CAS-81874-H9L5

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Mrs S' complaint concerns NHS BSA's decision to grant her a Tier 1 ill health early retirement (**IHER**) award instead of a Tier 2 award.

Background information, including submissions from the parties

3. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

4. The relevant regulations are 'The National Health Service Pension Scheme Regulations 2015' (SI2015/94) (as amended) (**the 2015 Regulations**). Extracts from the 2015 Regulations are provided in Appendix 1.

5. On retirement from active status, the 2015 Regulations provide 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 incapable of efficiently discharging the duties of her/his NHS employment; and

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

   'Permanently' is to the members normal pension age (**NPA**). Mrs S' NPA is 67.

6. Regulation 90, defines "employment of like duration" as:

> "(5)(a) in the case of a practitioner or non-GP provider, such as employment as the scheme manager thinks would involve a similar level of engagement to M's current pensionable service as a practitioner or non-GP provider;
>
> (b) in any other case, where prior to ceasing NHS employment, M was employed –
>
> (i) on a whole-time basis, regular employment on a whole-time basis;
>
> (ii) on a part-time basis, regular employment on a part-time basis, regard being had to the number of hours, half days and sessions M worked in employment."

7. Regulation 93 provides that if an applicant is awarded a Tier 1 IHER pension, the case may be considered once for reassessment for Tier 2 benefits, under regulation 90(3)(b), within three years of the date Tier 1 benefits were awarded. This regulation is of assistance where it is not possible, at the time of the IHER application, to determine whether the applicant's condition(s) will deteriorate to such an extent that they are unable to undertake alternative employment, of like duration, in the future.

8. When Regulation 93 is invoked, new medical evidence must be provided which, at the date of the reassessment, demonstrates that the applicant now meets the Tier 2 criteria. The recipient of the IHER benefits can request for a Tier review anytime between when the Tier 1 award was made up until the "relevant date". Regulation 93(4)(a) defines the relevant date as the last day of the three-year period, starting from the date the member was notified of their Tier 1 award.

9. Mrs S was employed as a part-time NHS 111 clinical advisor working 30 hours a week.

10. In 2019, Mrs S was involved in a near fatal car crash resulting in a number of critical injuries.

11. On 18 August 2020, Mrs S applied for the early payment of her benefits through IHER (**the 2020 Application**). She was then age 50. Mrs S completed form AW33E and submitted it to NHS BSA along with her supporting medical evidence for her conditions.

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

13. On 26 January 2021, Dr Raynal, the Medigold appointed MA (**the First MA**) issued his report to Mrs S, following a review of Mrs S' IHER application (**the First Report**). In drafting the First Report, the First MA considered Mrs S' IHER application statement and the following medical reports (extracts from which are provided in Appendix 2):

- Dr Abbas' (Specialist Registrar) report dated 27 November 2019;

- Dr Sahal's (Consultant Respiratory Physician) reports dated 1 May and 9 September 2020;
- Dr Yusuf's (Consultant Cardiologist) report dated 16 September 2020;
- Dr Cutler's (Clinical Psychologist) reports dated 18 June and 9 July 2020;
- Dr Mutagi's (Locum Consultant in Pain Management) report dated 21 July 2020; and
- Dr Macheridis' (Occupational Physician) report dated 24 November 2020.

14. The First MA said that Mrs S met the criteria for a Tier 1 IHER pension; however, he did not agree that she was permanently incapable of undertaking work of "like duration" up until her NPA. The MA said:-

- The medical evidence indicated that Mrs S suffered from reduced mobility and effort tolerance, she found it difficult to lift/carry loads, her focus/concentration was diminished, and she struggled with going out. These were generally symptoms related to the post-traumatic stress disorder (**PTSD**) that followed after two traumatic events.
- The first traumatic event was due to a car crash in February 2019 which resulted in a skull injury, internal bleeding, multiple fractures in her sternum and ribs, fractures in her vertebrae and left arm, dislocations and injuries to her legs, and a collapsed lung. The second event was when she was admitted to intensive care, for two weeks, after catching COVID-19.
- There was evidence that Mrs S also suffered from underlying conditions before the two traumatic events. These included obesity, polycystic ovarian syndrome, paroxysmal atrial fibrillation and flutter (irregular heartbeat), high blood pressure, brittle asthma and 30% hearing loss.
- Dr Cutler's reports of 18 June and 9 July 2020 agreed that Mrs S was suffering from PTSD. Dr Cutler also believed that Mrs S losing her NHS role should also be considered as a traumatic event.
- The Neurologist, Consultant Cardiologist, Consultant Respiratory Physician, and Pain Management reports indicated that Mrs S was left with mild to moderate symptoms from her previous conditions, which were unlikely to impact the substantive element of her role. However, the flashbacks, poor sleep, and depression/anxiety related to the PTSD meant that Mrs S was unlikely to be able to return to her NHS role.
- When considering Mrs S' eligibility for Tier 2 benefits, consideration needed to be given to whether, in the absence of future treatment, Mrs S' conditions were permanent. If so, to what degree would this permanency be altered with appropriate and available treatments.

