CAS-71748-K5M5

Ombudsman's Determination

Applicant	Mr S
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

1. I do not uphold Mr S' complaint and no further action is required by NHS BSA.

Complaint summary

2. Mr S has complained that NHS BSA incorrectly decided in December 2019 to decline his application for Tier 2 ill health early retirement (**IHER**) benefits from the Scheme.

Background information, including submissions from the parties

3. The relevant regulations are the National Health Service Pension Scheme Regulations 2015 (as amended) (**the Scheme Regulations**).

4. On retirement from active service, regulation 90[1], of the Scheme Regulations, provides for two tiers of pension depending upon the level of the member's incapacity for employment. Briefly, these are:-

   Tier 1: the member is permanently[2] incapable of efficiently discharging the duties of his/her NHS employment; and

   Tier 2: in addition, the member is permanently incapable of engaging in regular employment of like duration[3].

5. If a member satisfies the Tier 1 condition, he/she is entitled to the retirement benefits that he/she has earned to date in the Scheme without actuarial reduction for early payment. If a member also meets the Tier 2 condition, then his/her accrued benefits

[1] Relevant sections of this regulation have been set out in Appendix One below.

[2] "permanently" means the period until NPA. In Mr S' case, his NPA is 67 years.

[3] "like duration" means, in summary, a regular employment for similar hours to the member's NHS job.

are enhanced by 50% of his/her prospective membership up to Normal Pension Age (**NPA**).

6. Tier 2 benefits are payable only if a member is accepted as permanently incapable of both doing his/her NHS job and regular employment of like duration to his/her NHS job.

7. Mr S was previously employed by the NHS as a full-time maintenance assistant.

8. In October 2018, Mr S applied for IHER from the Scheme using form AW33E prior to leaving NHS employment. At the time, he had been diagnosed by his Occupational Health (**OH**) doctor as suffering from: (a) a fractured right leg; and (b) a head injury following an accident in Turkey.

9. The OH doctor also said on form AW33E that:-

   - Mr S' response to surgery had been poor.

   - Mr S' was suffering from low mood because of the "constant pain, poor healing and instability".

10. Mr S' NHS employment was terminated in December 2018[4] on the grounds of incapability due to ill health.

11. Decisions on applications for IHER are made by the Scheme's Medical Adviser, Medigold Health (**Medigold**), in the first instance, and by NHS BSA on appeal, under delegated authority from the Secretary of State, "the Scheme manager".

12. An application for IHER benefits is considered at the member's date of severance. However, if the Scheme member has not yet left NHS employment, the assessment is made as at the date of consideration.

13. In its letter 27 November 2018, Medigold informed Mr S that his application for IHER benefits had been declined.

14. Mr S was dissatisfied with the outcome of his IHER application and made a complaint in December 2018 under the Scheme's Internal Dispute Resolution Procedure (**IDRP**).

15. In its Stage One IDRP decision letter dated 17 January 2019, NHS BSA informed Mr S that his application for IHER benefits had been accepted because it agreed with the medical advice given by one of its Medical Advisers (**MAs**) that he satisfied the Tier 1 condition at the time he left NHS employment.

[4] Mr S' employer originally completed form AW33E to show that his date of termination was 7 September 2018. NHS BSA updated its records in February 2019 to show that his actual date of leaving was 31 December 2018.

16. The MA said that Mr S would, after retraining, most likely be capable of undertaking "sedentary/semi-sedentary, full time, regular employment" prior to attaining his NPA, if he complied with reasonable treatment including:

    - planned surgical intervention and physiotherapy;.
    - specialist management of his chronic pain using analgesia, other modalities and a biopsychosocial approach;
    - medication, psychological therapy, behavioural therapy and specialist services involvement for his depression/low mood; and
    - assessment of dizziness by his GP with onward referral, if necessary.

17. The MA recommended that Mr S should be given an opportunity to seek a further review of his claim against the Tier 2 condition once, within three years from the date of his award notification letter.

18. Relevant paragraphs from the Stage One IDRP letter including the opinions expressed by the MA are set out in Appendix Two below.

19. In October 2019, Mr S sought reassessment of the Tier 2 condition[5] in accordance with the Scheme Regulations and provided NHS BSA with further medical evidence.

20. Medigold requested a medical report[6] from Mr S' pain management specialist, Dr Rastogi, before making its decision.

21. In its letter dated 18 December 2019, Medigold informed Mr S that his request for Tier 2 benefits had been declined. It quoted from its Medical Adviser (**MA**):

    "This is an application for reassessment for Tier 2 ill health retirement benefits…

    The medical evidence considered:

    - The referral documents.
    - Report from GP, Dr Carstairs, dated 20 December 2017.
    - Report from Dr Rastogi, consultant in pain management, dated 5 December 2019.
    - Report from Mr Worlock, consultant orthopaedic surgeon, dated 20 August 2019.

[5] Mr S informed NHS BSA verbally that he was not appealing its decision made at Stage One of the IDRP.

[6] This report was dated 5 December 2019

- Reports from Mr Borland, consultant orthopaedic surgeon, dated 13 December 2017, 25 June 2018, 13 November 2018 and 5 February 2019.
- Referral letter from Mr Borland to pain clinic, dated 14 November 2018.
- Report from Dr Wong, occupational physician, on form AW33E, dated 10 August 2018.
- Reports from OH advisor Maclennan, dated 25 August 2017, 2 November 2017, 8 December 2017, 22 March 2018, 16 June 2018 and 22 August 2018.
- Report from Dr Wong, occupational physician, dated 25 July 2018.
- Applicant's statement on form AW33E.
- Applicant letter submitted at IDR1 in respect of refusal of ill health retirement.
- Letter from applicant requesting reassessment.

