PENSION SCHEMES ACT 1993, PART X
DETERMINATION BY THE PENSIONS OMBUDSMAN

Applicant	Dr J Kochan
Scheme	NHS Injury Benefit Scheme
Respondent(s)	The NHS Business Services Authority (**NHS BSA**)

Subject

Dr Kochan has complained that the NHS BSA have not assessed her eligibility for a permanent injury benefit in a proper manner.

The Pensions Ombudsman's determination and short reasons

The complaint should be upheld against the NHS BSA because they have not taken all relevant matters into account when considering Dr Kochan's eligibility for a permanent injury benefit.

DETAILED DETERMINATION

Material Facts

1. Dr Kochan was employed by North West London Hospitals Trust (the **Trust**) as an anaesthetist from 2005 to 2011. She applied for a permanent injury benefit (**PIB**) in April 2012 on the grounds that she suffered an injury to her back in September 2008 when assisting in the movement of a patient. Dr Kochan went on sick leave in November 2008 and did not return to work.

2. The relevant regulations are the National Health Service (Injury Benefits) Regulations 1995 (as amended) (**the Regulations**). Regulation 3 states,

> "Persons to whom the regulations apply
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> (1) ... these Regulations apply to any person who ...
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> ... sustains an injury, or contracts a disease, to which paragraph (2) applies.
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> (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. Regulation 4 sets out the scale of benefits. Regulation 4(1) states,

> "... 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, ..."

4. The incident report relating to Dr Kochan's accident records that, whilst moving a patient onto a bed after an operation, she experienced a sharp pain in her thoracic spine, radiating to her scapulae and sternum, and a sharp pain in her cervical spine. The report states that Dr Kochan found it difficult to take a breath because of the pain. It also states that the pain continued and progressed, with pins and needles and numbness in her arms. At the time of the incident, Dr Kochan took a short rest and some painkillers, before completing her shift. It is accepted that the incident occurred as described.

5. The incident was the subject of a personal injury claim, in connection with which the Trust admitted breach of duty in relation to its manual handling policy.

6. Whilst Dr Kochan was on sick leave with reduced pay, she was awarded temporary injury allowance (**TIA**) the amount of which is provided for under Regulation 4(4) of the Regulations. The qualifying criteria are those set out in Regulation 3 (that is, the same as apply to PIB).

7. A first instance decision was issued on 29 October 2012 by the medical advisers to the Scheme, Atos Healthcare (**Atos**). They declined Dr Kochan's application and quoted from their doctor, Dr Scott,

> "The medical evidence consists of the application, sick record, incident report, Trust and applicant's version of events, GP and OH records, and translated copies of the treatment records, and medico legal reports from Poland.
>
> The incident is well recorded, along with the symptoms the applicant experienced immediately afterwards. This resulted in MRI scanning being carried out on 5.11.08, which showed extensive changes of osteoarthritis, all disc spaces narrowed with prominent anterior and posterior osteophytes, C4/5 disc bulging but not encroaching on the cord, and no focal disc herniations. The most striking abnormality was the degenerative changes. This was repeated in Poland (6.12.08), and whilst the report is much more detailed it appears to describe a very similar scenario. It also comments that as in the previous examination there is herniation of the T6/7 disc. Surgery was planned but postponed due to a respiratory infection. She was seen by 2 neurosurgeons in NHNN in London, where a repeat MRI was carried out, which again showed degenerative changes, without cord compression, and narrowing of the root canals at right C5 and 6 levels; however, it was felt that her symptoms could not be attributed to this. Her symptoms have steadily worsened, requiring surgery, with only limited success, and this has had a considerable impact on her mental health, living with chronic pain.
>
> The incident is not in doubt, nor is the applicant's current level of disability. The issue which arises here is causation. There has been extensive degenerative disease identified within 6 weeks of the incident, which must have predated the incident by many years, coming on gradually. Osteoarthritis is a degenerative condition, which cannot be attributed to her NHS duties. The incident clearly triggered this episode; however, the details of the incident when 5 people were involved in the uneventful controlled transfer of a very obese patient, does not suggest that an abnormal load fell upon the applicant. The subsequent progression suggests that the incident accelerated the onset of symptoms from this condition which would nevertheless have become symptomatic in time. The contemporaneous information

> has a lot of evidence of degenerative changes, and no real evidence of acute trauma. Subsequent reports refer back to post traumatic herniation of discs; however, this was specifically sought at the time and not found. In view of this the incident appears to have accelerated the onset of symptoms from extensive degenerative disease, which would have developed in time despite the incident. Any PLOEA* cannot therefore be wholly or mainly attributed to her NHS duties."

