it is accepted that, on balance, Dr T was attending the conference in the course of his role with the Trust. I have therefore given careful consideration to the relevant case law.

22. As a starting point, the Working Time Regulations 1998 S1 1833 (WTR 98) states:-

> "Working time, in relation to a worker, means –
>
> (a) any period during which he is working, at his employer's disposal and carrying out his activity or duties,
>
> (b) any period during which he is receiving relevant training, and
>
> (c) any additional period which is to be treated as working time for the purpose of these Regulations under a relevant agreement;
>
> and "work" shall be construed accordingly".

23. The Edwards judgment established that "At the employer's disposal" must mean something broader than under the employer's specific direction and control. Following the case law, it is apparent that, if the employer has already required the employee to be in a specific place and to hold him or herself ready to work to the employer's benefit, that can be sufficient. So the appeal tribunal disagreed with the narrow approach of the employment tribunal and slightly extended the scope of the meaning.

24. Applying the Edwards judgment to Dr T's claim, I note that the Trust did not require him to attend the conference. On the contrary, the conference organisers invited him personally; he asked the Trust for permission to attend and this was agreed as professional leave. Moreover, Dr T was not ready to work, as was the case in the

Edwards judgment, which involved the employees' attendance at a trade union meeting which could be rescheduled. Alternatively, if necessary, the employer could recall them to regular duties.

25. Fundamentally, professional leave is not time spent working. It is an agreement by the employer, upon application, for leave of absence from work to do something which benefits the individual, and also often the employer. If, hypothetically, Dr T had been asked by the Trust to give a speech as a regular part of his work role, or even if he had been invited to give one and the Trust had seen it as part of his role and agreed, he would not have required professional leave to attend. He would simply attend as part of his regular work week.

26. This is further reinforced by clause 16(iii) of the 2003 Consultant Terms and Conditions of Employment, which formed the basis of Dr T's employment contract, and states:-

> "Where an application is made under paragraphs 14 [Additional periods of professional and study leave in the United Kingdom] and 15 [Professional and study leave outside the United Kingdom] for a period of leave with pay, and this exceeds three weeks, it shall be open to the leave-granting organisation to require that one half of the excess over three weeks shall be counted against annual leave entitlement, the carry forward or anticipation of annual leave within a maximum of three weeks being permitted for this purpose".

27. This means that the Trust is entitled to require its employees to offset a portion of any professional leave which exceeds three weeks against the employee's annual leave entitlement. As such, a finding that Dr T's professional leave constituted work time would imply that, in certain circumstances, the 2003 Consultant Terms and Conditions of Employment made it acceptable for the Trust to require its employees to use up some of their annual leave entitlement to fulfil their employment duties. Such a requirement would be unlawful and as such, I conclude that professional leave cannot be considered to entail work time within the meaning of the 2003 Consultant Terms and Conditions of Employment. It follows that Dr T cannot reasonably be said to have attended the conference in the course of his NHS employment.

28. Accordingly, I find no evidence that NHS BSA's decision to reject Dr T's application for TIA was improperly reached.

29. Therefore, I do not uphold Dr T's complaint.

Anthony Arter

Pensions Ombudsman
18 July 2017

Appendix 1

The NHS Injury Benefit Regulations 1995

30. Regulation 3(2) (a) says:

> "(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 –
>
> it is wholly or mainly attributable to the duties of his employment;
>
> it is sustained while, as a volunteer at an accident or emergency, he is providing health services which his professional training and code of conduct would require him to volunteer; or
>
> it is sustained while he is travelling as a passenger in a vehicle to or from his place of employment with the permission of the employing authority and if in addition -
>
> (i) he was under no obligation to the employing authority to travel in the vehicle but, if he had been, the injury would have been sustained in the course of, and have been wholly or mainly attributable to, his employment, and
>
> (ii) at the time of the injury, the vehicle was being operated, otherwise than in the ordinary course of a public transport service, by or on behalf of the employing authority or by some other person by whom it was provided in pursuance of arrangements made with the authority."

Appendix 2

Medical evidence

31. On 2 April 2014, Dr E M O'Neill, Acting Director of Occupational Health and Safety at the Trust, issued a report which said:-

> "As you know, [Dr T] is off work on sick leave because of a severe and persistent Arthralgia, post Dengue and Chikungunya infection, and early onset osteoarthritis. In addition, he has other ongoing medical conditions, for which he receives appropriate treatment and supervision.
>
> [Dr T] has undergone a range of treatment for the joint symptoms, including Hydroxychloroquine and Methotrexate, which have not improved his symptoms. He continues to undertake a regular physiotherapy exercise programme which provides some symptomatic relief.
>
> Although [Dr T] remains under rheumatological care, he is not being considered for any further drug treatment at present. Therefore, given his length of absence from work and his persisting symptoms, we discussed the options with regard to a return to work. At present, [Dr T] remains limited in terms of his activity level and becomes easily tired. He is also unable to undertake fine manipulative skills because of his hand and finger symptoms. We were therefore unable to identify duties which he would be able to undertake at present and could not identify a timescale within which he might be able to return to work to undertake his duties, even in part".

