**PO-27649**

# Ombudsman's Determination

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

## Outcome

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

## Complaint summary

2. Ms L has complained that her application for a temporary injury allowance (**TIA**) regarding a period of sickness absence from 2013 has not been considered in a proper manner.

## Background information, including submissions from the parties

3. The relevant regulations are the NHS (Injury Benefit) Regulations 1995 (SI1995/866) (as amended) (**the Injury Benefit Regulations**).

4. Regulation 3(1) provides that the Injury Benefit Regulations apply to a person in the paid employment of an employing authority who "sustains an injury before 31st March 2013, or contracts a disease before that date, to which paragraph (2) applies".

5. Regulation 3(2) provides:

> "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; …"

6. Regulation 4(5) provides:

> "Where, on or after 1st April 1991 but before 31st March 2018, a person … is or was on leave of absence from an employment … with reduced emoluments by reason of the injury or disease, there shall be payable by that person's employing authority on behalf of the Secretary of State, during

or in respect of the period of such leave and without regard to any reduction in the person's earning ability, an annual allowance of the amount, if any, which when added to the aggregate of -

(a) the emoluments payable to the person during his leave of absence, and

(b) the value, expressed as an annual amount, of any of the pensions and benefits specified in paragraph (6) (including the value of any equivalent benefits payable under the enactments consolidated by the Social Security Contributions and Benefits Act 1992),

will provide an income of 85 per cent of his average remuneration."

7. Ms L was employed by Cardiff and Vale University Health Board (**the Board**) as a part-time (15 hours per week) research nurse. She went on long-term sick leave on 31 July 2013. In 2014, she applied for a TIA. Her application was turned down. Her subsequent appeals, under the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**), were similarly turned down. Ms L's sickness absence continued until she retired on the grounds of ill health in May 2015.

8. This is Ms L's second complaint in respect of this matter. The first complaint (*PO-15551*) was considered by an Adjudicator who found that NHS BSA should reconsider Ms L's application for a TIA. Specifically, NHS BSA should consider whether Ms L had experienced work-related stress in 2013 and whether, as a result, she had been on sick leave with reduced pay. In answering the first question the fact that Ms L had an underlying mental health condition which may have led her to react more severely to stress should be set aside. The fact that there may have been other stressors in Ms L's life was not fatal to her claim and there needed to be an assessment of the part which each played in her relapse.

9. Ms L and NHS BSA accepted the Opinion's outcome and NHS BSA duly asked its Medical Adviser to review Ms L's application.

10. A doctor for the MA gave their opinion that the medical evidence was that multiple factors were contributing to both Ms L's perceived stress and recurrent depressive illness, which was the reason for her absence from work. In conclusion the MA said Ms L's stress and depressive illness were not wholly or mainly attributable to her NHS employment.

11. Summaries of and extracts from the MA's report and other medical evidence are provided in the Appendix.

12. NHS BSA accepted the MA's opinion and turned down Ms L's application in July 2018.

13. Ms L appealed the decision via the IDRP.

14. NHS BSA referred Ms L's appeal to its MA. Another doctor for the MA gave their opinion that Ms L's "mental health disruption" was due to work exacerbating her pre-existing medical condition (a recurrent depressive disorder), as such she had not sustained an injury or contracted a disease wholly or mainly attributable to the duties of her employment.

15. NHS BSA accepted the MA's opinion and turned down Ms L's appeal in August 2019.

16. Ms L appealed.

17. NHS BSA sought further advice from its MA. Another doctor for the MA gave their opinion that Ms L's perception of her work circumstances contributed to her perceived stress and to the relapse of her depressive disorder to the extent that she required sickness absence in 2013. However, the absence was more likely to have been due to her underlying mental health problems (60%) than to work circumstances which she perceived to be stressful (40%). So, on the balance of probabilities, Ms L's stress and her depressive illness were not wholly or mainly attributable to her NHS employment.

18. NHS BSA accepted the MA's opinion and turn down Ms L's final appeal in January 2020.

**Ms L's position**

19. Ms L submits that NHS BSA has:-

- Not applied its own criteria. For example, regarding pre-existing conditions.
- Utilised irrelevant, historical, and inaccurate factors – personal, non-work related.
- Ignored relevant factors directly employment linked – historical, accurate & evidenced.
- Discounted the weight of valid evidence, clearly stating that the sick leave was due her NHS employment.
- Failed to sufficiently consider to what degree her work was a contributory factor in causing her ill-health.
- Not sought clarification from the medical experts for their view on how much work was the cause of her ill health.
- Failed to clarify 'other factors' that may have contributed to her ill health and wrongly interpreted the causes and effects.
- Failed to respond to points she raised in her appeal. For example, that her PTSD had totally resolved and the use of irrelevant or inaccurate factors.