*Permanent Loss of Earning Ability

8. Summaries of certain of the key medical reports referred to by Dr Scott are provided in an appendix to this document.

9. Dr Kochan submitted an appeal under the Scheme's two-stage appeal procedure. Her solicitor submitted an appeal document, together with a (translated) "Certificate on Health Status" provided by a neurosurgery consultant, Dr Sumara, in Poland. The key points from the appeal document are summarised as follows:

- During the lifting procedure, Dr Kochan was lifting the patient's shoulders and head. One nurse was at the patient's right side, two at her left side and one at her feet. They turned the patient on to her right side. This necessitated Dr Kochan lifting the patient's right shoulder and head with her right arm and manoeuvring her with her left arm and the left side of her body. She received no assistance from the nurses.
- Dr Kochan had worked as an anaesthetist in a number of countries prior to working in the UK and had never been required to move patients manually.
- Dr Kochan worked approximately 72 hours per week for 48 weeks of the year over the four years prior to the incident. Many of the patients she handled in that time were of substantial weight.
- The Trust had admitted liability in that its manual handling policy did not deal with pregnant heavier and bariatric patients, it did not provide advice via a dedicated manual handling advisor, it did not provide training to staff on the manual handling needs of heavier and bariatric patients, and did not carry out risk assessments.

- Atos' doctor had not referred to reports obtained from a consultant neurosurgeon, Mr Ameen, or a neuropsychiatrist, Dr Bodani (see Appendix). He must, therefore, have ignored these and his decision was not based on all the available medical evidence. These reports dealt in detail with the causal link between the Trust's failures and Dr Kochan's current condition.
- Atos' doctor had referred to the lifting process as uneventful and had ignored the actual circumstances of the lifting process. He had also ignored the Trust's admission of liability for breach of duty. This information and relevant documents were in his possession, but were ignored.
- The issue to be decided was whether the Trust's admitted failures "wholly or mainly attributed to [Dr Kochan's] current state".
- Dr Kochan accepts that she had an asymptomatic degenerative condition. This is very normal for persons of her age.
- Atos' doctor did not appear to be a practicing surgeon or an expert in a relevant field. It was not clear which documents he had relied upon in coming to his view.
- The medical reports provided identified acceleration of Dr Kochan's degenerative condition by a period of approximately 7.6 years. But for the Trust's failings, Dr Kochan would have remained asymptomatic and would have enjoyed a normal life and continued with her career for most of her remaining working years. Her current condition was, therefore, clearly wholly or mainly attributed to her work for the Trust.
- Atos' doctor ignored the fact that Dr Kochan was awarded a TIA. In so doing, the Trust had admitted a causal link between its failings and her current condition. The award of TIA relied on the same test as PIB.

10. The Certificate on Health Status recorded a diagnosis of "cervical myelopathy with tetraparesia in the course of hernia nucleus pulposus at C4-5 and C6-7", together with post traumatic depressive disorder. It recorded that Dr Kochan had undergone surgery in 2009, after which she had experienced a small improvement but was still suffering paraplegia and weakness in her lower limbs.

Dr Sumara had expressed the view that the prognosis was uncertain, but "rather bad". He said that Dr Kochan was not able to work as an anaesthetist.

11. Atos requested an additional report from Mr Ameen. In particular, they asked him to clarify his view that Dr Kochan would have needed the same surgery and had the same outcome within 5-6 years of the incident. Atos asked whether Mr Ameen meant that Dr Kochan would have developed the same disc disease within that period of time. They also asked whether Dr Kochan's disc prolapses would have occurred without the September 2008 incident and whether they could occur spontaneously.

12. In response to the request from Atos, Mr Ameen prepared a further report on 22 December 2012. He pointed out that he was not Dr Kochan's treating physician and had only examined her once, on 1 October 2011, for the purposes of writing a medicolegal report. Mr Ameen said Dr Kochan would have developed the same disc disease within five to six years of the 2008 incident. He went on to say that, if the 2008 incident had not happened, the same disc prolapses would have occurred five to six years later. With regard to spontaneous occurrence, Mr Ameen said it was extremely difficult to predict with any degree of certainty. He expressed the view that the probability of spontaneous occurrence of disc prolapses of the same nature as Dr Kochan's was more than 50%.

13. Dr Kochan's case was reviewed by another of Atos' doctors, Dr Wladyslawska. She said that she had reviewed:

- A letter from Dr Kochan's husband dated 29 October 2012
- A letter from Dr Kochan's solicitor dated 26 November 2012, together with subsequent amendments
- The Certificate on Health Status from Dr Sumara
- Reports from Mr Ameen dated 8 October and 27 December 2011 and 22 December 2012
- A report from Dr Bodani dated 24 September 2012
- Correspondence and reports from various Polish doctors

14. Dr Wladyslawska noted that Dr Kochan had experienced sharp pain in her thoracic and cervical spine whilst transferring a patient along with four other members of staff and that she had been standing behind the patient's head. Dr Wladyslawska referred to the results of the MRI scans taken in November and December 2008 and a discharge report provided following Dr Kochan's hospital admission in January 2009. She also referred to the surgery Dr Kochan had undergone in November 2009. Dr Wladyslawska said,