32. On 9 April 2014, Dr H N Snowden, Consultant Rheumatologist, issued a report which stated:-

> "Previous correspondence has outlined the background of severe and persistent arthralgia following viral arthritis (with serological proof of infection with both Dengue and Chikungunya viruses. Of these, Chikungunya is more likely to be the cause of severe arthritis, although co-infection may be an explanation for the particularly severe clinical presentation), coupled with a development of quite severe early onset osteoarthritis involving the spine, acromioclavicular joints, small joints of the hands and the hips".

33. In July 2014, NHS BSA's medical adviser issued a report which read:-

> "This is an initial application for TIA.
>
> In order for this application to succeed, it must be accepted that the applicant has a medical condition that is wholly or mainly attributable to the duties of his NHS employment.
>
> The applicant, Dr T, is a 56 year old full time NHS Consultant in Paediatric Intensive Care …

The medical evidence considered for this application is as follows:

Copies of his occupational health records.

Copies of his GP records, including e-GP entries and specialist correspondence.

The AW33E ill-health retirement application form, dated 22 May 2014 by the applicant, and 25 June 2014 by Dr O'Neill, Consultant Occupational Physician.

A report from Dr O'Neill, Consultant Occupational Physician, dated 25 June 2014 (in the ill-health retirement application).

A report from Dr Snowden, Consultant Rheumatologist, dated 9 April 2014, also in the ill-health retirement application.

Also noted are the contents of the TIA initial application folder, including the employer and employee versions of events (including correspondence between the two parties), a job description and sickness absence records.

The applicant's claim:

The applicant states that he has persistent fatigue and multiple joint pains, secondary to contracting Dengue and Chikungunya fevers whilst attending an international Paediatric Intensive Care conference in India, and seeks to causally relate this to the duties of the NHS employment.

There is one test to be satisfied when considering this claim – was there an illness or injury that was wholly or mainly attributable to the normal duties of the NHS employment? This is the Attribution Test.

Attribution Rationale:

He has a history of contracting Dengue and Chikungunya fevers (serology positive) in India in 2010, whilst attending an international conference, as an expert speaker. It is noted that the Trust has refused his TIA application to them, on the basis that such a trip was not part of his usual NHS duties and the infection was therefore not contracted in the course of his employment.

The key points here are:

He was under no contractual obligation with his employing Trust or the wider NHS to attend such a conference. He attended the conference of his own volition, at the organisers' invitation.

It is understood that the conference was for a few days. There was no requirement for him to remain in India for longer than this – it is understood that he stayed there for two weeks after the end of the conference, on an annual leave basis.

It is impossible to say at what point during the conference and subsequent holiday he might have contracted the infections – on balance of probability, the longer of the two time durations would be higher risk (i.e. during his holiday).

Appropriate continuing professional development (CPD) and medical revalidation requirements would not have obliged him to attend such a conference.

The key duties of his job role as a Consultant in Paediatric Intensive Care can reasonably be expected to be based at his usual place of work and immediate environs.

He was diagnosed with Hashimoto's thyroiditis in 2009 and received appropriate treatment. This condition is described as difficult to fully control ever since, with thyroid hormone replacement therapy, and he remains chronically and easily fatigued. Some degree of his chronic fatigue would therefore be attributable to this condition.

It is clear from the medical evidence that he has been diagnosed with multiple joint, early onset, osteo-arthritis, affecting his spine, hands/fingers, hips and shoulders (acromio-clavicular joints), which would be unlikely to have been directly caused by a period of post-viral inflammatory arthritis secondary to the tropical diseases listed above.

Dr T has been treated with disease-modifying anti-rheumatic drugs (DMARDs), with little effect, and a course of intensive physiotherapy, also with little sustained improvement. This would tend to indicate that the inflammatory (post-infective) component to his arthralgia and arthritis is less relevant to his current condition than the degenerative/wear and tear (osteo) arthritis.

In no way is this report intended to convey that Dr T does not have very significant and genuine fatigue and multiple joint pains, which are likely to seriously and adversely affect his ability to perform his NHS duties, or indeed any other form of work, in the longer term.

The key matter for this report is whether or not the evidence leads to the conclusion that he has, more likely than not, been injured in the course of his NHS employment, and which has led fully or partially to his current health status.

The evidence does not support such a conclusion.

Concluding advice:

It is my opinion that, on the balance of probabilities, the evidence in this case does not confirm that the following injury/disease – fatigue, arthralgia and osteo-arthritis – was contracted in the course of the person's NHS employment and is wholly or mainly attributable to that NHS employment.

The application is therefore not successful."