- Without future treatment for Mrs S' PTSD, it was likely that Mrs S would be permanently incapacitated. Mrs S had received appropriate assessments and medical interventions, under the NHS, for PTSD. However, there was no treatment that would be "…likely to alter the ultimate course of the condition or reverse the underlying process. Therefore, future treatment is unlikely to alter the permanence of [Mrs S'] incapacity…"

- Nonetheless, "although there is evidence that [Mrs S'] condition is likely to permanently prevent a return to capacity to undertake her substantive role, it is likely in my opinion that further interventions that are currently planned … are likely to improve her functional capacity to the extent that she will be able to undertake alternative paid work…".

- In particular, Mrs S was undergoing eye movement desensitization and reprogramming therapy (**EMDR**); however, it was paused due to the impacts of COVID-19. Once she restarted this treatment, it was expected that it would be likely to improve her functional capacity enough for her to undertake alternative employment before her NPA.

- Alternative employment would likely need to be home based using telephonic, and or computer equipment. Support and adjustments would be required, which would include a workplace workstation, ergonomic adjustments and postural breaks. It was likely that Mrs S would be able to undertake alternative employment before her NPA, which was within 17 years.

- Mrs S' IHER award should be reviewed within the next three years as the likely prognosis of her PTSD was not clear.

15. On 13 February 2021, Mrs S wrote to NHS BSA and asked for her 2020 Application to be reconsidered under stage one of the Scheme's Internal Dispute Resolution Procedure (**IDRP**). She said, in summary:-

- The First Report failed to mention most of the symptoms that she suffered from daily. She had attempted to contact the First MA to discuss the First Report as she did agree that it represented her conditions in full. In response to this, she was told to submit an appeal if she was unhappy with the First Report.

- The First Report described her pain as "mild to moderate", which she did not agree with as she took opiate medication to help alleviate the pain; however, this medication only "took the edge off the pain".

- Prior to COVID-19 she undertook weekly hydrotherapy, physiotherapy and acupuncture sessions. She also attended physiotherapy sessions within a pain management clinic. As appointments could no longer proceed face-to-face, her pain and joint issues had increased.

- There was no mention of her left side weakness, which was the result of her left leg being trapped during the car accident, sustaining nerve damage. She now had

to walk using a crutch. It was believed that her left sided weakness may possibly be the result of a brain injury incurred during the crash.

- She was referred to a Neurosurgeon due to a decline in her cognitive abilities, which affected her memory, speech and understanding. She was so concerned about the cognitive decline that she paid to see a private Neurosurgeon, and to have an MRI scan.

- She still had eight broken ribs that, after a scan, were revealed to be misaligned which needed to be corrected. She felt daily pain by her liver, which was thought to be due to scar tissue after her liver was lacerated during the crash. The accident also caused five spinal fractures. She had arthritis in her hips causing widespread pain. She was unable to sleep due to the pain, which caused daily exhaustion, meaning she slept most afternoons.

16. NHS BSA referred Mrs S' stage one IDRP appeal onto Medigold to review.

17. On 24 March 2021, Medigold wrote to Mrs S and explained that it had written to her GP to request additional information needed to review her appeal.

18. On the same day, Medigold wrote to Mrs S' GP and asked for the following information:

- was Mrs S currently certified as unfit to work;

- a list of her current medical conditions, including diagnosis', treatments received, the extent of any disability, and likely prognosis until her NPA;

- whether any future treatments would significantly improve her functionality;

- a list of any inactive conditions that were likely to reoccur;

- any correspondence from her specialists referring to the likely benefits of any future treatments;

- whether or not, in their opinion, if Mrs S received appropriate treatment, if she would sufficiently recover to allow her to undertake work comparable to that of her NHS role.

19. On 5 May 2021, Dr B Hassam (GP), responded to Medigold's information request. In summary, Dr Hassam said:-

- Mrs S was currently certified as unfit for work as a result of internal injuries caused by the car crash in 2019.

- She suffered from multiple active medical problems, which included, uncontrolled pain, thoracic (chest) pain, the sensation of movement in her ribs, multiple arthralgia (joint) pain, ongoing asthma and bronchiectasis with recurrent infections, and PTSD from the car crash. She was also suffering with hypertension and the lasting effects of COVID-19.

- She had ongoing problems with left sided weakness, for which she saw a neurosurgeon and was awaiting a neurology review. She did, however, have the results of an MRI scan which were normal.

- He was unable to provide any kind of prognosis for any of the active conditions that Mrs S was suffering from. Nor was he aware of any inactive condition that might reoccur.

- He was unable to comment on whether, or not, appropriate treatment would sufficiently rehabilitate Mrs S to the level that she could undertake regular employment.

- He provided copies of any hospital correspondence relevant to Mrs S.