> "… Mr Ameen's, opinion is that she is still left with the cervical spine instability at C3/4 which needs to be addressed by her treating neurosurgeon as soon as possible to prevent persistent damage to her already diseased spine. It is noted that her ongoing physical symptoms have had adverse impact on her psychological condition. She was diagnosed with depression and anxiety disorder and has been receiving treatment …
>
> The Consultant Neurosurgeon indicates that she sustained soft tissue injury to her cervical and dorsal spine during the accident at work and confirms background degenerative disease of her cervical and dorsal spine which pre-existed the index accident although it was asymptomatic. It is Mr Ameen's opinion that her symptoms are the result of an exacerbation of pre-existing asymptomatic degenerative changes. According to Mr Ameen on the balance of probabilities if the index accident had not happened the above disc prolapse would have occurred five to six years after the date of index accident on 21/09/2008, approximately 5 years prior to the age of 65, which is the criterion of permanency under consideration. He states that the probability of spontaneous disc prolapse of the same nature is more than 50%. The disease and the resultant disability would have been triggered anyway, even without Dr Kochan being in her employment or sustaining index accident, being part of the naturally developing inevitable ageing process that affects all human beings.
>
> Although her cervical and thoracic spine symptoms occurred during the incident at work the significant contributing effect of pre-existing extensive degenerative disease of her cervical and dorsal spine has been carefully assessed and supported by the Consultant Neurosurgeon. Therefore it cannot be confirmed that her neck pathology and any associated permanent loss of earnings ability are wholly or mainly attributable to her NHS employment."

15. Dr Wladyslawska concluded that Dr Kochan's disc prolapse was contracted in the course of her NHS employment, but was not wholly or mainly attributable to that employment.

16. This opinion was reviewed by the NHS BSA at stage one of the appeal process. They wrote to Dr Kochan, on 16 January 2013, saying that they did not uphold her appeal on the basis of the advice they had received from Dr Wladyslawska. The decision maker said that Dr Wladyslawska appeared to have taken all of the relevant medical and other evidence into account and had offered a reasonable rationale for not recommending payment of a PIB.

17. Dr Kochan submitted a further appeal. In addition to reiterating the points raised under her first appeal, Dr Kochan's husband also submitted a report from her treating consultant neurosurgeon, Dr Maciejczak. In the undated report, Dr Maciejczak explained that he had first seen Dr Kochan in December 2008 when she had sought advice in connection with her cervical spine. He said that she had presented with symptoms of cervical brachialgia and cervical myelopathy which had developed immediately as a result of lifting heavy patients. Dr Maciejczak said,

> "One may define the biomechanical background of the accident as an excessive load superimposed on pre-existing clinically silent degenerative changes of the cervical spine. This overload provoked appearance of clinical symptoms of degenerative disease of the cervical spine. This is a scenario often seen in clinical practice. I believe that the index incident not only provoked the onset of clinical symptoms in the cervical spine but also resulted in T6/T7 disc herniation."

18. Dr Kochan's case was reviewed by another Atos doctor, Dr McLaren. He confirmed that he had considered Dr Maciejczak's report, along with the previous evidence. Dr McLaren said,

> "It is accepted that the applicant did sustain a soft injury to her cervical and thoracic spine, and this can be wholly or mainly attributed to the duties of the NHS employment.
>
> The MRI scan result, dated 17/11/08, showed prominent degenerative OA (osteoarthritis) changes at multiple levels in the cervical spine (C4/C5, C5/C6, and C6/C7). All of the disc spaces were narrowed and there were prominent anterior and posterior osteophytes. There was bulging of the C4/C5 disc, but this was not encroaching on the cord or on the exiting nerve roots. There was no focal disc herniation.
>
> No MRI scan of the thoracic spine was undertaken at that time …
>
> In Mr Maciejczak's opinion, there is a causative connection between the index incident and her ongoing symptoms. Mr Maciejczak believes that the index incident resulted in:

- C4/C5, C5/C6 and C6/C7 disc herniation with associated cervical myelopathy
- T6/T7 disc herniation

This differs from Mr Ameen's opinion. Mr Ameen has stated the applicant sustained a soft tissue injury to her cervical and thoracic spine on 21/09/2008. Such an injury would be expected to show steady improvement over a period of 6-12 months. Instead the applicant's symptoms progressively deteriorated. Mr Ameen has stated that this normally indicates that there is a background of degenerative disease.

Due weight has been given to all of the evidence; however the opinion of Mr Ameen is preferred. This is corroborated by the fact that the MRI scan performed shortly after the index incident showed well established degenerative changes in the cervical spine and thoracic spine. These degenerative changes, although asymptomatic, would have pre-existed the index incident. Furthermore, Mr Ameen estimates that the duties of the NHS employment contributed by approximately 20% to the development of the degenerative disease of the cervical and thoracic spine. Other (constitutional) factors will therefore have contributed by approximately 80%.

It is advised that the applicant's ongoing symptoms are due to degenerative disease of the cervical and thoracic spine. The index incident resulted in a soft tissue injury to the cervical and thoracic spine; the symptoms arising from this were temporary in nature with no permanent loss of earning ability."