Cases are considered on an individual basis and decisions are made on the balance of probabilities.

It has already been determined that the member meets the Tier 1 condition. I consider that the relevant medical evidence indicates that, on the balance of probabilities, the applicant is not permanently incapable of regular employment of like duration. The Tier 2 condition is not met.

The medical evidence currently available does not provide evidence that Mr S is currently incapable of undertaking suitable regular full-time employment.

There is no doubt that Mr S does have significant medical issues. In summary, he sustained a fracture of the tibia in 2017 with subsequent complications that left him with compromised function and residual neuropathic pain. These problems are ongoing. He therefore clearly has a physical infirmity.

However, a further consideration is whether the infirmity has given rise to incapacity for regular employment of like duration, in this case, regular full-time employment. The medical evidence currently available does not demonstrate that this is the case.

Writing in August 2019, Mr Worlock stated that, from an orthopaedic perspective, Mr S would be capable of undertaking sedentary work in an office environment. Mr Worlock was unable to comment on the impact Mr S' pain on his employability. This is clearly a relevant consideration. I therefore requested a report from Mr S' pain management specialist, Dr Rastogi. I specifically asked Dr Rastogi to give an opinion on Mr S' ability to undertake regular full-time employment. While Dr Rastogi confirms that Mr S does have severe

neuropathic pain, he does not comment on the impact of this. I therefore do not have evidence that Mr S is currently incapable of undertaking suitable regular full-time employment.

Even if one did consider that Mr S was currently incapable of undertaking suitable regular full-time employment because of his neuropathic pain, it would still be necessary to demonstrate that this incapacity was likely to be permanent in order for the Tier 2 condition to be met. Given the duration of Mr S' symptoms despite medical intervention, it does seem unlikely that his symptoms would, at this stage, be expected to spontaneously improve to any significant extent. It follows from this that any current incapacity that might be present would, in the absence of future treatment, be likely to be permanent. However, further treatment, in the form of spinal cord stimulation, is to be undertaken. It is reasonable to consider that Dr Rastogi would not offer this to Mr S if he did not consider it likely to be of benefit. A further consideration is the likely extent of that benefit. Dr Rastogi has felt unable to comment on this at present. My understanding is that spinal cord stimulation is generally considered to be successful if it brings about a 50% reduction in pain or requirement for analgesia. This treatment would therefore be unlikely to completely resolve Mr S' pain. However, it does hold the possibility of a significant reduction in his symptoms. Therefore even if one did accept that Mr S was currently incapable of regular employment of like duration, future treatment could well alter this. Since Mr S is over 14 years from reaching scheme pension age and given that the benefits of the proposed treatment are likely to be realised in a matter of months, any benefit would be likely to come about before Mr S reaches scheme pension age.

Given the fact that Dr Rastogi describes Mr S' pain as "severe", I think that there is an element of balance to this application. However, in my opinion, the evidence currently presented does not demonstrate that, on the balance of probability, Mr S is permanently incapable of undertaking regular employment of like duration. The Tier 2 condition is therefore unlikely to be currently met."

22. Mr S was dissatisfied with the outcome of his reassessment and made a new complaint under the Scheme's IDRP.

23. At both stages of the IDRP, NHS BSA informed Mr S that his complaint was not upheld because it agreed with the medical advice given by its MAs that he did not satisfy the Tier 2 condition at the reassessment date of 18 December 2019.

24. The MA at Stage One of the IDRP said that:-

- The medical evidence indicated that as of 18 December 2019, Mr S was unfit for any kind of regular full-time employment, due to "chronic neuropathic pain and its mental health sequelae".

- In the absence of future treatment, his incapacity would be likely to continue beyond his NPA of 67 and consequently be considered "permanent"

- However, spinal cord stimulation was outstanding as of 18 December 2019. The likely outcome from this treatment for Mr S was "a degree of additional pain relief, with a corresponding improvement in…mental state with reduced pain levels."

- It was considered, more likely than not, that such future treatment would lead to sufficient functional capacity to enable Mr S to return to some kind of regular full-time employment, during the following 14 years until his 67th birthday.

25. The MA at Stage Two of the IDRP said that:-

    - On the balance of probability, as of 18 December 2019, "further treatment in the form of implantation of a permanent spinal cord stimulator was more likely than not to have altered the permanence of Mr S' incapacity for regular full-time employment".

    - Regular full-time employment included work across the whole field of employment and was not confined to Mr S' job as a maintenance assistant or to work within the NHS. It would include work outside of the NHS in a sedentary role which was not physically demanding and did not require complete mobility.

    - It was likely that Mr S' case would comprise a disability under the Equality Act 2010. Alternative full-time work for Mr S would consequently require appropriate reasonable adjustments to allow for limitations in his mobility.

26. Relevant paragraphs from the Stage One and Stage Two IDRP decision letters dated 16 July 2020 and 29 April 2021, including the opinions expressed by the MAs, are set out in Appendix Three.

27. Following the complaint being referred to The Pensions Ombudsman (**TPO**), Mr S and NHS BSA made further submissions that have been summarised in paragraphs 28 to 36 below.