20. Ms L says:-

- NHS BSA has failed to recognise that her mental health has been wholly or mainly attributable to her employment experiences.
- She has produced a significant amount of medical evidence in support of her assertion that the deterioration of her mental health was attributable to her employment. This includes Dr Lever's letter of 27 March 2013, in which Dr Lever said:

  ''[Ms L] has a long history of a mental health related problem […] However, following my discussions with [Ms L], it would appear that the current difficulties that she is experiencing are as a result of work related stress''.

  Such comments contradict NHS BSA's position that her employment did not wholly or mainly impact on her mental health.
- NHS BSA has acknowledged that her mental health was impacted by the stress she experienced. Its reliance on her previous mental health conditions appears to be an attempt to mitigate the work-related stress as opposed to an impartial assessment of the specific circumstances at the relevant time.
- NHS BSA's decision is perverse.

**NHS BSA's position**

21. NHS BSA submits:-

- It has correctly considered Ms L's application, using the correct test, taking into account relevant evidence and ignoring anything irrelevant.
- It has sought and accepted the advice of its MAs. That it has weighed the evidence differently or drawn a conclusion that differs from Ms L's own opinion of the cause of her incapacity is unfortunate, but it is a finding for NHS BSA to make based on the facts.
- Ms L maintains that NHS BSA has not "applied its own criteria regarding a pre-existing condition". But for a TIA there is no criterion regarding pre-existing conditions. The *Young v NHS BSA*[1] judgment focused on the narrow issue over the statutory interpretation of a specific provision regarding Permanent Loss of Earning Ability, that is regulation 4(1) of the Injury Benefit Regulations and not regulation 3(2) or 4(5). Claims for a TIA, in particular consideration of regulation 4(5), are completely unrelated to claims for Permanent Injury Benefits, which the *Young* judgment relates to, and regulation 4(1), which Nugee J interpreted as not relevant to any TIA application.

[1] *Young v NHSBSA* [2015] EWHC 2686 (Ch)

- At Stage 1 IDRP, NHS BSA determined that there was a recurrence of Ms L's depressive disorder while she was employed by the NHS, but there was no evidence that the duties of her NHS employment caused the recurrence. Ms L did suffer stress during this period, however prior to the claimed injury Ms L was already suffering because of her depression and PTSD. There is no evidence of an incident causing trauma. The symptoms are not wholly or mainly attributable to the duties of her NHS employment.

- At Stage 2 IDRP, NHS BSA determined that there was an injury or disease in respect of an exacerbation of her recurrent depressive disorder while she was in NHS employment. However, the whole or main cause of these symptoms was not her employment but family and personal stressors. Namely, relationship difficulties, neighbour disputes, childhood experiences and fertility problems.

- There is no evidence that NHS BSA failed to gather relevant evidence or was obstructive once it agreed to collect it; it is for the applicant to provide evidence that they consider to be relevant to their claim, and the MAs to collate evidence they deem to be required.

- The opinion that Ms L's recurrent depression was caused by her NHS employment is unsupported by evidence and is based solely on Ms L's account of experiences she had. There is no evidence that her employers did not attempt to support her. The evidence shows that her claims of excessive demands of the role, lone working, insufficient working conditions, team issues and lack of professional development are not corroborated.

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

## Adjudicator's Opinion

22. Ms L's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA. The Adjudicator's findings are set out in paragraphs 23 to 32 below.

23. The Adjudicator noted that Ms L had submitted a report by Dr Akenzua (Consultant Psychiatrist), dated 11 November 2021. The Adjudicator said he had put the report to one side as it post-dated NHS BSA's decisions and was prepared for ongoing legal matters that Ms L had with UNISON and a firm of solicitors, which were separate from this complaint.

24. NHS BSA refuted that the *Young* judgment had any bearing on TIA applications. The Adjudicator acknowledged that the *Young* judgment concerned regulation 4(1), which applied to PIB applications, but was of the view that it was helpful in the interpretation

of related regulations, in the absence of any contrary precedent. This was a reasonable approach to take, from a legal perspective.

25. It was not the role of the Ombudsman to review the medical evidence and come to a decision of his own as to Ms L's eligibility for payment of a TIA. The Ombudsman was primarily concerned with the decision-making process. The issues considered included: whether the relevant regulations had been correctly applied; whether appropriate evidence had been obtained and considered; and whether the decision was supported by the available relevant evidence.