19. The NHS BSA wrote to Dr Kochan's husband, on 16 April 2013, saying that they accepted that Dr Kochan had suffered an injury in September 2008 which was wholly or mainly attributable to her NHS employment, but that this had not resulted in a PLOEA. They said that the condition which Dr Kochan now suffered from and which she claimed was incapacitating her for work was the result of constitutional degenerative disease and not connected to her NHS employment. The NHS BSA quoted Dr McLaren and said that they could see no reason to disagree with his advice and had, therefore accepted it. The NHS BSA said that, considering the impact of the index incident in the context of Dr Kochan suffering comparable degenerative changes for a woman of her age, it could not have caused more than temporary soft tissue injury. They went on to say that the condition Dr Kochan now suffered from was constitutional in origin, which they defined as part of a person's body make-up. The NHS BSA acknowledged that degenerative changes could be permanently or temporarily exacerbated by work activities. However, they went on to say that this was not

the same as saying that the condition was wholly or mainly attributable to NHS employment. The NHS BSA referred to Mr Ameen's opinion, that only 20% of Dr Kochan's degenerative disease was causally linked to her NHS employment, and said that this was insufficient to meet the wholly or mainly attributable requirement.

20. The NHS BSA also referred to "wear and tear" injuries, which they said the Scheme was never intended to cover. They said that, where there had been a number of accidents or incidents over the course of an NHS career, a claim could only be considered where there was corroboration of the alleged events; it was not sufficient to claim that NHS employment was the cause of a condition merely because of the nature of the duties and the length of employment.

21. With regard to TIA, the NHS BSA said that payment of TIA did not create a precedent and each application was considered separately. They said that they had accepted that the index incident had resulted in a soft tissue injury which would have been expected to improve over a period of 6-9 weeks. The NHS BSA said that the index incident may have caused Dr Kochan to be absent from work for a period and attract a TIA, but would not have resulted in a PLOEA. They also explained that the Injury Benefit Scheme was a "no blame" income protection scheme and it did not matter who was to blame or whether or not an employer had done everything they should have done to prevent injury.

Summary of Dr Kochan's position

22. In addition to the points raised in her first appeal (see above), Dr Kochan submits:

- The Trust admitted breach of duty. The 'eggshell skull' rule holds a party liable for all consequences resulting from his/her activity even where there is a pre-existing condition. This rule is a principle of common law which states that victims should be fully compensated for their losses, even where the damages arising out of their predisposing condition were not foreseeable to the defendant.
- The NHS BSA have relied on the opinion of Mr Ameen, but his opinion has been misconstrued and misrepresented. The Atos doctors appear to suggest that Mr Ameen was of the opinion that her NHS employment contributed to the symptoms she suffered following the accident by 20%;

this is incorrect. Mr Ameen referred to the acceleration of her condition by approximately 7.6 years. This figure included general acceleration of her condition as well as an additional 20% caused by the unsafe working conditions at the Trust.

- But for the accident, she would have remained asymptomatic until age 61.5 to 62. She is currently 58. Her current condition is, therefore, clearly wholly or mainly attributable to her NHS employment.
- The Atos doctors failed to acknowledge that, at the present time, her loss of earning ability is entirely caused by her employment with the Trust. Her employment with the Trust will continue to cause her total loss of earning ability until age 61.5 to 62.
- Her employment was not terminated until three years after the accident. If her symptoms had begun to occur naturally at age 61.5 to 62, then her permanent loss of earning ability would have occurred at age 64.5 to 65.
- The Atos doctors failed to take account of the reports prepared by Dr Bodani. In his view, had she begun to suffer from her symptoms naturally at age 61.5 to 62, she would not have developed her psychiatric condition. This psychiatric condition resulted from the acceleration of her condition. This acceleration is accepted by the NHS BSA as being wholly or mainly attributable to her NHS employment. Her permanent loss of earning ability resulting from her psychiatric condition exceeds 10% and qualifies her for a PIB.
- She has lost everything, including savings and credibility with her banks, and faces repossession of her flat because of debts and mortgage arrears. She has submitted a number of letters from her bank, mortgage lender and debt collection agencies.

23. Dr Kochan's solicitor has submitted a letter from Dr Bodani, dated 10 June 2014, in which he confirms that it is his opinion that Dr Kochan's psychiatric condition was caused by the accident and that she would not have gone on to develop this condition but for the accident.

Summary of the NHS BSA's position

24. The NHS BSA submit:

- They have considered Dr Kochan's application for a PIB using the correct test, taking into account all relevant evidence and ignoring anything irrelevant. They have sought and considered the advice of their own medical advisers. They have weighed up the evidence and come to a different conclusion to Dr Kochan. This is unfortunate, but the decision is a finding for them to make on the facts.
- The Scheme provides income protection for eligible employees who suffer a permanent reduction in their earning ability in excess of 10%. In this context, permanent means to normal retirement age; not normal pension age. They apply the civil burden of proof; on balance of probabilities.
- There are two tests which must be satisfied before payment of a PIB can be made – the person must have sustained an injury which is wholly or mainly attributable to their NHS employment and, if that test is passed, they must suffer a PLOEA in excess of 10% by reason of that injury.
- They acknowledge that the 2008 incident occurred as described by Dr Kochan, but this is not the reason she was unable to attend work. She suffers from a degenerative disease of the spine whose cause is not related to her NHS employment.
- The incident caused Dr Kochan to feel pain from the degenerative disease in her spine, but this is not the same as saying that her condition was caused by her work. It is their view that Dr Kochan is unable to work because of her degenerative spinal condition rather than an injury sustained or a disease contracted at work.
- The experiencing of a symptom (pain) is not sufficient in itself to satisfy the requirements of the Regulations. There must have been an injury, that is, a pathological change for the worse which is wholly or mainly attributable to the NHS employment and which has resulted in a PLOEA in excess of 10%.