Mr S' position

28. He has been left with significant long term damage to his right leg following the accident. This has detrimentally impacted on his life both physically and mentally. His wife is now his full time carer.

29. NHS BSA disregarded the letters from his doctors and the pain clinic team when declining his application for Tier 2 IHER benefits from the Scheme.

30. NHS BSA simply accepted the advice of its MAs who did not medically examine him before providing their recommendation.

31. He says that:

> "Medigold has declared me fit enough to work where there are aids and adjustments provided to help me. The evidence Medigold used to justify their decision was because I can drive my automatic car to the gym. In the gym, I engage in exercises recommended by my physio and upper body exercises, helping to improve my mental health.
>
> A working environment would be impossible for me as I struggle to sit without having to raise my legs and without falling asleep as I am so tired. I suffer from depression and anxiety; I have panic and sweat attacks. Additionally, I suffer from dizzy spells where everything goes black around me, making me feel like I am going to pass out. I often choose not to go out of the house with fear of this happening to me.
>
> Although I have had a spinal nerve stimulator fitted, the 30% reduction of the nerve damage is to my foot and not my leg. I am in chronic pain 24/7, unable to sleep, restless all night and finding it impossible to reduce my medication. I have also gained 3 stone in weight, which makes this even more difficult for me to deal with…
>
> In conclusion, I would be unfit for work and could not tolerate a working environment as evidenced above."

32. He is registered as disabled. He receives both Employment Support Allowance (**ESA**) and Personal Independent Payments (**PIP**) from the Department for Work and Pensions (**DWP**).

NHS BSA's position

33. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Mr S' application for IHER benefits. It took into account all the available evidence that was relevant and weighed it appropriately. In making its decision, it followed a proper process and considered the advice of its MAs.

34. Whilst its MAs are not experts in all the various medical conditions, they are all specially trained OH physicians, expert in carrying out a forensic analysis of the available medical evidence provided in each case and considering that against the tightly prescribed requirements of the Scheme Regulations. Its MAs also have access to specialist advice, if necessary.

35. It does not consider that Mr S meets the Tier 2 condition for IHER. In its opinion, he will be capable of regular employment of like duration to his NHS job before he attains NPA.

36. In medical matters, decisions are seldom "black or white". A range of opinions may be given from various sources, all of which must be considered and weighed appropriately. The fact that Mr S does not agree with the conclusions drawn in this case, and the weight attached to individual pieces of evidence, does not mean that the conclusion NHS BSA reached is flawed.

Adjudicator's Opinion

37. Mr 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 38 to 66 below.

38. It is not the role of the Pensions Ombudsman (**the PO**) to review the medical evidence and come to a decision of his own as to Mr S' eligibility for IHER benefits from the Scheme.

39. The PO is primarily concerned with the decision-making process. Namely, whether NHS BSA's decision was supported by the available medical evidence and any other evidence relevant to the case.

40. The PO would consider: (a) whether the applicable scheme rules or regulations had been correctly interpreted, (b) whether appropriate evidence had been obtained and considered, and (c) whether the decision was supported by the available relevant evidence.

41. If the PO finds that the decision-making process is flawed, or that the decision reached by NHS BSA is not supported by the evidence, the case is normally remitted to NHS BSA to reconsider.

42. The PO cannot overturn the decision just because he might have acted differently.

43. Under regulation 90 of the Scheme Regulations, Tier 1 IHER benefits were available to Mr S if NHS BSA, acting on medical advice, decided that his medical conditions would prevent him from permanently discharging the duties of his NHS employment efficiently. Its decision was made on the balance of probabilities.

44. So, for Mr S to meet the criteria for Tier 1 IHER benefits, he must be considered by NHS BSA to be permanently incapable of undertaking efficiently the duties of his NHS post until his NPA of 67 years.

45. If NHS BSA considered that Mr S was, more likely than not, also permanently incapable of regular employment of "like duration" to his NHS role, he would be entitled to Tier 2 IHER benefits.

46. It was for NHS BSA (Medigold in the first instance) to decide the weight to attach to any of the evidence, including whether to give some of it little or no weight. It was open to NHS BSA to prefer evidence from its own MAs; provided, that is, there was no good reason why it should not do so. The kind of things the Adjudicator had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations. Moreover, NHS BSA was not expected to challenge medical opinion unless the evidence on which the medical opinion was based was obviously flawed or insufficient.

47. The original decision to decline Mr S' IHER application was made by Medigold in November 2018, under delegated authority from the Secretary of State. Mr S was

dissatisfied with the outcome and appealed under Stage One of the IDRP in December 2018.

48. After carefully considering the evidence submitted by Mr S for both Stage One of the IDRP and his original IHER application, NHS BSA informed him that his appeal had been successful. It said that it accepted the view of one of its MAs who had not previously been involved in his case that: (a) he was permanently incapable of carrying out his NHS duties, and (b) he satisfied the conditions laid down in the Scheme Regulations for payment of Tier 1 IHER benefits from the Scheme.

49. The MA recommended that Mr S be allowed the opportunity to request one reassessment of the Tier 2 condition within three years of the Tier 1 award notification. Mr S asked for a reassessment in October 2019 and provided new medical evidence. In December 2019, Medigold informed him that his request for Tier 2 benefits from the Scheme had been declined.

50. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to decline Mr S' IHER application for Tier 2 benefits, was taken after its MA had considered the medical evidence provided with the application for reassessment which it listed in its letter dated 18 December 2019. Medigold had to weigh the evidence and take a decision based on the balance of probabilities.