26. Medical (and other) evidence was reviewed in order to determine whether it supported the decision made. However, the weight which was attached to any of the evidence was for NHS BSA to decide (including giving some of it little or no weight[2]). It was open to NHS BSA to prefer evidence from its own MAs; unless there was a cogent reason why it should not or should not without seeking clarification. For example, an error or omission of fact, consideration of irrelevant matters, or a misunderstanding of the Injury Benefit Regulations by the MA. If the decision-making process was found to be flawed, the appropriate course of action was for the decision to be remitted for NHS BSA to reconsider. The Adjudicator said it was on this basis that he had reviewed Ms L's complaint.

27. Ms L's entitlement to a TIA turned on satisfying two criteria. Firstly, Ms L must have suffered an injury or disease that was wholly or mainly attributable to her NHS employment (Regulation 3(2)). Secondly, as a result of the injury or disease, Ms L must have experienced a loss of earnings during her sickness absence (Regulation 4(5)).

28. A qualifying injury, as referred to in Regulation 3(2), excluded the exacerbation of a pre-existing injury or condition to the extent that such an injury or condition was not wholly or mainly attributable to the person's NHS employment. It included the possibility of more than one cause, but the NHS employment must be more than 50% of the cause.

29. The advice from the first doctor for the MA was that multiple factors contributed to Ms L's stress and the relapse of her recurrent depressive illness, which was the reason for her absence from work in 2013. Namely, at home (problems with her partner and neighbours) and at work (not getting on with her manager). To support this, the first doctor referred to GP records in March 2013 and reports by Dr Thomas (Consultant Psychiatrist) (2012) and Dr Lever (Occupational Health Physician) (2013). While the first doctor did not directly say that they considered non-work factors were the main reason for Ms L's absence from work, it was implied by their conclusion that, on balance, Ms L's stress and depressive illness were not wholly or mainly attributable to her NHS employment.

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

30. At Stage 1 IDRP, a second doctor for the MA concluded that Ms L's stress was more likely attributable to an underlying depressive illness/condition than to Ms L's work. Work may have exacerbated the pre-existing condition, but this took the injury outside of the scope of regulation 3(2).

31. At stage 2 IDRP, a third doctor for the MA agreed that Ms L had sustained workplace stress. But the doctor was of the opinion that Ms L's absence from work was primarily due to underlying mental health problems (60%) than to work circumstances which she perceived to be stressful (40%). So, on the balance of probabilities, Ms L's stress and her depressive illness were not wholly or mainly attributable to her NHS employment.

32. The Adjudicator acknowledged that Ms L disagreed with the advice NHS BSA received from its MAs. But a difference of opinion (even between doctors) was not sufficient for the Ombudsman to require a decision to be reviewed. There would have to be some other reason why NHS BSA should not have relied on the advice it received from its MAs in coming to its decision. The Adjudicator said he had not identified any such reason in the advice, such as an error or omission of fact, consideration of irrelevant matters or a misunderstanding of the Injury Benefit Regulations.

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

**Ms L's further comments**

34. Ms L's further submission is set out below in paragraphs 35 to 38.

35. The Adjudicator has omitted to take her TIA 2007 application and appeals into account, which clearly set out the initial work-related injury and all employment issues ongoing since approximately 2000/1.

36. The medical report from Dr Akenzua clearly states the causality as employment, as does her [Ms L's] personal statement submitted in 2020[3]. But both appear to have been omitted.

37. Her circumstances fulfil the Injury Benefit Regulations, in that the initial injury, later its exacerbation and the permanent injury[4], is wholly or mainly attributable to the duties of her employment.

38. There are numerous reasons why her application should be reconsidered by NHS BSA:-

[3] Ms L's 'Statement in support of Temporary Injury Allowance application 2013-14'.

[4] Ms L has submitted a separate complaint to TPO that NHS BSA has refusal to award her a Permanent Injury Benefit (**PIB**).

- The vast differences of opinion between on one side NHS BSA's MAs and on the other her doctors. All the evidence she has provided has come from independent professionals of various grades and appropriate specialisms. This evidence is consistent and supports the claims of a mental health injury from approximately 2000/1 and a further relapse in 2013.

- There was no "underlying condition". The initial injury was caused by her employment. All records clearly state that the initial mental health injury was reported and diagnosed during her employment with Royal Glamorgan Hospital. It was defined as a "mental health disability" during her successful appeal against unfair dismissal in 2008.