- Dr Kochan suffered a soft tissue injury in 2008, which would have resolved before she reached 65 in the absence of her pre-existing degenerative disease.
- The Scheme does not extend to cases of exacerbation or aggravation, even if that exacerbation or aggravation is wholly or mainly attributable to NHS employment.
- Dr Kochan's psychiatric condition is directly consequential to the ongoing effects of her degenerative spinal problems. As these have not been accepted as wholly or mainly attributable to her NHS employment, the consequential psychological injury must also be declined.

Conclusions

25. Regulation 3 applies where an individual has sustained an injury or contracted a disease which is wholly or mainly attributable to their NHS employment. If that is the case, Regulation 4 provides for a PIB to be paid where, as a consequence, the individual has suffered a PLOEA in excess of 10%. Determining whether Dr Kochan met the criteria for payment of an injury benefit is a finding of fact for the NHS BSA to make.

26. In coming to a decision as to Dr Kochan's eligibility for PIB, the weight that the NHS BSA attach to any piece of the evidence is for them to determine. It is open to them to prefer the advice they receive from their own medical advisers over that provided by Dr Kochan's. However, they should not do so blindly. If they are to rely on the advice from the Atos doctors, the NHS BSA should be sure that their advisers have taken all of the relevant medical evidence into account, have not made any errors or omissions of fact and have applied the correct eligibility test.

27. The question for the NHS BSA and their advisers was whether Dr Kochan's continued incapacity was wholly or mainly attributable to an injury sustained or a disease contracted which is attributable to her NHS employment. If so, they had then to ask themselves whether this condition has resulted in a PLOEA in excess of 10%.

28. The key issue in Dr Kochan's case is the presence of degenerative disease which pre-dates her accident in 2008. Dr Kochan accepts that she had degenerative changes in her spine prior to the accident, but says that this is normal for someone of her age. If that were the case, I would say that the presence of any degenerative disease in Dr Kochan's spine which pre-dated the accident should have been disregarded in assessing her eligibility. However, if the degenerative changes disclosed by the MRI scans in 2008 were more than would be expected in someone of Dr Kochan's age, it would be proper for the NHS BSA and their advisers to take this into account when assessing her eligibility for PIB. They would, however, also need to ask whether those degenerative changes were themselves caused by Dr Kochan's NHS employment. Mr Ameen addressed this question when he advised that, in his opinion, Dr Kochan's NHS employment had contributed approximately 20% to the development of her degenerative disc disease. On that basis, it could not be said to be "wholly or mainly" attributable to her NHS employment; for that to be the case, the contribution would have to be (at the very least) greater than 50%.

29. Dr Kochan and her solicitor have referred to the eggshell skull rule. That is a rule which is relevant to liability for an injury caused by negligence. What is at question here is whether Dr Kochan is entitled to a PIB under the Scheme on its terms, which has nothing to do with liability or fault. For the same reason, the fact that the Trust accepted liability for breach of duty in relation to its manual handling policy is not relevant to the question to be decided here.

30. The first instance decision making in PIB applications is undertaken by Atos on behalf of the NHS BSA. Dr Scott reviewed the medical evidence, including reports provided by Dr Kochan's treating physicians and other specialists. He concluded that the 2008 accident had accelerated the onset of symptoms from degenerative disease which "must have predated the incident by many years". Dr Scott noted references to post traumatic herniation of discs in subsequent reports, but said that this had not been found at the time. Dr Kochan's application was declined on the basis that the 2008 accident had accelerated the onset of symptoms from pre-existing degenerative disease and, as a result, any PLOEA was not attributable to her NHS duties. I note that Dr Scott did not mention the finding of a protrusion of the nucleus pulposus at T6/T7 found in the MRI scan taken in December 2008. It is not clear whether he overlooked this

piece of evidence or whether he did not think it relevant. Dr Scott mentioned that "living with chronic pain." had "had a considerable impact on [Dr Kochan's] mental health". He did not refer to Dr Bodani's opinion that, but for the accident, Dr Kochan would not have suffered any psychological symptoms. It is not clear, therefore, whether he considered this aspect of her case or whether he simply disagreed with Dr Bodani and, if so, why.