34. On 1 October 2015, Dr Simpson produced a medical report for NHS BSA, in which he stated:-

"[Dr T] makes the point that it is impossible to prove beyond doubt when he contracted Dengue Fever (serotype 3) and Chikungunya. He states that following an infected mosquito bite, the incubation period for Dengue Fever is 4 to 7 days and for Chikungunya it is 2 to 7 days. He adds that he became symptomatic 2 days after the Conference, therefore this places the time of the infected mosquito bite during the Conference period. He admits he has no documentary corroboration.

He goes on to say that, during his time at the Conference, there was an outbreak of the above infections there and the serotypes matched his infection, and he argues further that the mosquito type and distribution in India, and the infections carried, makes it more likely that he was bitten and infected in Surat. He states he sustained three bites in the Conference period and none subsequently.

Dr T first sought medical help when he returned to Britain and he states that there was then serological confirmation of his infection.

It is accepted that Dr T sustained an infected mosquito bite during his time in India from 26/10/10, however it is not possible to state exactly where and when this occurred. It appears likely that both infections were contracted at the same time. The incubation period for Dengue Fever ranges from 3 to 15 days, usually 5 to 8 days. The incubation period for Chikungunya ranges from 1 to 12 days, usually 3 to 7 days. If, as he states, Dr T developed infective symptoms 2 days after the end of the Conference period, then it is likely, on balance, that he sustained the infected mosquito bite during this period of time".

35. On 27 April 2017, Dr N Snowden, Consultant Rheumatologist, provided a letter on Dr T's behalf with respect to his application to this service, which reads:-

"Dr T was simultaneously infected with Dengue and Chikungunya viruses (only carried simultaneously by the Aedes albopticus mosquito) while he was attending an international conference in Surat, India in October 2010. Both of these viruses are known to cause severe muscle and joint pain, as well as systemic symptoms, and Chikungunya can cause a severe arthritis which resembles acute rheumatoid arthritis. Prior to these infections, he was fit and active, with no major musculoskeletal problems, although he had had some surgery on both shoulders for mechanical problems, one associated with osteoarthritis, the other trauma from a previous car accident. He also had autoimmune hypothyroidism and allergic rhinitis …

I would have no doubt that the primary cause of Dr T's severe and persistent pain was Chikungunya infection acquired in October 2010, and that without this infection it is likely that he would have remained as fit and active as he was before his trip to India. I do not consider that his current symptoms are due to osteoarthritis pre-dating his Chikungunya infection".

36. On 24 April 2017, Dr J Vilar, Consultant Physician, provided a letter on Dr T's behalf, in support of his application for TIA, in which he stated:-

"This is to confirm that Dr T was a patient of mine back in 2010. I am writing this report based on the medical records available for him at my department. I met him for the first time on 15 December 2010. Prior to that, he had been assessed by our senior specialty doctor (on 23 November 2010, which I understand from our record that it was about 11 days from his return to the UK), who had arranged a number of tests. He had developed symptoms over a period of eight weeks. He had a rather unrewarding recovery and two attempts to go back to work, which were disappointingly unsuccessful. He reported to be usually fit and well, except from thyroid issues. He travelled to India and attended a medical conference (Surat) and then he travelled to Delhi, from where he started a two week holiday. During his journey, he developed classical symptoms of these infections. This lasted for about six days, according to our record from the time. He then also developed a rash around that time, felt a bit better for a day and then worse again. I understand that he attended a hospital in Delhi and a Dengue test at that time was negative but his white blood cells were low, in keeping with both Dengue and Chikungunya.

Her clinical diagnosis initially was that of Dengue and this was confirmed by the blood test with positive IgG and IgM and RNA, which made the diagnosis 100% certain. He also had a positive serology for Chikungunya and with his atypical presentation with arthritic symptoms, particularly involving the hands, make this diagnosis also very solid [sic]. Dual infection is not infrequent, as the areas where these viruses circulate overlap. His white cells were normal in our hospital and there were no significant clinical signs. This indicates that there would not have been an acute infection within the preceding two weeks.

From his initial presentation, he was left with severe symptoms, which were joint pains, particularly affecting his shoulder and his right hip. This is quite typical of Chikungunya and can last for years as part of a reactive arthritis type of condition. He also had other symptoms, including profound muscle pains and profound fatigue. Clinical examination revealed some lymphadenopathy.

Since the treatment of this condition is supportive, we advised him to continue to seek care from rheumatology. In my opinion, the fact that his rheumatological symptoms started at the same time that he contracted the above illness, and with the evidence that these symptoms can persist for years and be very severe, is proof that these issues were triggered by viral infection.

Both Dengue and Chikungunya are viruses easily transmissible in India. There are frequent outbreaks in different regions in the area and transmission of the infection is more likely during these. Isolated cases can be found anywhere in the area but on balance one is more likely to become infected during an outbreak. The incubation period of Chikungunya is usually 2 – 4 days (range 1 – 12 days)".