- Other factors considered by the MA were misinterpreted or are irrelevant:-

    - The "neighbour dispute" was resolved in Court in 2008[5]. She still lives at the same address and has the same neighbour. She would have moved if there was an ongoing a dispute between them.

    - "and at work (not getting on with her manager)". The manager was responsible for not resolving work overload issues. She was forced to deal with matters that were clearly identified as management responsibilities. That said her manager was one of the nicest people she has ever worked with.

    - "problems with her partner". It is well researched that work-related stress and work overload severely impacts on outside life and relationships. The NHS TIA guide states: "if both NHS related and non-NHS related factors are involved, it is necessary for the Trust to assess their relative importance…may also wish to seek specific advice from their occupational health department."

      She has been with her partner for 33 years. So, the MA's[6] reference to "problems with her partner" was insignificant and irrelevant.

- NHS BSA's MAs misapplied the Injury Benefit Regulations and failed to provide any valid reason why her application had been refused.

## Ombudsman's decision

39. Ms L says the Adjudicator's Opinion omitted to take her TIA 2007 application and appeals (in relation to her application for a TIA from 2013) into account.

40. The complaint accepted for investigation pertains to NHS BSA's reconsideration of Ms L's application for a TIA from 2013, following both parties' acceptance of a previous Adjudicator's Opinion[7].

[5] Ms L has provided a copy of the Court Order dated 2 May 2008.

[6] The first doctor for the MA.

[7] PO-15551.

41. Ms L submitted to The Pensions Ombudsman (**TPO**), a separate complaint in respect of NHS BSA's refusal of her application for a TIA from 2007[8]. This was not accepted for investigation as it was statutorily timed out and there were insufficient grounds to justify exercising discretion to investigate the complaint outside of the time limits, so it cannot be considered.

42. As the sequence of events was not disputed, the Adjudicator set out in his Opinion the salient points, while acknowledging that there were other exchanges of information between the parties. The Adjudicator noted that Ms L had appealed the initial decision and stage 1 IDRP decision and set out Ms L's position following the stage 2 IDRP decision. So, I do not agree that her appeals were not considered by the Adjudicator.

43. Ms L refers to the omission of a reference to Dr Akenzua's report of 11 November 2021. But, as explained by the Adjudicator, this has been put to one side as (i) it post-dates NHS BSA's decisions to refuse her a TIA from 2013, so it was not available to NHS BSA when it made its decisions, and (ii) the report was prepared for ongoing legal appeals, which are separate from the complaint TPO accepted for investigation.

44. Ms L similarly says her 'Statement in support of Temporary Injury Allowance application 2013-14' was omitted. I disagree. The Adjudicator referred to Ms L's statement in his summary of her position (see paragraph 20 above).

45. Ms L comments that there are vast differences of opinion between NHS BSA's MA and her treating doctors. But, as the Adjudicator said, on its own, a difference of medical opinion is not sufficient for me to find that NHS BSA's acceptance of its MA's opinion means, that its decision to refuse her application for a TIA, from 2013, was not properly made.

46. As the Adjudicator explained, my role in this matter is not to decide whether Ms L is entitled to a TIA from 2013 but to look at NHS BSA's decision-making process.

47. Ms L's entitlement to a TIA turns on satisfying two criteria. Firstly, Ms L must have suffered an injury or disease that is wholly or mainly attributable to her NHS employment (Regulation 3(2)). Secondly, as a result of the injury or disease, Ms L must have experienced a loss of earnings during her sickness absence (Regulation 4(5)).

48. A qualifying injury, as referred to in Regulation 3(2), excludes the exacerbation of a pre-existing injury or condition to the extent that such an injury or condition is not wholly or mainly attributable to the person's NHS employment. It includes the possibility of more than one cause, but the NHS employment must be more than 50% of the cause.

49. I am satisfied that the MA's doctors understood the criteria for a TIA.

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[8] CAS-100865-S5Q0.

50. Ms L says the evidence she submitted was mostly dismissed, disregarded or misinterpreted.

51. There is a difference between evidence being dismissed/disregarded and being considered but having little or no weight attached to it. It was for the MA's doctors to consider the medical evidence and attach weight (if any) to it. I am satisfied that they did that.

52. Ms L says there was a misinterpretation of evidence by the MA's first doctor. But the doctor was referencing an entry in her GP records for March 2013, that she was not getting on with her partner, having problems with her neighbours and not getting on with her manager. Similarly, Dr Thomas (Consultant Psychiatrist) said, in his July 2014 report, that Ms L's health had destabilised due to a degree of social and professional pressures. These included her job, long-term difficulties with a neighbour and within her relationship.