20. On 25 May 2021, Dr Fisher (**the Second MA**) issued his report (**the Second Report**) to Mrs S for her to comment on before it was referred onto NHS BSA. Having reviewed her stage one appeal Dr Fisher did not agree that Mrs S met the criteria for Tier 2 IHER benefits under the 2015 Regulations.

21. Dr Fisher issued the Second Report to NHS BSA. In considering Mrs S' appeal, Dr Fisher reviewed the 2020 Application, the First Report and the supplementary medical reports (see Appendix 2) that Mrs S submitted alongside her stage two appeal, which were:

- Dr Simpson's (Consultant Cardiologist) report dated 10 August 2020;

- Dr Matharu's (Consultant Gynaecologist) report dated 2 November 2020;

- Dr Cutler's (Clinical Psychologist) report dated 16 December 2020;

- Dr Harland's (Consultant Spinal Neurosurgeon) reports dated 8 February 2021 and 18 February 2021;

- Dr Yusuf's (Consultant Cardiologist) reports dated 13 March 2020, 25 November 2020 and 23 February 2021;

- a report from the chronic pain team dated 26 February 2021;

- Dr Sahal's (Consultant Respiratory Physician) reports dated 30 April 2020, 9 September 2020, 13 October 2020 and 18 March 2021;

- Dr Davies' (Consultant Neurologist) report dated 7 April 2021; and

- Dr Hassam's report dated 5 May 2021.

22. A summary of the Second Report is provided below:-

- Based on the medical evidence submitted, it was reasonable to suggest that Mrs S was suffering from a physical or mental infirmity which, at present, meant that she was incapable of employment of like duration. However, the key consideration

was whether this was to be permanent, based on available or future treatments. In Mrs S' case, employment of like duration was employment of 30 hours a week.

- Dr Davies, a Consultant Neurologist, said in their report of 7 April 2021 that Mrs S' left sided weakness was "most likely to be due to a conversion syndrome i.e. a physical manifestation of an underlying psychological issue, possibly related to the psychological trauma of the accident…".

- Dr Hassam, Mrs S' GP, said in his report of 5 May 2021:

  "she has multiple active medical problems…significant uncontrolled pain for which she remains under the Pain Team…ongoing thoracic pain and a sensation of movement from her ribs for which she awaiting review from the cardiothoracic team…multiple arthralgia with no explanation on blood results and is awaiting the outcome of a referral to the rheumatology team…under the care of the Respiratory team for ongoing asthma and bronchiectasis from which she gets recurrent infections…been under the gynaecology team for ongoing PV bleeding and is awaiting a surgical procedure…ongoing problems with her memory and left sided weakness for which she has seen a neurosurgeon and is awaiting a neurology review…has a normal MRI scan…has AF and hypertension which is controlled on medication…suffered with Covid-19 infection and has lasting effects from this and is being referred to a Long Covid Clinic."

- Many of Mrs S' perceived medical conditions were medically unexplained, occurring in the context of two serious traumatic incidents within the last two years. It was unlikely that without appropriate treatments Mrs S would be capable of employment of the like duration. However, available future treatments were expected to improve her capability to work.

- The following available treatments, for Mrs S' mental health were: antidepressant/anxiolytic medications; mood stabilising drugs; low-dose antipsychotic drugs for anxiety/severe insomnia; referrals for assessment and treatments with the community mental health team and consultant psychiatrist; psychological therapies including trauma-based cognitive behavioural therapies (**CBT**) and eye movement desensitization and reprocessing (**EMDR**).

- The following recommended treatments for Mrs S' physical conditions were: attending a pain management clinic; an intensive neuro-rehabilitation programme; endometrial ablation surgery to resolve the uterine bleeding; referral, assessment and treatment to a consultant rheumatologist, a cardiothoracic surgeon and a physician specialising in long-covid.

- Dr Davies' report of 7 April 2021 noted that Mrs S was still undergoing the litigation process for the car accident. It was a recognised phenomenon that patients failed to make meaningful progress with treatment for chronic pain and

mental health issues until any legal process was complete, and any compensatory payment made.

- It was more likely than not that the listed mental and physical treatments would allow Mrs S to sufficiently undertake employment of like duration up until her NPA. Such employment would be non-complex, non-physical, sedentary and supported.

- Mrs S did not, on the balance of probability, meet the Tier 2 IHER criteria. However, in-line with the First Report, it was suggested that Mrs S undergo a Tier review, in accordance with the 2015 Regulations, within three years of the date her Tier 1 benefit was payable.

23. On 7 June 2021, upon receipt of the Second Report, NHS BSA agreed with Dr Fisher that Mrs S did not meet the Tier 2 conditions for IHER. NHS BSA wrote to Mrs S to inform her of the decision and that she may request a reassessment for Tier 2 within three years and provided her with a copy of the Second Report, which supported its decision to decline her stage one IDRP appeal.