51. The MA was required to consider whether as of 18 December 2019 Mr S was, more likely than not, permanently incapable of regular employment of like duration to his NHS role until his NPA of 67 years.

52. In Mr S' case, it was the MA's medical opinion that:-

- Appropriate treatment in the form of implantation of a permanent spinal cord stimulator was available that would allow Mr S to undertake alternative employment in "a sedentary role which was not physically demanding and did not require complete mobility" at some point before his NPA of 67.

- It was reasonable to consider that Dr Rastogi, a consultant in pain management, would not have offered this to Mr S if he did not consider it likely to be of benefit.

- Spinal cord stimulation was generally considered to be successful if it resulted in a 50% reduction in pain or requirement for analgesia.

- This treatment would consequently be unlikely to completely resolve Mr S' pain. It was possible, however, that such future treatment would lead to significant reduction in his symptoms.

53. Based on the evidence presented, the MA concluded, on the balance of probabilities, that at the date of reassessment:-

- Mr S' conditions did not permanently prevent him from undertaking regular employment of like duration up to his NPA of 67 years; and so

- the Tier 2 condition for IHER had not been met.

54. Mr S was dissatisfied with the outcome of his reassessment and appealed it twice under the IDRP. On each occasion, after carrying out a thorough assessment, NHS BSA informed Mr S that his appeal had been unsuccessful because it accepted the view of its MA.

55. Mr S had contended that NHS BSA:

- disregarded the medical opinions expressed by his doctors and the pain clinic team supporting his application for Tier 2 IHER benefits from the Scheme; and

- simply accepted the advice of its MAs who had not medically examined him.

56. There was a difference, however, between disregarding medical evidence and attaching little or no weight to it. NHS BSA listed the medical evidence which its MAs considered in its IDRP decision letters. The medical evidence submitted by Mr S' treating doctors were on these lists. The Adjudicator was satisfied that all the medical evidence was considered that pertained to Mr S' conditions at the time of reassessment.

57. There was no requirement in the Scheme Regulations for an applicant to be seen by the MA. It was for the MA to decide whether it was necessary to see the applicant and whether they had sufficient medical evidence to give their opinion or require further information from the applicant's treating doctor(s), OH or Mr S' former employer.

58. It should also be noted that a difference of opinion between doctors, in and of itself, was not usually sufficient for the PO to find that preferring the opinion of its MA meant that NHS BSA's decision was not properly made.

59. The Adjudicator was also satisfied that NHS BSA addressed the issue of untried treatments properly by asking its MAs to give a view as to their likely efficacy and whether, on the balance of probabilities, Mr S' condition rendered him permanently incapable of undertaking regular employment of like duration up to his NPA of 67 years.

60. At the time of the reassessment on 18 December 2019, Mr S was around 14 years from his NPA. The MAs opinions were that future treatment in the form of implantation of a permanent spinal cord stimulator would, more likely than not, restore Mr S' fitness for alternative work of like duration before he reached his NPA. It was, however, acknowledged that alternative full-time employment would require appropriate reasonable adjustments to allow for Mr S' limitations in mobility.

61. The Adjudicator had not identified any obvious error or omission of fact, irrelevant matters or misunderstanding of the Scheme Regulations in the MAs advice which NHS BSA should have queried.

62. So, it was the Adjudicator's view that there was no reason why NHS BSA should not have accepted the advice it received from its MAs when reaching its decision in Mr S' case.

63. The fact that Mr S was still suffering from the same medical conditions did not, in and itself, invalidate NHS BSA's decision. NHS BSA could only be expected to make its decision based on the medical opinions expressed at the time of reassessment pertaining to Mr S' health. NHS BSA chose to prefer the opinion of its MAs, who are occupational health experts.

64. It was consequently the Adjudicator's opinion that NHS BSA took appropriate action at both stages of the IDRP after obtaining further medical opinions from its MAs. He was also satisfied that NHS BSA: (a) gave proper consideration to Mr S' reassessment at the time by considering all the relevant medical evidence available, and (b) acted in accordance with the Scheme Regulations and the principles outlined in paragraph 40 above.

65. In the Adjudicator's view, its decision not to award Mr S Tier 2 IHER benefits from the Scheme on reassessment was consequently supported by the available evidence and within the bounds of reasonableness.

66. Mr S said that he was in receipt of both ESA and PIP payments. Receipt of these benefits did not, however, mean that Mr S would automatically qualify for Tier 2 IHER benefits from the Scheme because the criteria used to determine whether or not he qualified for ESA and PIP were different and less stringent.

67. Mr S did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr S provided his further comments which do not change the outcome.

68. Mr S said that:-

- The Adjudicator's decision was based solely on the fact that he could drive to the gym once or twice a week in order to carry out his physiotherapy exercises.

- Dr Rostogi admitted that the spinal cord stimulator "did nothing" for his leg where he has 90% of his chronic pain.

- The spinal cord stimulator has become less effective in providing relief to his foot pain over time.

- A letter dated 7 May 2025 to him from Mr Borland, Consultant Orthopaedic Surgeon, showed how wrong NHS BSA's decision was to decline his request for Tier 2 IHER benefits from the Scheme.