31. Some considerable thought went into determining when Dr Kochan was likely to have begun to experience the symptoms of her degenerative disc disease had the 2008 accident not occurred. Mr Ameen said that Dr Kochan was likely to have suffered similar symptoms and required similar treatment, including surgery, within the next five to six years after the accident. He later calculated that, since the accident contributed 20% to the development of Dr Kochan's disc disease, it would have taken a further 6 to 7.2 years to develop the disease. The estimates are not completely consistent, but that does not affect Dr Kochan's case because the Scheme does not provide for the acceleration or exacerbation of a condition.

32. Whilst it is unnecessary for the reviewing doctors to refer to each piece of medical evidence, there were key omissions from Dr Scott's report which meant that it was not possible for Dr Kochan to be sure that he had considered all the relevant medical evidence.

33. Dr Kochan appealed. As a result, Atos sought further advice from Mr Ameen and another of their doctors reviewed the case. Dr Wladyslawska concluded that Dr Kochan's disc prolapse was contracted "in the course of" her NHS employment, but was not wholly or mainly attributable to that employment. She appears to have based her opinion largely on the advice from Mr Ameen that the possibility of a disc prolapse occurring spontaneously within the five to six years after the 2008 accident was greater than 50%. Mr Ameen offered this view because Atos had asked whether Dr Kochan's disc prolapses would have occurred without the September 2008 incident and whether they could occur spontaneously. This is not the question. What Atos needed to know was what, if any, contribution the 2008 accident had had in the occurrence of Dr Kochan's disc prolapse(s). As I have said, acceleration or exacerbation is not provided for under the Scheme rules. Therefore, the fact that Dr Kochan might have experienced a spontaneous prolapse at some point in the future was not the issue.

34. Dr Wladyslawska noted that Dr Kochan's "ongoing physical symptoms have had adverse impact on her psychological condition". From this, I take her to mean that Dr Kochan's psychological condition was a consequence of her ongoing physical condition rather than the 2008 accident. However, Dr Wladyslawska did not make this clear in her report; nor did she explain why she disagreed with Dr Bodani.

35. The NHS BSA declined Dr Kochan's appeal on the basis of the advice they received from Dr Wladyslawska without clarifying these matters with her. In doing so, they did not give proper consideration to Dr Kochan's eligibility for a PIB.

36. Following a further appeal, Dr Kochan's case was reviewed by Dr McLaren. He had been provided with all the previous medical evidence and a report from Dr Kochan's treating consultant neurosurgeon, Dr Maciejczak. Dr McLaren noted that there was a difference of opinion between Mr Ameen and Dr Maciejczak and said that he preferred Mr Ameen's view because it was corroborated by the MRI scans taken at the time. However, Dr McLaren also said that no scan had been taken of Dr Kochan's thoracic spine when this was not the case. In addition, Dr McLaren does not appear to have considered Dr Kochan's psychological condition.

37. The NHS BSA declined Dr Kochan's appeal on the basis of the advice they received from Dr McLaren without clarifying matters with him. Taking this together with the deficiencies in the earlier reviews, I cannot find that they have given proper consideration to Dr Kochan's eligibility for a PIB. I uphold her complaint.

38. In the circumstances, I find that the proper course of action is for me to remit the decision for reconsideration by the NHS BSA and I have made directions to this effect. That is not to say that I find that Dr Kochan should be considered eligible for a PIB; I make no decision on that point. It may well be that the NHS BSA find, on further consideration, that she does not meet the criteria for payment of a PIB, but that decision must be reached in the correct manner.

39. Dr Kochan has submitted that, as a consequence of the NHS BSA's failure to properly consider her for a PIB, she has encountered financial difficulties. The evidence submitted by Dr Kochan dates from early 2013 and relates to mortgage

arrears and other debts incurred in 2012/13. In the case of the mortgage, this is a liability which Dr Kochan assumed prior to her accident in 2008. The other debts accumulated over the 2012/13 period at which time her application for PIB was under consideration. Even if her application had been dealt with in the proper manner, Dr Kochan would still have found herself in the position of having to deal with arrears of mortgage and other debts. I cannot find that her financial circumstances are a direct result of any failures on the part of the NHS BSA.

40. However, I do find that Dr Kochan will have suffered non-financial distress as a consequence of the maladministration I have identified. It would be appropriate for her to receive some modest compensation to recognise this.

Directions

41. I direct that, within 28 days, the NHS BSA are to give further consideration to Dr Kochan's eligibility for a PIB. Before doing so, they are to seek further advice to address the deficiencies in the previous reports from the various Atos doctors. In particular, the NHS BSA are to ask their medical adviser to comment on the likelihood that the 2008 accident caused a disc prolapse in Dr Kochan's thoracic spine and whether her current psychological condition was caused wholly or mainly by the accident and alone, or with other factors, results in a relevant reduction in earnings capacity.

42. Within the same timeframe, the NHS BSA shall pay Dr Kochan £300 for the distress and inconvenience she has suffered as a consequence of the failure to consider her for a PIB in the proper manner.