53. Ms L quotes from an NHS TIA guide that if both NHS related and non-NHS related factors are involved, their relative importance needs to be assessed.

54. At stage 2 IDRP, a third doctor for the MA agreed that Ms L had sustained workplace stress, but considered Ms L's absence from work was primarily due to underlying mental health problems (60%) than to work circumstances which she perceived to be stressful (40%). So, on the balance of probabilities, Ms L's stress and her depressive illness were not wholly or mainly attributable to her NHS employment.

55. NHS BSA accepted the MA's opinion and refused Ms L a TIA from 2013. I have found no reason why NHS BSA should not have accepted the MA's opinion and no grounds on which to remit the matter back to NHS BSA.

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

**Anthony Arter CBE**

Deputy Pensions Ombudsman
27 September 2023

## Appendix

### Medical Evidence

*Dr Lever (Occupational Health Physician), 27 March 2013*

57. Dr Lever reported that Ms L had a long history of mental health related problems secondary to both personal and work issues. She noted Ms L's current difficulties were the result of work-related stressors.

58. Dr Lever expressed the view that Ms L was fit to be in work and that, if management were able to resolve "the issues", her mental wellbeing would improve considerably.

*Dr Thomas (Consultant Psychiatrist),16 July 2014*

59. In his report Dr Thomas said:-

- Ms L's health had destabilised due to a degree of social and professional pressures. These included her job, long-term difficulties with a neighbour and within her relationship.

- Ms L had been treated for recurrent depression since 2000. He described her condition as waxing and waning over the years, often precipitated by work-related stressors.

- Ms L's relapses had been precipitated by stress and often by a number of concurrent stressors, which she was unable to manage. He noted that, when unwell, Ms L's reactions to stressors were disproportionate. She had found leaving work beneficial and he was of the view that redeployment would be unhelpful. He supported ill health retirement.

- He had been monitoring Ms L between 2008 and 2012 and she had maintained a good degree of stability in her mental health. He discharged her in September 2012.

- Ms L self-referred to his team in March 2013 after relapsing due to work-related stressors. This had been a recurrent theme. Ms L was on sickness absence "which had directly removed her from the trigger of her relapse".

- Ms L was able to carry out her role to the best of her ability for a finite period of time, after which her mental state would deteriorate either through work-related stressors or social stressors. He referred to Ms L as having a maladaptive psychological coping strategy.

*Professor Sullivan (Consultant Psychiatrist), 27 July 2016*

60. Professor Sullivan said Ms L had a major recurrent depressive disorder. She was diagnosed with PTSD and received treatment. Ms L had responded to treatment, but this was not sustained.

61. Professor Sullivan said gynaecological problems had contributed to Ms L's mental health difficulties as well as being the likely precipitating factor. Ms L appeared to cope with the gynaecological stressors when not working. He suggested that "work related stressors are paramount in contributing to her relapses of depression".

62. Professor Sullivan expressed the view that, unless work related stressors were removed, it was unlikely that further therapeutic interventions would do more than maintain the status quo.

*First MA's report, initial decision July 2018*

63. The MA noted the eligibility criteria for a TIA and the medical evidence considered.

64. The MA said:

> **"Q1: Was there an injury or is there a disease?**
> Yes.
>
> [The Adjudicator] has opined that the injury in this case is stress. However, I would point out that in her application, [Ms L] appears to base her application not only on work related stress, but also a recurrent major depressive disorder with anxiety. [The Adjudicator's] opinion begs the question as to what is "stress"? My copy of the Concise Oxford English Dictionary defines stress as: "a state of mental, emotional or other strain".
>
> Illnesses related to stress are listed in section F43 of ICD-10. ICD is an abbreviation for the International Classification of Diseases produced by the World Health Organisation and is the diagnostic classification for all clinical and research purposes. Section F43 contains a number of conditions. Of the conditions listed, the condition of F43.2, an adjustment disorder, would seem to be the medical condition that best fits the definition of "stress" as specified by [the Adjudicator] and as defined in the Concise Oxford English Dictionary. An adjustment disorder is a state of subjective distress and emotional disturbance arising in the period of adaptation to a significant life change or stressful life event.
>
> I would, however, comment that none of the medical reports diagnose [Ms L] as having an adjustment disorder. All of the medical evidence consistently describes [Ms L] as having a recurrent depressive disorder and that her illness in 2013 was a relapse of her recurrent depressive disorder.
>
> **Q2a: Was there an injury or disease in the course of the applicant's NHS employment?**

Yes, but only in the sense that [Ms L's] impaired mental health occurred during a period of time when she was employed by the NHS.