69. I note the additional points raised by Mr S but agree with the Adjudicator's Opinion.

Ombudsman's decision

70. At the outset, it is important to highlight my role in this process. I am not tasked with reviewing the medical evidence and deciding whether Mr S should in fact receive a Tier 2 IHER pension – that decision is made by NHS BSA (as set out in paragraph 11 above) in accordance with the Scheme Regulations. Rather, my role and that of my office is to look at the process followed by NHS BSA.

71. When considering how a decision has been made by NHS BSA, I will generally look at whether:

- the appropriate evidence had been obtained and considered;
- the applicable scheme rules and regulations have been correctly applied; and
- the decision was supported by the available relevant evidence.

72. Providing NHS BSA has acted in accordance with the above principles and within the powers given to it by the Scheme Regulations, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Mr S' eligibility for Tier 2 IHER benefits from the Scheme. I am primarily concerned with the decision making process.

73. NHS BSA was required to assess Mr S' IHER application in accordance with the Scheme Regulations, and to do so in consultation with its MAs.

74. Mr S feels that more weight should have been given by NHS BSA to the medical view expressed by Dr Rostogi, Consultant in Chronic Pain Management, in his letter dated 15 January 2021 that the spinal cord stimulator was only effective for capturing his foot pain and not his leg pain.

75. However, within the bounds of reasonableness, the weight which is attached to any of the medical evidence is for NHS BSA to decide. It is open to NHS BSA to prefer evidence from its own advisers unless there is a cogent reason why it should, or should not do so without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant rules by the MA.

76. As the Adjudicator set out, the decision to give little or no weight to any of the evidence is not the same as failing to consider it. NHS BSA listed the medical evidence which its MAs considered in the two IDRP decision letters dated 16 July 2020 and 29 April 2021. It is clear that Dr Rostogi's letter dated 15 January 2021 was provided to the MA for consideration at Stage Two of the IDRP. I am consequently satisfied that all the medical evidence relevant to Mr S' conditions at the time of reassessment was considered.

77. Mr S contends that NHS BSA reached their decisions to decline his application for Tier 2 IHER benefits from the Scheme based solely on the fact that he could drive to the gym once or twice a week in order to carry out his physiotherapy exercises.

78. However, both IDRP decision letters said that NHS BSA, together with the MA, had taken into account all the available evidence when carrying out a comprehensive review of Mr S' application and there is no evidence to suggest that was not the case.

79. It is consequently clear that NHS BSA had given most weight to the MA's detailed opinion that, at the time of the reassessment on 18 December 2019, Mr S' condition did not, on the balance of probabilities, permanently prevent him from regular employment before his NPA of 67.

80. I find that NHS BSA did give proper consideration to Mr S' IHER application by assessing all the relevant medical evidence available at the time and it had acted in accordance with the Scheme Regulations and the above principles.

81. I consider its decision not to award Mr S Tier 2 IHER benefits was not one that no reasonable body would make, and it was within the bounds of reasonableness.

82. Mr S says that a letter dated 7 May 2025 to him from Mr Borland, Consultant Orthopaedic Surgeon, showed how wrong NHS BSA's decision was to decline his request for Tier 2 IHER benefits from the Scheme.

83. The fact that Mr S is still suffering from the same medical condition does not impact upon the validity of the original decision. NHS BSA could only be expected to make its decision in December 2019 on the basis of the condition as it was understood at the time and to reconsider that decision in light of the medical prognosis available at each stage of the review process.

84. That Mr S' condition may not have followed the course anticipated at the time of the reassessment does not in itself provide evidence that the original decision made in December 2019 was incorrect.

85. While I sympathise with Mr S' circumstances, the evidence does not support a finding of maladministration by NHS BSA in coming to the decision it did.

86. Therefore, I do not uphold Mr S' complaint.

Dominic Harris

Pensions Ombudsman
18 August 2025

Appendix One

The National Health Service Pension Scheme Regulations 2015

At the time Mr S' NHS employment ended, Regulation 90 provided:

"Entitlement to ill-health pension

(1) An active member (M) is entitled to immediate payment of -

(a) an ill-health pension at Tier 1 (a Tier 1 IHP) if the Tier 1 conditions are satisfied in relation to M;

(b) an ill-health pension at Tier 2 (a Tier 2 IHP) if the Tier 2 conditions are satisfied in relation to M.

(2) The Tier 1 conditions are that—

(a) M is qualified for retirement benefits and has not attained NPA;

(b) M has ceased to be employed in NHS employment;

(c) the scheme manager is satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of efficiently discharging the duties of M's employment;

(d) M's employment is terminated because of the physical or mental infirmity;

and

(e) M claims payment of the pension.

(3) The Tier 2 conditions are that—

(a) the Tier 1 conditions are satisfied in relation to M; and

(b) the scheme manager is also satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of engaging in regular employment of like duration."

Appendix Two

Relevant excerpts from the Stage One IDRP decision letter dated 17 January 2019

"…I have undertaken a full and thorough review of your application, taking into account all the available relevant evidence.

The MA has commented…

I have considered the documents submitted in respect of this first stage IDR review, specifically:

- The referral documents
- Form DRP1 dated 02/12/18 with a letter from the applicant.
- In his dispute letter the applicant indicates that he intended to provide additional medical evidence that has not previously been seen by NHS Pensions. No further evidence from a medical source has been provided, however, the applicant does, himself, provide more details of his medical issues. The evidence held is considered to be sufficient.