Tony King
Pensions Ombudsman

1 August 2014

Appendix

Medical evidence

1. It would not be practical or helpful to provide summaries for all of the medical records provided in Dr Kochan's case; many of them deal with the diagnosis and treatment of her condition and do not comment on causation. The following summaries are of those reports which do deal with the causation of Dr Kochan's condition, since this is key to her eligibility for injury benefit. Summaries of the two MRI scan reports from 2008 have also been included.

MRI Scan 5 November 2008

> "FINDINGS: In the cervical spine there are quiet (*sic*) prominent OA changes at C4/C5, C5/C6 and C6/C7. All the disc spaces are narrowed and there are prominent anterior and posterior osteophytes. At C4/C5 there is also bulging of the disc which is more marked on the right side. The disc does not appear to encroach significantly on the cord or on the exiting nerve roots. There are no focal disc herniations. The cord itself looks normal. The foramen magnum is normal. There is no stenosis.
>
> COMMENT: The striking abnormality are the degenerative changes at C4/C5, C5/C6 and C6/C7 with the osteophytes both anterior and posteriorly and a bulging right sided disc at C4/C5."

MRI Scan 6 December 2008 (certified translation)

> "The bodies of vertebrae with degenerative changes C_4-C_7 in the form of osteophytes on the anterior and posterior edges. Features of degenerative reconstruction (Modic I) of the vertebrae bodies on C_5/C_6 level.
>
> Features of dehydration and diminishing the height of intervertebral discs on 3 levels: C_4/C_5, C_5/C_6 and C_6/C_7.
>
> The saggital dimension of the spinal canal on levels C_4/C_5 and C_6/C_7 diminished to 10mm. On levels C_4/C_5 and C_5/C_6 intervertebral foramina are narrowed down on the right-hand side by the osteophytes of posterior-right-side edges of vertebral bodies and there are crowns on posterior-right-side circuits of intervertebral discs on the depth of 3 and 2mm, respectively – the possibility of collision with spinal nerves.
>
> There is also slighter narrowing down of the left root recess on level C_5/C_6. On level C_6/C_7, as above – visible osteophytes of the posterior-right-side edges of vertebral bodies, narrowing down the right intervertebral foramen (possibility of collision with spinal nerve C_7) and a diluted crown of the posterior circuit of the

> intervertebral disc on the depth of 3 and 2 mm, narrowing down both intervertebral foramina.
>
> On levels C_4/C_5 and C_6/C_7 the deficiency of anterior fluid reserve of the subarachnoid space, with discrete modeling of anterior-right-side surface of the spinal cord on C_4/C_5 level. The dimension of the spinal cord correct. The signal of the spinal cord on the level of C_4-C_6 in the T_2 dependent areas – discretely heterogeneous.
>
> On level Th_6/Th_7 like in the previous examination – posterior-central protrusion of the nucleus pulposus visible on the depth of about 3 mm with a discrete modeling of anterior-right-side surface of the spinal cord, without the change of signal."

Mr Hawranek 27 September 2010

2. Mr Hawranek is a specialist in traumatology and a court expert. He said,

> "Mrs Kochan has suffered from overload trauma during her professional activities. This trauma has left permanent damage …
>
> Characteristics of trauma: Static overload acting transversely to the long axis of the vertebral column.
>
> Trauma suffered: Overload trauma of the cervical region of the vertebral column.
>
> …
>
> The complaints reported currently by Mrs Kochan are in general a result of the event that took place on: 2008-09-22. Their character and presentation are consistent and are in a logical continuity with the event described, they may even have been the result of the events, the timing and circumstances reported by the injured party. They bear the characteristics of an accident at work and should be fully considered as such.
>
> The posttraumatic changes are superimposed on the complaints related to degenerative disease of the cervical and thoracic vertebral column, probably caused by the type of work, but the intensity of the degenerative changes does not exceed 1/5 of the complete changes."

3. Mr Hawranek graded the impairment to Dr Kochan's health, after consideration of the degenerative changes in her spine, at 35%

Mr Wojtowicz 2 December 2010

4. Mr Wojtowicz is a consultant neurologist. He wrote a report at Dr Kochan's request. Having outlined the development of Dr Kochan's symptoms following

the accident and described the results from MRI scans taken in 2008 and 2009.

Mr Wojtowicz said,

> "Health prognosis unfavourable, fixed character of pathology with tendency to deepen, example of which is appearance of hernia at the level of Th2/Th3 as a complication of posttraumatic static-dynamic disturbances of the vertebral column …
>
> Prognosis as to coming back to work is unfavourable.
>
> Requiring permanent pharmacological treatment, physiotherapy and psychotherapy."