24. On 15 November 2021, Mrs S' Tier 1 benefit was put into payment.

25. On 29 December 2021, Mrs S left NHS employment.

26. On 11 February 2022, Mrs S asked for her appeal to be considered under stage two of the IDRP. In support of her stage two appeal, Mrs S submitted several medical reports (see Appendix 3 for extracts from the reports). Mrs S also said:-

- It was accepted that she was unable to continue in her NHS role; however, she was expected to be able to undertake some form of employment of like duration.

- She experienced complete memory lapses, she needed to sleep multiple times a day due to exhaustion, speech was difficult, she suffered from left sided weakness, and she became overwhelmed quickly. She also suffered from light and noise sensitivity.

- She did not believe that the "damage to [her] brain]" would recover, though she was due to attend a specialist neurorehabilitation centre once a week to help understand her symptoms and manage her brain injury.

- In her view, she would never be able to work again in any capacity.

27. On 26 April 2022, NHS BSA did not uphold Mrs S' stage two IDRP appeal. It explained that the stage two appeal had been reviewed by a new Medigold MA (**the Third MA**). The Third MA drafted a report (**the Third Report**) which took into consideration the 2020 Application, the First and Second Reports and the medical information Mrs S submitted with her appeals. The Third MA agreed that, at the time of leaving NHS employment, Mrs S was not permanently incapable of undertaking employment of the like duration, so the Tier 2 criteria were not met.

28. A summary of the Third Report and NHS BSA's decision is set out below:-

- The causes for Mrs S' incapacity for work were chronic widespread musculoskeletal pain, PTSD, and perceived neurocognitive impairment following a road traffic accident. It was accepted that without appropriate treatment, Mrs S would be unlikely to return to any form of work.

- The medical evidence available indicated that Mrs S was suffering from a mild head injury with subsequent post-concussion symptoms. Most of her subjective neurological and cognitive symptoms were unexplained and any medical investigations found no underlying causes.

- At the time Mrs S left NHS employment, she was some 16 years away from her NPA. With the benefit of available and future treatments, it was expected that Mrs S would undertake less complex work, with lower levels of responsibility. This would need to be office/home based using a telephone, computer or paperwork.

- The Third Report reiterated the available and potential treatments that were outlined in the Second Report.

- It was open for Mrs S to request a reassessment against the Tier 2 criteria, within three years of the Tier 1 award. Any requests for a Tier 2 reassessment needed to be submitted by 15 November 2024, with any medical evidence provided relating to the physical/mental infirmity that qualified her for the Tier 1 benefits.

- If after the Tier 2 reassessment she was granted Tier 2 benefits, it would be payable from the date of the Tier 2 award, not the Tier 1 award.

29. NHS BSA has explained that Mrs S did not subsequently apply for a Tier 2 reassessment by 15 November 2024, three years from the date she was awarded Tier 1 benefits.

The Pension Ombudsman's Position on Ill Health Benefits

30. When someone complains that they have not been awarded the ill health (or incapacity) pension they think they should get, the Pensions Ombudsman looks at the way the decision has been reached.

31. The Pensions Ombudsman will not look at the medical evidence in order to make his own decision based on it, nor will he ask for more medical reports. Rather, he will consider whether the decision-maker has: (i) gone about making the decision in the right way; and (ii) made a decision that is reasonable based on the evidence. The Pensions Ombudsman does not have to agree with the decision. He will not intervene just because he thinks the decision-maker could have reached a different decision.

32. The Pensions Ombudsman will look at whether the decision-maker has followed the scheme's rules. Different pension arrangements have different rules about ill health pensions. For example, sometimes the decision will be made by the employer, sometimes by the scheme's trustees or managers and sometimes by a combination

of these. The Pensions Ombudsman will look to see whether the right person has made the decision.

33. If the Pensions Ombudsman thinks the decision-maker has reached the decision in the wrong way he will usually direct them to take the decision again in the proper way. For example, he may ask them to obtain more evidence.

34. The Pensions Ombudsman can also look at whether there was any maladministration, such as delay. If he finds maladministration, he may award compensation for any non-financial injustice, such as distress or inconvenience.

Adjudicator's Opinion

35. Mrs S' complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA. The Adjudicator's findings are set out below in paragraphs 36 to 51.

36. Regulation 90, of the 2015 Regulations, provided that Mrs S would be entitled to the immediate payment of a pension if she satisfied the Tier 1 conditions at the date her NHS employment ended. If she also satisfied the Tier 2 conditions, she would be entitled to a Tier 2 addition. The Tier 2 conditions included the requirement that Mrs S was considered permanently incapable of regular employment of like duration to her NHS employment. Under the 2015 Regulations, permanently meant likely to last until Mrs R attained NPA, which was 67.

37. When referencing employment of like duration, the 2015 Regulations made clear that the decision-maker must have due regard to the number of hours previously worked, which in Mrs S' case was 30 hours a week as a 111 clinical adviser. The employment did not have to be of the same or similar type to that which Mrs S undertook for the NHS; it could be any kind of employment for the same number of hours per week, in a similar shift pattern.