I have also considered the documents submitted in respect of the original application, specifically:

- The referral documents submitted with the original application
- Job description
- Form AW33E with Part C, completed by the OH physician, Dr Wong, dated 10/10/18 and copy OH reports, dated 25/08/17, 02/11/17, 08/12/17, 22/03/18, 12/06/18, 25/07/18 and 22/08/18
- Correspondence from Mr Borland, Consultant Orthopaedic Surgeon, dated 25/06/18 and 13/12/17
- Correspondence from Dr Carstairs, GP, dated 20/12/17
- A report commissioned from Mr Borland, Consultant Orthopaedic Surgeon, dated 13/11/18.

Cases are considered on an individual basis and decisions are made on the balance of probabilities.

I consider that the relevant medical evidence indicates that, on the balance of probabilities, the applicant is permanently incapable of the NHS employment. The Tier 1 condition is met. The applicant is not permanently incapable of regular employment of like duration. The Tier 2 is not met.

The rationale for this is as follows:

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that the member has a physical or mental infirmity as a result of which the member is currently incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member's current incapacity is likely to be permanent.

NHS BSA has indicated that NHS employment is due to be terminated on 29/12/18 and so evidence available now has been used for this advice.

Outline of dispute:

The applicant states that, following a car accident, he had fasciotomy for compartment syndrome, in Turkey, and was in hospital for 3 weeks. It was left as an open wound for 29 days rather than being repaired after 10 days. He still endures pain because of this and he has a series of long-term problems with his right leg and foot. These affect his mental and physical ability to carry out activities in everyday life. In addition to leg symptoms…he has dizziness and intermittent hearing problems resulting from head injury and depression.

In the initial application the evidence is as follows:

Orthopaedic correspondence indicates that the applicant had a right leg injury in June 2017. It is inferred that the applicant has been on sick leave since then. The employer indicates that reviews were ongoing from 04/10/17. The applicant indicated that he has been unable to work or live a normal life since an accident in Turkey and that he is only able to get out of the house in a wheelchair. Dr Wong wrote that the reason for incapacity are his leg injury and complications. The applicant had leg injury and head injury. He had surgical fixation of a fracture, compartment syndrome, further fasciotomies and skin graft and further numerous surgeries in the UK with poor response. He had constant pain, poor healing and instability that were causing low mood. He uses crutches. The Consultant Orthopaedic Surgeon has indicated that neuropathic pain may be an ongoing issue. His role is physically demanding and he is not safe to carry out his role. His response to conventional treatments has been poor. He is likely to have long-term incapacity for his NHS duties. Even in a more sedentary role, 'I am unsure if he would be able to provide regular employment', due to possible long-term neuropathic pain. On 25/06/18, Mr Borland wrote that further surgery may be needed, once the leg is healed a full OH assessment is recommended as climbing ladders will be a long way off and given the fasciotomies and compartment syndrome, it is likely that he has an element of neuropathic pain, which may be an ongoing issue for him. On 13/11/18, Mr Borland wrote that the applicant was unfit for work due to the need for ongoing treatment for his tibial fracture and ongoing neuropathic pain affecting the lateral aspect of the leg. He had knee stiffness, non-union right tibia, previous compartment syndrome and chronic neuropathic pain. The expectation was that his tibia would unite with further

surgery, he would be able to weight bear and his mobility would improve with physiotherapy. He has been referred to the Chronic Pain Management Team for evaluation of treatments for his chronic pain affecting the lateral aspect of his leg. Given the nature of his injury and the nature of his ongoing symptoms it is unlikely that he would ever be able to return to work as a maintenance assistant or work safely on ladders and scaffolding.

The evidence indicates, on balance, that this applicant is currently incapable of his NHS job and of regular employment of like duration.

When considering if a medical condition is likely to give rise to permanent incapacity I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this.

The evidence indicates, on balance, that sufficient spontaneous improvement to render him clinically capable of and resilient to his NHS job, or regular employment of like duration within the period to his normal benefit age, is not likely.

Reasonable treatment in this case would likely include:-

- Planned surgical intervention and physiotherapy under the care of the treating Orthopaedic Surgeon, Mr Borland.
- Specialist and Specialist Multidisciplinary Team management of his chronic pain using analgesia, other modalities and a biopsychosocial approach.
- Medications from different classes (at adequate dosage, for adequate duration and perhaps in combination), psychological therapy, behavioural therapy and specialist/specialist services involvement for depression/low mood.
- GP involvement for assessment of dizziness with onward referral if and as indicated.

The evidence indicates that, even with reasonable treatment, this applicant is unlikely to be clinically capable of and resilient to, his NHS within the period to his normal benefit age.

This applicant is more likely than not to be clinically capable of and resilient to, retraining for and undertaking, sedentary/semi-sedentary, full time, regular employment, within the 16-year period to his normal benefit age, given compliance with reasonable treatment.

In my opinion, the member does have physical or mental infirmity as a result of which the member is currently incapable of efficiently discharging the duties of

their employment. This incapacity is likely to be permanent. The Tier 1 condition is likely to be met for the reasons given above.

As actual response to treatments remains to be seen, there is sufficient uncertainty regarding relevant functional prognosis and so this applicant may request reassessment of the Tier 2 condition, once, within three years of the date of notification of award of the Tier 1 pension or before normal benefit age, whichever is the sooner, in addition to recourse under the internal dispute resolution procedure.”

Appendix Three

Relevant excerpts from the Stage One IDRP decision letter dated 16 July 2020

"…I have undertaken, together with the Scheme's MA, a very full and thorough review of your application, taking into account all the available evidence.