Mr Ameen 8 October 2011

5. Mr Ameen saw Dr Kochan and her husband on 1 October 2011 for the purposes of preparing a report. Having outlined Dr Kochan's history, treatment and his examination results, Mr Ameen said,

> "Dr Kochan sustained a soft tissue injury to her cervical and dorsal spine as a result of the index accident. This is a musculoligamentous injury, the nature of which is consistent with the mechanism as described to me by Ms. Kochan when she was involved in the transfer of an exceptionally heavy patient … Further investigations confirmed the presence of multilevel degenerative cervical and thoracic disc disease.
>
> …
>
> The majority of the patient who sustain such a soft tissue injury to the cervical and the dorsal spine will have improvement in their symptoms which are at their maximum for a period of approximately six weeks after the injury followed by a steady improvement over a period of 6-12 months from the date of the accident. Rather than improving Dr. Kochan's symptoms deteriorated and this normally indicates that there is a background of degenerative disease of the cervical and dorsal spine which pre-existed the index incident on 21.09.2008 although it was asymptomatic.
>
> Dr. Kochan's MRI scan performed shortly after the index accident clearly showed well established degenerative changes of her neck and dorsal spine which certainly existed prior to the index accident … but at that time [were] asymptomatic.
>
> Dr. Kochan estimates the improvement she had following her cervical spine surgery … to be near 30%. Unfortunately, she is still left with the cervical spine instability of at C3-C4 which needs to be addressed by her treating neurosurgeon as early as possible as this could be causing persistent damage to her already diseased spinal cord.

> My examination was consistent with the MRI scan confirming a diagnosis of cervical myelopathy as well as radiculopathy, i.e. pressure on the spinal cord as well as on the nerve roots.
>
> It is my opinion that Dr. Kochan's symptoms are the result of an exacerbation of pre-existing asymptomatic degenerative cervical and dorsal spine disease … It also caused her depression as a result of the limited improvement in her symptoms after surgery and being without a job …
>
> The main question to answer in her case is the duration of acceleration/aggravation in her degenerative cervical and dorsal spine disease caused by the index accident. Assuming that she had no symptoms whatsoever prior to the index accident, I feel it is reasonable to believe that Dr. Kochan would have carried on working without her present level of symptoms and disability for a period of 5-6 years from the date of the accident …
>
> It is also my opinion that without the index accident and on balance of probabilities, Dr. Kochan would have needed the same surgical treatment and had the same outcome but within 5-6 years from the date of this accident. This is due to the progressive degenerative nature of her cervical and thoracic … disc disease …"

6. Mr Ameen said that he did not expect any further improvement in Dr Kochan's condition. He also said that any additional deterioration in her condition would be due to the progressive degenerative changes in her spinal condition. Mr Ameen said that Dr Kochan would not be fit to work as an anaesthetist again and that, without the accident, she would not have been able to return to work in five to six years from the date of the accident. He went on to say,

> "Dr Kochan's long working hours and being involved in lifting patients many of whom are obese during the 4 years period of working as an anaesthetist in UK, has certainly increased her risk of developing the degenerative cervical and dorsal disc disease resulting in cervical myelopathy and radiculopathy for which she required surgery. The percentage of this risk can not be estimated with any degree of accuracy. However I personally estimate her 4 years of long working hours and lifting patients to have contributed by near 20% to the development of degenerative cervical and dorsal disc disease and the resultant neurological disability. The remaining 80% was due to the naturally occurring degenerative cervical and dorsal disc disease that has been accelerated by the index accident."

Mr Ameen 27 December 2011

7. Mr Ameen provided a supplementary report having been provided with Dr Kochan's medical records dating from before her accident. He reported that, having reviewed these records, he maintained the opinion he had expressed in his previous report regarding the acceleration of Dr Kochan's condition. Mr Ameen had also been asked specific questions by Dr Kochan's solicitors. In response to a question regarding the development of Dr Kochan's condition without the accident, Mr Ameen said that, since the accident contributed 20% to the development of the disease, he would estimate it would have taken her 6-7.2 years from the date of the accident to develop the disease. In response to a question concerning the role of Dr Kochan's lifestyle in the development of the disease, Mr Ameen said,

> "Yes, the development of the disease could have been initiated simply by Dr Kochan's lifestyle activities i.e. the disease and the resultant disability would have developed anyway simply by Dr Kochan's performing her normal daily tasks to include walking, shopping and general household chores being part of a naturally developing inevitable aging process that affect all human beings."

Dr Bodani 24 September 2012

8. Dr Bodani is a consultant neuropsychiatrist. He prepared a report at the request of Dr Kochan's solicitors. Having met with Dr Kochan, Dr Bodani diagnosed generalised anxiety disorder, moderately severe depression and post traumatic stress disorder. He reported,

> "It is this expert's view that with respect to the period of time over which Dr Kochan's psychological problems have been present this dates from the time of her accident on 21.9.08. Her psychological condition has been progressively deteriorating with time elapsed from 21.9.08, as the duration of her inability to pursue her chosen profession increases."

And,

> "This expert accepts the view of Dr Ameen, in which he states that given the degenerative changes noted an imaging of Dr Kochan's neck and dorsal spine, she was likely to suffer a pain syndrome in later life, which he estimates likely to occur within 7.5 years from the date of the triggering accident. Whilst this may be the case, Dr Kochan, in this expert's view, would have gradually adapted to changes in her physical health over time.

Whilst the above is acknowledged Dr Kochan would not have suffered any psychological symptoms to the degree that she has now … These are causal to the events of 21.9.08."