38. The decision as to whether Mrs S met the eligibility requirements for Tier 1 or Tier 2 was for the SMA to make in the first instance, under delegated authority from NHS BSA. This was a finding of fact; Mrs S either met the conditions set out in Regulation 90 or she did not. The stage one and two IDRP decisions were made by NHS BSA. The Adjudicator was satisfied that the decisions were made by the correct decision-maker, so the decisions could not be challenged on such a basis.

39. The Adjudicator considered that the part of Mrs S' complaint which related to Medigold was outside the remit of the Pensions Ombudsman's (**the PO**) Jurisdiction. The Personal and Occupational Pension Scheme (Pensions Ombudsman) Regulations 1996 and sections 145 to 152 of Part X of the Pension Schemes Act 1993 provided that the PO could only accept, and investigate, claims brought against a scheme manager/administrator, trustee, or employer. Medigold fell outside of each of the outlined categories.

40. The MAs were governed and answerable to their own professional bodies and the General Medical Council. However, the Adjudicator's view was that if there had been an error or omission of fact on the part of the MA, NHS BSA, as the decision-maker, would be expected to seek clarification.

41. The decision as to whether Mrs S satisfied the Tier 1 or 2 criteria was one that could not be made with the benefit of hindsight. Consequently, the way in which Mrs S' condition progressed after her NHS employment ceased was not relevant. However, this did not preclude the MA from taking into account later reports that provided further insight and context to Mrs S' condition at the date her NHS employment ended.

42. The Medigold MA's said Mrs S suffered from a number of different conditions; however, a great deal of her conditions and resultant symptoms were attributed to two traumatic events that occurred between 2019 and 2020. The first event was a near fatal road traffic accident in February 2019. The second was when Mrs S caught COVID-19 and had to be taken into hospital for two weeks in 2020. Primarily, Mrs S was suffering from chronic pain, PTSD brought on by the traumatic events and also left-sided weakness, the cause of which was unknown, at the time of the 2020 Application.

43. The Medigold MA's also accepted that Mrs S' PTSD would not resolve permanently. However, the First MA was of the opinion that once Mrs S re-started her EMDR and reprogramming treatment, she would, on the balance of probabilities, regain sufficient functionality to undertake a sedentary office/home based prior to her NPA. The Second MA agreed with this and highlighted a number of treatments that Mrs S could undergo to allow her to return to employment of like duration (see paragraph 22 above for the listed treatments).

44. The Second MA noted that Dr Davies' report of 7 April 2021, hypothesised that Mrs S' left-sided weakness could be the result of: "conversion syndrome i.e. a physical manifestation of an underlying psychological issue, possibly related to the psychological trauma of the accident". The Second MA also inferred that there may be a connection between Mrs S' pain and mental health as she was still undergoing the litigation process for her road traffic accident.

45. The Third MA agreed with the previous MAs opinions and reiterated that with the benefit of a number of treatments, for both Mrs S' mental and physical health, it was likely that Mrs S could undertake alternative employment before her NPA. However, it was agreed that Mrs S may apply for a reassessment review, in accordance with Regulation 93.

46. Having taken into account the reports of each respective MA, the Adjudicator agreed that the MAs had considered all of the medical evidence available to them. Further, each of the MA's understood the criteria that needed to be met for Mrs S to be eligible for a Tier 1 or 2 benefit. The reason why Mrs S did not meet the Tier 2 criteria was clearly explained in that there were still treatments, such as EMDR and trauma-based

CBT, that could still be undertaken to help improve Mrs S' overall functionality. The type of alternative work and duties that Mrs S could potentially undertake were all considered by the MAs, as well as Mrs S' former NHS role/hours.

47. Mrs S had commented that the MAs did not sufficiently consider the effects of her left sided weakness and cognitive impairment, following the road traffic accident. In the Adjudicator's view, the MAs did consider this aspect of Mrs S conditions; however, at the time of the 2020 Application, and the stage one and two appeals, there was no confirmed diagnosis, or apparent cause, for these symptoms. Based on the medical reports, there were theories that it was linked with the psychological impacts of the road traffic accident. However, the symptoms were still under investigation at the time.

48. It was open to NHS BSA to accept Medigold's MAs opinions, unless there was a good reason why it should not do so or should not do so without seeking clarification. NHS BSA could only be expected to review the medical evidence from a lay perspective; it was not expected to challenge medical opinions. The kind of things it could be expected to look out for were errors or omissions of fact on the part of the MA, or a misunderstanding of the relevant Regulations.

49. NHS BSA, as the decision-maker, needed to consider Mrs S' IHER appeals in line with the 2015 Regulations and properly explain why her application could, or could not, be approved. In this instance, NHS BSA accepted the MAs opinions expressed in the First, Second and Third Reports.

50. The Adjudicator did not identify any reason/s why NHS BSA should not have relied on the advice it received from the MAs. So, there was, in the Adjudicator's opinion, no grounds to remit the matter back to NHS BSA to reconsider.