The MA has commented…

My understanding is that I am required to provide advice as to whether the member was likely to have met the Tier 2 condition, as of 18 December 2019.

Medical Evidence

I have considered the documents submitted in respect of this first stage IDR review, specifically:

- The referral documents;
- A submission from the applicant, dated 29 January 2020;
- A report from Dr Rastogi, Consultant in Pain Management, dated 1 June 2020, commissioned by Medigold

I have also considered the documents submitted in respect of the original reassessment application, specifically…

Cases are considered on an individual basis and decisions are made on the balance of probabilities.

It has already been established that, at the time of leaving employment, the applicant was permanently incapable of the NHS employment. The Tier 1 condition was met.

I consider that the relevant medical evidence indicates that, on the balance of probabilities, as of 18 December 2019, the applicant was not permanently incapable of regular employment of like duration. The Tier 2 condition was not met.

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, as of 18 December 2019, the member had a physical or mental infirmity, as a result of which the member was incapable of regular employment of like duration. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent.

In considering whether a medical condition would be likely to give rise to permanent incapacity, I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this.

In this case, 'permanent' means at least until normal NHS pension age of 67, which was 14 years and 1 month in the future, as of 18 December 2019.

Some of the medical evidence post-dates 18 December 2019. Changes in the member's health after this date are not relevant to the determination of whether he satisfied the pension scheme definitions as of this date. I have therefore not taken the subsequent course of his illness into account.

I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, his circumstances at that time.

It should first be noted that 'regular employment of like duration', in Mr S' specific case, means any kind of regular full-time work, in the wider field of employment, including outside the NHS, in a more suitable job role, of a sedentary and low physical and cognitive demand nature, with appropriate disability adjustments under the relevant equality legislation. There is considered more than sufficient time, prior to his 67th birthday, for him to re-train to undertake some other kind of work, including something completely different to his previous NHS role.

In his appeal statement, Mr S states "undergone 10 operations on the tibia to my right leg…left me unable to walk unaided and in constant pain…surgeons said unfortunately there is nothing else that can be done…have allodynia caused by my second operation…also have foot drop…add to the difficult and pain I have when walking and standing…some days I am unable to move around at all, as the pain is unbearable…extremely difficult for me to sleep…need help and assistance when showering and also use a shower chair…take sertraline as I suffer from depression and anxiety…I now have to rely on 5 different types of pain relief and antidepressants to cope with everyday life…this has been the worst time in my life; it has been turned upside down…as I am unable to work I receive disability benefits from PIP and ESA".

On 5 December 2019, Dr Rastogi, consultant in pain management, stated "Mr S has severe neuropathic pain affecting his right lower limb following a traumatic proximal tibia fracture in June 2017…proposed plan for Mr S is to undergo a trial of spinal cord stimulation to help reduce his pain, improve his physical function and quality of life…had undergone all of the necessary assessments to proceed towards a trial of this therapy and he is currently awaiting a date".

On 1 June 2020, Dr Rastogi stated "currently unfit for work due to chronic neuropathic and nociceptive pain affecting his right lower leg…was deemed a suitable candidate for trial of spinal cord stimulation and he underwent a trial of this therapy on the 18th March 2020…following the two week trial of spinal cord stimulation therapy, he was assessed and the trial was deemed to be successful as it helped reduce his pain and improve his sleep…subsequently

been listed for a permanent implant…once his spinal cord stimulator battery is implanted and the system commenced, it is usual to make further assessments at both three and six months post implantation, by which time we will be able to make more accurate assessments of his capacity for work".

The medical evidence is that, as of 18 December 2019, Mr S was unfit for any kind of regular full-time employment, due to chronic neuropathic pain and its mental health sequelae.

The natural history of this condition is one of persistence. Spontaneous recovery is not likely. Thus, in the absence of future treatment, his incapacity would be likely to continue beyond his 67th birthday (normal NHS pension age) and therefore be considered "permanent".

However, future treatment (as outlined by Dr Rastogi), is considered likely to alter the permanence of his incapacity.

The spinal cord stimulation was outstanding as of 18 December 2019. The likely outcome from this was for a degree of additional pain relief, with a corresponding improvement in his mental state with reduced pain levels. As of 18 December 2019, it is considered more likely than unlikely, on balance of probability that, such future treatment would lead to sufficient functional capacity to enable Mr S to return to some kind of regular full-time employment, during the following 14 years until his 67thbirthday. (Dr Rastogi's report of 1 June 2020 indicates that the likely outcome as of 18 December 2019 has actually occurred subsequently, although he still awaits a permanent spinal cord stimulator and further rehabilitation treatment).

Thus, permanent incapacity for regular employment of like duration is not supported by the medical evidence and the medical criteria for the Tier 2 condition were not satisfied, as of 18 December 2019, on balance of probability.

In my opinion, as of 18 December 2019, the member had a physical or mental infirmity, as a result of which the member was incapable of regular employment of like duration. This incapacity was unlikely to have been permanent. The Tier 2 condition was unlikely to have been met for the reasons given above."

Relevant excerpts from the Stage Two IDRP decision letter dated 29 April 2021

"NHS Pensions takes advice on medical matters, from professionally qualified, experienced and specially trained OH doctors who also have access to expert resource where necessary.

I have undertaken a very full and thorough review of your application, taking into account all the available relevant evidence.