**Q2b: Was there an injury or disease that is wholly or mainly attributable to the duties of their NHS employment?**

No.

The medical evidence is that a number of factors contributed to [Ms L's] stress in 2013. An entry in her GP records dated 6 March 2013 makes reference to [Ms L] experiencing stress from sources both at home and at work. The entry makes reference to [Ms L] not getting on with her partner, having problems with neighbours and not getting on with her manager. This is consistent with a report written following attendance at a clinic appointment on 24 January 2012 by Dr Thomas, consultant psychiatrist, in which Dr Thomas refers to [Ms L's] perceived difficulties at work as well as long term difficulties that she was having with her neighbours and within her own relationship. It is also consistent with the report of Dr Lever dated 27 March 2013 in which Dr Lever refers to both work and personal issues contributing to [Ms L's] difficulties.

All the medical evidence is that [Ms L's] decline in her mental health in 2013 was the result of a recurrence of her depressive illness. [Ms L] had been diagnosed with depression around 2000. The natural history of depression is that it is typically recurrent in nature. [Ms L] is documented as having periods of depression beginning in 2000, 2007 and 2012. [Ms L's] depressive illness did not begin as a result of her employment. It began following a gynaecological condition in 1998. I would also comment that genetic factors play an important role in the development of depression as evidenced by the fact that first degree relatives of individuals with depression are three times more likely to develop depression than the general population. My understanding is that [Ms L] does have a family history of depressive illness. It is also my understanding that a qualifying injury as referred to in regulation 3(2) excludes the exacerbation of a pre-existing injury or condition to the extent that such an injury or condition is not wholly or mainly attributable to NHS employment. The relapse in [Ms L's] depressive illness would therefore appear to fall outside the scope of the scheme rules for this reason.

I think it is likely that [Ms L's] perception of her work circumstances has contributed to her perceived stress and also contributed to the relapse of her depressive illness. However, this is insufficient to demonstrate that the criteria of regulation 3(2) are met. In order to satisfy the criteria of regulation 3(2), the injury or condition must be wholly or mainly attributable to the applicant's NHS employment. The medical evidence is that multiple factors were contributing to [Ms L's] perceived stress and also multiple factors contributed to her recurrent depressive illness, which was the reason for her

absence from work. In my opinion, on balance of probability, [Ms L's] stress and her depressive illness are not wholly or mainly attributable to her NHS employment."

*Second MA's report, IDRP Stage One*

65. The MA noted the criteria for a TIA and the medical evidence considered.

66. The MA said:

"**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**

In carrying out my assessment of her entitlement to TIB I have advised:

**Mental Health**

**Q1: Yes. Recurrent depressive disorder**.

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

Dr Thomas provided a report on 16 July 2014 with a diagnosis of major recurrent depressive disorder stating that the condition had waxed and waned over the years "often precipitated by work related stressors". Dr Thomas was of the opinion that for finite periods of time [Ms L] would be capable of working as a nurse but that because of perfectionist traits in her personality, work related stressors or social stressors she would experience a relapse. Dr Thomas considered that the potential for redeployment is a requirement by an

employer however notes that previous changes of job have each ended up with a recurrence of her depression. Also that as she experiences further recurrence a reduced stimulus would be required each time.

Professor Sullivan reports that following her treatment for PTSD in 1998 she returned to work and due to closures and moves of hospital services, found herself on a ward where a lot of patients were being admitted for termination of pregnancy. For this reason, for the reason of being publicly demeaned by a doctor on the ward on a couple of occasions and because she was having ongoing gynaecology treatment she found another post and moved. Professor Sullivan reports that it was at this time that she moved into the post in endoscopy and started to be bullied by the department manager over various issues such as annual leave and sick leave (injury to her hands, ruptured tendon in her ankle) and trying to take annual leave to undergo continuing IVF treatment. In 2007 she suffered a further miscarriage (three ectopic and other miscarriages were prior to 2000) and following on with long term sick leave she was dismissed but reinstated following appeal. Further jobs followed with a retirement on ill health grounds in March 2015 from mental health issues. Professor Sullivan reviewed her mental health records and identified that she attended the PTSD clinic following the ectopic in 1998 and was given a course of psychological therapy. The beneficial effects were not sustained from this and in 2000 she was commenced on antidepressant treatment. Psychological treatment as detailed above from Dr Herbert continued from 2001 to July 2002. She was referred back to secondary care mental health services in 2007. Professor Sullivan identifies that within the mental health record it was noted that her working environment may have precipitated her recurrence of depression. Improvement when away from the workplace was then again followed by a recurrence in March 2013 with workplace stressors being identified. Professor Sullivan concurs with the diagnosis of major depressive disorder (recurrent) and identifies the precipitating event as the PTSD following the ruptured ectopic pregnancy in 1998. The further contributing factors are her ongoing gynaecological treatment and workplace stressors.