51. The MAs recommended that Mrs S should be subject to a Tier review, within three years of the date her Tier 2 IHER began. She had until 15 November 2024 to request a Tier review, but she did not. The Adjudicator believed that Mrs S was provided with sufficient warning/information, about her eligibility to request the Tier review. As the deadline of 15 November 2024 had passed, she was no longer entitled to a Tier review.

52. Mrs S did not accept the Adjudicator's Opinion, and the complaint was passed to me to consider. Mrs S has provided copies of up-to-date medical reports from her specialist, as well as a list of diagnosed conditions that she suffers from. She also says:-

- She did not apply for the review of her Tier 1 IHER pension as her complaint was awaiting investigation by TPO.
- Her health issues are deteriorating.
- Several of the referrals made during or after COVID were unsuccessful in repairing her physical and mental health.

- She has Osteoarthritis (OA) all over. She had a thumb replacement and a finger fused in November 2024 and is now waiting to have her other hand done. In January 2025, she had a hip replacement. Her hip continues to cause her pain. She also has OA in her feet and spine.

- Her lungs have deteriorated and there are no other medications she can try. Her consultant wants her to try biological medication.

- Her brain injury continues to impact her daily functionality by causing cognitive delays, memory issues, as well as hearing delays. She has been provided with two white noise machines to help deal with the tinnitus that she suffers from;

- She spends most days at home as she finds it difficult to communicate. She has to lip read due to the hearing delays which she finds exhausting. How could she work from home?

Ombudsman's decision

53. While I have considerable sympathy for Mrs S, it is important to highlight my role in this process. My role is not to review the medical evidence and decide whether Mrs S should in fact have been awarded a Tier 2 IHER pension. I am primarily concerned with the decision-making process that was followed by NHS BSA.

54. When considering how a decision has been made, I will generally look at whether:

- the appropriate evidence has been obtained and considered;

- that the applicable scheme rules or regulations have been correctly applied; and

- that the decision is explained and supported by the available relevant evidence.

55. NHS BSA was required to assess Mrs S' IHER application in accordance with the 2015 Regulations, and to do so in consultation with its MAs. Having reviewed the First, Second and Third Reports, I find that each of the MA's understood the relevant regulations, considered the medical evidence and explained their rational clearly in their respective reports. The MAs agreed that while Mrs S met the criteria under regulation 90(2)(c), it could not be said with any certainty that she met the Tier 2 criteria under regulation 90(3)(b). That is, on the balance of probabilities, that she was "permanently incapable of engaging in regular employment of like duration".

56. The MAs were of the opinion that there were mental and physical treatments that could, or were, still to be undertaken. Their view was that these treatments were likely to improve Mrs S' overall functionality allowing her to be capable of undertaking office/home-based employment that was non-complex, non-physical, sedentary and supported before her NPA.

57. Concerning Mrs S' comments regarding the way in which the MAs considered any evidence relating to her "left-sided weakness". It was for the MAs to decide the weight

to be attached to the medical evidence (including little or none). It appears that less weight was placed on this condition given that it was still under investigation as its cause was, at the time, unknown. However, it was still considered during the decision-making process.

58. I have every sympathy for Mrs S that her conditions have not improved since she left her NHS employment. I do not doubt that the incapacity she experiences has increased. But, in and of itself, that does not invalidate the decision that was made. A decision is made on the balance of probabilities and there will always be an element of uncertainty about a prognosis.

59. An assessment as to the propriety of the decision-making process should not apply the benefit of hindsight. A decision can only be assessed based on the evidence which was, or could have been, available to the decision-maker at the time it was made. So, I have set aside Mrs S' newly submitted medical evidence as it was not available to NHS BSA and the MAs at the time of her IHER application and appeals.

60. I find that the MAs, and NHS BSA, properly considered Mrs S' application and appeals.

61. The MAs recommended that, in accordance with regulation 93, that Mrs S be allowed the opportunity to apply within three years of the date of the Tier 1 award for a Tier 2 review, as there was some uncertainty as to the likely prognoses of her conditions. This was clearly communicated by Medigold to Mrs S at the time of the Tier 1 award and by NHS BSA when it issued its stage one and two IDRP decisions.

62. Mrs S did not request a Tier review by the relevant date. Mrs S says this was because she was waiting for the outcome of her TPO application. Nonetheless, Mrs S could have applied for a review. If she was unsure, she could have queried with either NHS BSA or TPO whether doing so would impinge on her complaint. But she did not do so. Unfortunately, Mrs S is no longer eligible for a review, and there is no discretion open to NHS BSA under the 2015 Regulations to enact a review outside of the three-year period.