The MA considering your case has recommended that you do not satisfy the Tier 2 condition for payment of ill health retirement benefits and I have accepted the MA's recommendation...

In reaching the recommendation the MA… provided the following comments:

"I have considered the documents submitted in respect of this second stage IDR review, specifically:

- The referral documents.
- Letter from Dr S Rastogi, Consultant in Chronic Pain Management, dated 15 January 2021.

I have also considered the documents submitted in respect at stage 1 IDR, specifically…

I have also considered the documents submitted in respect of the original reassessment application, specifically…

I note that some of the medical reports post-date 18 December 2019. Changes in the applicant's health after this date are not relevant to the determination of whether the applicant satisfied the pension scheme definitions as of 18 December 2019. I have therefore not taken the subsequent course of the applicant's illness into account. I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, the applicant's circumstances as of 18 December 2019.

Cases are considered on an individual basis and decisions are made on the balance of probabilities. In considering this application I have taken into account the requirements of the relevant scheme regulations.

It has already been established that, as of 18 December 2019, the Tier 1 condition was met. I consider that the relevant medical evidence indicates that, on the balance of probabilities, as of 18 December 2019, the applicant was not permanently incapable of regular employment of like duration. The Tier 2 condition was not met.

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, as of 18 December 2019, the applicant did have a physical or mental infirmity as a result of which the applicant was incapable of regular employment of like duration. The key consideration is whether the applicant's incapacity was likely to have been permanent.

On 15 January 2021, Dr Rastogi wrote:

"I spoke to Alan this afternoon over the telephone from the Pain Clinic. He told me that his pain is much the same as last time with his foot pain manageable thanks to the spinal cord stimulator, though his leg pain is still significantly

bothersome. …. It has always been the case that the stimulator was effective for capturing his foot pain not his leg pain. He told me his sleep is also poor, though he is grateful he is able to get his shoes on. He has tried to remain physically active by going back to the gym though this has been curtailed recently due to the lockdown. He is not keen on any further physiotherapy. He can manage to drive … I wonder whether there is any value in changing his mode of spinal cord stimulation to burst or paraesthesia based, rather than high frequency, and I will discuss this with my nursing colleagues. Otherwise I will review him in 12 months' time."

When considering whether a medical condition would be likely to give rise to permanent incapacity, I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and if so, then go on to consider whether future treatment would be likely to alter this.

Medical evidence indicates that Mr S suffered a traumatic proximal tibia fracture in June 2017. Mr Borland, Consultant Orthopaedic Surgeon, advised that Mr S would undergo further surgery to obtain union of his tibial fracture and the expectation was that this would enable his tibia to unite, he would be able to weight bear and would be able to improve his mobility with the aid of physiotherapy. Mr S was referred to the Chronic Pain Management Team and, following a trial of spinal cord stimulation therapy, he underwent a permanent implant of a spinal cord stimulator. As of 18 December 2019, it was accepted that spontaneous recovery was not likely, but that future treatment (implantation of a spinal cord stimulator) would likely produce a degree of additional pain relief, with a corresponding improvement in his mental state with reduced pain levels. It was considered more likely than unlikely, on the balance of probability, that such future treatment would lead to sufficient functional capacity to enable Mr S to return to some kind of regular full-time employment before he reached his 67th birthday.

Although Dr Rastogi's letter of 15 January 2021 post-dates 18 December 2019, I consider that the report provides insight into Mr S' circumstances at that time. The letter reports overall improvement in pain (foot pain manageable, though leg pain still significantly bothersome …. sleep is also poor) however, the letter indicates that Mr S has been able to go back to the gym (although curtailed by the lockdown) and can manage to drive.

In my opinion, on the balance of probability, as of 18 December 2019, further treatment in the form of implantation of a permanent spinal cord stimulator was more likely than not to have altered the permanence of Mr S' incapacity for regular full-time employment. As of 18 December 2019, Mr S was some 14 years away from his normal benefit age and was therefore likely to realise the benefits of treatment before he reached his normal benefit age.

Regular full-time employment includes work across the whole field of employment and is not confined to Mr S' job as Maintenance Assistant or to

work within the NHS. It would include work outside of the NHS in a sedentary role which was not physically demanding and did not require complete mobility.

Although the interpretation of the Equality Act 2010 is a legal question and ultimately one for an Employment Tribunal, in my opinion, it is likely that Mr S' case would comprise a disability under the Act. Alternative full-time work would therefore require appropriate reasonable adjustments to allow for limitations in mobility.

It has already been accepted that as of 18 December 2019, the applicant had a physical or mental infirmity as a result of which the applicant was permanently incapable of efficiently discharging the duties of their NHS employment and that, in consequence, the Tier 1 condition was met. In my opinion, as of 18 December 2019, the applicant was incapable of regular employment of like duration. This incapacity was unlikely to have been permanent. The Tier 2 condition was therefore unlikely to have been met for this reason…

It is my opinion that relevant medical evidence has been considered in this case and, on the balance of probabilities, indicates that as of 18 December 2019:

That the applicant was not permanently incapable of regular employment of like duration; the Tier 2 condition was not met.

The Scheme's MA has carefully considered all the evidence presented and has explained that as of 18 December 2019, which is the date of the original reassessment decision, he does not consider that you were permanently incapable of engaging in regular employment of like duration. The Tier 2 condition is therefore not met.…

Having very carefully considered the comments of the MA I can see no reason to disagree with his conclusion…"