**Q2a:** Yes. It is clear from [Ms L] statements and from the occupational health and mental health evidence that she had recurrences of her depressive disorder during the course of her employment. For consideration of causative relationship, please see below.

**Q2b:** No. [Ms L] has experienced work related stress which must be wholly or mainly caused by employment. The consideration is whether she went on to suffer psychological symptoms because of the stress or whether her psychological symptoms were due to another condition.

The evidence indicates that [Ms L] has suffered recurrent episodes of her depression and that triggers have included both those associated with her health and attempts at assisted pregnancies and her workplace stressors.

These are against the background of a pre-existing PTSD with depression from 1999.

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

**My consideration is:**

No new evidence is submitted. [Ms L] has emphasised the extent of consultations which advise that she was experiencing stress at work. The evidence is compelling that she was experiencing pressures beyond the level that she was able to cope with. The response and symptoms ensuing were the result of pre-existing and prior mental health problems.

My advice has to be based on the regulations that the condition has to be wholly or mainly attributable to the NHS employment and that it is not a recurrence or exacerbation of a pre-existing disorder. My opinion is that [Ms L's] mental health disruption was due to work exacerbating her pre-existing medical condition.

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

*Third MA's report, IDRP Stage Two*

67. The MA noted the criteria for a TIA and the medical evidence considered.

68. The MA said:

"1. was there an injury or is there a disease?
**Yes**… there are many entries relating to the relevant period, which describe that [Ms L] was distressed. In my medical opinion, the main cause of this distress was due to an exacerbation of a pre-existing major depressive disorder.

2. a) Was there an injury or disease in the course of the applicant's NHS employment?
**Yes**, but only in the sense that [Ms L] impaired mental health occurred during a period of time when she was employed in the NHS.

b) Was there an injury or disease that is wholly or mainly attributable to the duties of the NHS employment?

**No**. Having gone through several thousand pages of medical evidence, I find the following reports to be the most pertinent for explaining the underlying cause for the mental health problems which have incapacitated [Ms L].

**The rationale is as follows:**

The report by Dr Rahman, staff grade psychiatrist, dated 3 October 2001 notes that [Ms L] was no better than when she was previously seen (3 months earlier). Dr Rahman noted; “she still complains of depressed mood. She has on-going problems with her relationships and at work. She does not get on with people. She has no confidence”. This demonstrates in my medical opinion that [Ms L] had a persistent depressive illness related to her difficulties with relationships well before she perceived that she was exposed to overwhelming stressful circumstances at work in the NHS prior to when she went off sick in 2013.

A report from a consultant psychiatrist in the Liaison Psychiatry Service of the University Hospital Wales dated 25 June 2008 noted; “this woman has a long history of recurrent depressive disorder dating back to 1998. In 1998 she had some form of counselling after a ruptured ectopic pregnancy, following which she nearly died… [Ms L] feels that she has never really recovered properly from that event. The second episode of depression occurred in 2000 and she was treated by my colleague…” The report then goes on to note that she has difficulty in her relationship with her partner… as well as other persons. “Socially she reports gradual isolation and disengagement. She has a strong positive history of mental disorder on her paternal side in that a parent attempted suicide, her father is said to be depressed, and a paternal cousin has received treatment with ECT (Electroconvulsive therapy – usually reserved for extreme case of depressive illness)”. The psychiatrist diagnosed a major depressive disorder, recurrent and advised on her treatment with medication and psychotherapy.

A report from consultant psychiatrist, Dr Thomas, to the occupational health department, dated 16 July 2014, noted that earlier that year her condition had relapsed due to work related stressors and that this has been a current theme throughout her presentation. The psychiatrist then went on to note that “it is relevant to point out that [Ms L] has marked perfectionist traits in her personality; one of her key psychological drives is to achieve high standards, this is obviously difficult to attain and maintain, particularly over a prolonged period of time. In my opinion whilst working as a nurse, [Ms L] is able to carry out her role to the best of her ability for a finite period of time, after which her mental health will deteriorate, either through work related stressors or social stressors. Ms Mansell’s maladaptive psychological coping strategy is then to raise her perfectionist standards making her goals harder to achieve and therefore the cycle of deterioration begins”.