63. I appreciate that Mrs S will find this outcome very disappointing, but I do not uphold her complaint.

Dominic Harris
Pensions Ombudsman

15 May 2025

Appendix 1

The National Health Service Pension Scheme Regulations 2015 (SI2015/94) at the date Mrs S' NHS employment ended

As relevant, regulation 90, 'Entitlement to ill-health pension', provided:

> "(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 has not attained normal pension age;
>
> (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 has 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."

Regulation 91 provided the criteria which NHS BSA must take into account when making a decision on whether a member is eligible for a Tier 2 IHER benefit. As relevant:

> "…
>
> (3) For the purpose of determining whether M is permanently incapable of engaging in regular employment of like duration as mentioned in paragraph (3)(b) of regulation 90, the scheme manager must –
>
> (a) have regard to the factors in paragraph (4), no one of which is to be decisive; and

(b) disregard the factors in paragraph (5).

(4) The factors mentioned in paragraph (3)(a) are –

(a) whether M has received appropriate medical treatment in respect of the infirmity;

(b) such reasonable employment as M would be capable of engaging in if due regard is given to –

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

(iv) M's previous practical, professional and vocational experience,

irrespective of whether or not such employment is available to M.

(c) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation, having regard to -

(i) M's mental capacity; and

(ii) M's physical capacity;

(d) the type and period of training it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the training, having regard to –

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

(iv) M's previous practical, professional and vocational experience; and

(e) any other matter the scheme manager thinks appropriate.

(5) The factors mentioned in paragraph (3)(b) are –

(a) M's personal preference for or against engaging in any particular employment; and

(b) the geographical location of M."

Regulation 93, 'Re-assessment of entitlement' provided:

"(1) This regulation applies if—

(a) in respect of a member (M) the scheme manager is satisfied as mentioned in regulation 90(2)(c); and

(b) at the time M is awarded a pension the scheme manager gives M notice in writing as mentioned in paragraph (2).

(2) The notice is that M's case may be considered once within a period of three years beginning with the date of the award to determine whether, at the date of the consideration, M meets the condition in regulation 90(3)(b).

(3) M may apply to the scheme manager for a review of whether M subsequently meets the condition in regulation 90(3)(b) if—

(a) M makes the application in writing no later than the relevant date;

(b) the application is accompanied by further written medical evidence—

(i) relating to whether, at the date of the scheme manager's review, M has the physical or mental infirmity mentioned in regulation 90(3)(b); and

(ii) that relates to the same physical or mental infirmity as a result of which M met the condition in regulation 90(2)(c);

(c) no previous application for a review has been made under this paragraph; and

(d) M has not become entitled to a Tier 2 IHP in respect of any later service under regulation 97.

(4) The relevant date in paragraph (3)(a) is—

(a) the last day of the period of three years after the giving of notice under paragraph (1)(b); or

(b) if M engages in further NHS employment during that period, the first anniversary of the day on which the employment commences or, if sooner, the last day of that period.

(5) If, after considering the further medical evidence the scheme manager determines that M has the physical or mental infirmity for the purposes of regulation 90(3)(b), with effect from the date the determination is made, M—

(a) ceases to be entitled to a Tier 1 IHP; and

(b) becomes entitled to a Tier 2 IHP.

(6) If a determination is made under paragraph (5), in calculating the Tier 2 addition pursuant to regulation 92(3), in the explanation of factor E for “period starting on L+1” substitute “period starting on day of the determination under regulation 93(5).”

Appendix 2

Extracts from the medical reports submitted with Mrs S' 2020 Application

Dr Sahal's (Consultant Respiratory Physician) reports dated 1 May 2020:

> "Unfortunately, [Mrs S] has had some troubles since her last appointment. She had Covid-19 pneumonia and was admitted to Good Hope Hospital where she was very unwell and required high flow oxygen. She told me that they even considered intubation but thankfully she has survived Covid-19 and has been discharged. She is making a gradual recovery but she is not feeling back to her usual self yet she says.
>
> … I explained the pathophysiology of bronchiectasis. We discussed the importance of doing regular chest clearance exercises. She will watch a YouTube and start exercises. I will also send her a prescription of carbocisteine as she finds it difficult to expectorate phlegm. It might help her expectoration. She also understands that if her phlegm become thick and sticky and difficult to expectorate and she gets more short of breath then she will have a two-week course of doxycycline. She will do peak flow monitoring as well. If her peak flow levels drop along with symptoms of infection then she could have a 5–7-day course of prednisolone along with 14-day course of doxycycline. I will see her again in the clinic in 3-4 months' time. In the meantime, hopefully if we start to get over the Covid-19 pandemic then she can have sleep studies and lung function test. If she keeps on having recurrent infections and the sputum specimens are positive then we will consider starting her on azithromycin prophylaxis."