The report by Dr Hopkins, who completed the AW33E form for [Ms L’s] ill health retirement application, dated 28 November 2014, summarised [Ms L’s] medical

conditions very accurately in my opinion. The following are excerpts from Dr Hopkins' report:

a) "Please list all currently diagnosed medical conditions:

- Recurrent severe depression since 1998;
- Back problems – intermittent acute exacerbations since 1993.

b) Provide details of reported reasons for incapacity.

- Episodes of severe depression make sustaining reliable attendance in work impossible during periods of illness. Decision making, sleep, concentration and planning become impossible and she is unable to fulfil the responsibilities of her job.

c) Provide details of the past course of any medical conditions currently reported as giving rise to incapacity.

- [Ms L] has had long periods off work through her mental health problems, going back to 1998. She initially experienced a traumatic ectopic pregnancy resulting in depression with aspects of post-traumatic stress disorder. Although this was treated her mental health has not fully recovered since. There has been a number of trigger factors including problems with work, multiple miscarriages, problems with her pension/payroll/HMRC and a dispute with a neighbour. Since 1998 she has been under the care of secondary mental health services for significant periods although there have been periods where her health has been stable in between. The clinic letters included in the application refer to a pattern of increasingly severe episodes over the years."[sic]…

G3 "[sic]Are there any workplace issues and how have they been addressed?

- [Ms L] has raised a number of issues in her workplace, which she feels have been a trigger for her ill health. These have been discussed and attempts made to address them."…

5 "Please summarise the information you consider to be relevant to this member's long term incapacity for the duties of their NHS employment.

- Work has been identified as one of the triggers of [Ms L's] ill health and her psychiatrist's report advises that returning to her work is likely to put her at risk of further ill health. She is unlikely to be able to fulfil the requirement for regular attendance, due to the likelihood of further episodes of severe depression.

6 Please summarise the information you consider to be relevant to this member's long term incapacity for any regular employment.

- [Ms L] has had a variety of roles within the NHS and all have had a negative effect on her health, precipitating episodes of severe depression. While it

is possible that she may in the future be able to undertake some other work, it has been advised by her psychiatrist that this would be a risk for her."

As I have been through the very extensive documentation, it is clear that [Ms L] suffered a life-threatening event in 1998 due to an ectopic pregnancy. This is a life-threatening event where the patient has to have emergency surgery to remove a pregnancy from a fallopian tube, where it has embedded and ruptured. Often intensive care or high care is required after this type of event. There is evidence that for [Ms L] it caused a severe psychological reaction in the form of a post-traumatic stress disorder and a recurrent depressive illness. In my opinion she has not recovered from these conditions and has remained vulnerable to them when she experiences situations which she perceives as stressful, or distressing. In addition, she has an underlying personality trait, which causes her to have a cycle of maladaptive coping strategies when she feels stressed. The available evidence shows that this has recurred time and again in several contexts at work and also in her personal relationships with her partner, neighbours, trade union and employer.

In my view, [Ms L's] previous traumatic gynaecological event and underlying personality trait (which the medical literature shows is likely to be genetically determined) are more likely to have caused the breakdown of her mental health to the extent that she required sickness absence from work or reduced pay from 31 July 2013. This absence was more likely to have been due to her underlying mental health conditions than to the work circumstances. In my medical opinion, [Ms L's] underlying mental health problems were likely to be causative to an extent of 60%, and the work circumstances, which she perceived as being stressful, were likely to be causative to the extent of 40% in my medical opinion.

The medical evidence supports the view that [Ms L's] perception of her work circumstances contributed to her perceived stress and to the relapse of her depressive illness. However this is insufficient to demonstrate that the criteria of regulation 3(2) were met. In order to satisfy the criteria of regulation 3(2), the injury or condition must be wholly or mainly attributable to the applicant's NHS employment. The medical evidence shows that [Ms L] had a recurrent major depressive illness and a personality trait which made her likely to adapt maladaptive coping skills when she perceived stressors. These were more likely to be the cause of the relevant period of sickness absence in my medical opinion than her perception of stress at work. In my opinion, on the balance of probabilities, [Ms L's] stress and her depressive illness are not wholly or mainly attributable to her NHS employment.

CONCLUDING ADVICE

I consider that the relevant medical evidence indicates that, on the balance of probabilities the applicant's claimed injury/disease was not wholly or mainly attributable to their NHS employment."