Dr Mutagi's (Locum Consultant in Pain Management) report dated 21 July 2020:

> "
>
> **Comments**
>
> …
>
> Still recovering physically and psychologically from the serious road traffic accident requiring ITU care for ongoing rehab. Currently in severe global body pain – magnified by and activity. Still leading sedentary lifestyle and admits to panic attacks and tearfulness. On moderate opiodis doses (Morphine equivalent 80-100mg day) with minimal benefit but dependence (withdrawal effects on missed doses). Admits to grieving her pre-accident lifestyle. Does not feel she will ever return to work.
>
> **Plan**

Continue ongoing psychological support. Discussed psychological treatments is the key therapy to reduce the pain threshold. Discussed link with her psychological circumstances. [Mrs S] will be reviewed in 6 months' time."

Appendix 3

Extracts from the medical reports submitted with Mrs S' stage one IDRP appeal

Dr Sahal's (Consultant Respiratory Physician) report dated 1 May 2020

> "Today I spoke to [Mrs S] on the phone. Since last clinic appointment she has had HRCT which showed evidence of mild bronchiectasis but unfortunately, due to Covid-19, she could not have her lung function test or sleep studies performed. Her blood test which she had after last clinic appointment showed no evidence of atopy and her eosinophil count was normal.
>
> Unfortunately [Mrs S] has had some troubles since her last appointment. She had Covid-19 pneumonia and was admitted to …Hospital where she was very unwell and required high flow oxygen. She told me they even considered intubation but thankfully she had survived Covid-19 and has been discharged. She is making gradual recovery but she is not feeling back to her usual self, yet she says.
>
> We had a lengthy discussion, and I explained the pathophysiology of bronchiectasis. We discussed the importance of doing regular chest clearance exercises. She will watch a video on YouTube and start exercises. I will also send her a prescription of carbocisteine as she finds it difficult to expectorate phlegm. It might help her in expectoration…"

Dr Harland's (Consultant Spinal Neurosurgeon) report dated 8 February 2021

> "…[Mrs S] underwent surgery as stated above for abdominal haematoma related to her liver laceration. Since the accident, [Mrs S] has been troubled by short-term memory issues in addition to left-sided arm weakness and generalised spinal pain. She also reports worsening stress incontinence which has been recently reviewed by a urologist.
>
> I had the opportunity to review a cervical MRI scan performer in August 2019. This is relatively normal apart from increased signal on the T2 sequences between the anterior arch of C1 odontoid peg and the clivus. I do wonder whether there may have been ligamentous disruption as a result of the trauma."

Dr Harland's report dated 18 February 2021

> "Her recent imaging was most reassuring. Her brain scan was reported as normal. Her tonsils are a little low but not enough to be symptomatic. Her cervical and thoracic spine are blameless.
>
> On examination, [Mrs S] mobilised with the aid of crutch. She appeared to have a slightly poor fine rapid hand movement on the left-hand side… Her reflexes were generally brisk, again, more on the left than the right.

I explained to [Mrs S] that in the absence of a structural abnormality, that further intervention on my behalf would not be of benefit. I am unclear as to the exact cause of [Mrs S'] ongoing symptoms, whether they may be secondary to a degree of hypoxia at the time of the accident is difficult to be certain."

Dr N Davies' (Consultant Neurologist) report dated 7 April 2021

"…has a past history of AF/atrial flutter with cardiac ablation September 2020, asthma, bronchiectasis, Covid-19 infection March 2020. 2x caesarean sections and road traffic accident February 2019, whilst in Iceland, subsequently requiring two laparotomies [abdominal surgery]. The patient has hypertension. She is currently on Edoxaban, Adizem, Azithromycin, Flecainide, Fostair, Gabapentin 300mg once daily, Omeprazole, Oxycontin, Ramipril, Carbocisteine, Venlafaxine 75mg once daily and PRN Tramadol…

The patient was a front seat passenger in a head-on crash with a 4x4, …in February 2019…the patient said that she had a fractured sternum, multiple rib fractures, hepatic lacerations and may have had a "bleed on the brain", although this is by no means certain. Ten days later, following increase in shortness of breath, she was found to have a pneumothorax.

…

The main issue now are that the patient does not feel "as she was before", she is forgetful with words finding difficulties, poor concentration and low mood and short fuse…she has left-sided weakness and loss dexterity without numbness.

…

I understand from the patient that litigation is ongoing, and I was very sorry to hear that a passenger in the other car had since died.

…

I have reviewed the MRI scan of the head and whole spine from Heath Lodge clinic carried out on 17 February 2021. These did not show any significant cerebral lesion or evidence of spinal-cord or root compression but mild tonsillar descent.

I explained to the patient that she had had a mild head injury with subsequent post-concussion symptoms, cervicogenic pain and I think the left-sided weakness is most likely to be due to a conversion syndrome i.e. a physical manifestation of an underlying psychological issue, possibly related to the psychological trauma of the accident…"

Appendix 4

Extracts from the medical reports submitted with Mrs S' stage two IDRP appeal

Dr Usuah's (Trauma/CFS fellow) report dated 24 August 2021

> "…This referral was made following ongoing complaints of memory lapses, headaches, word finding difficulties with word mixing, lack of concentration, persistent dizziness and blurriness of the eyes with bilateral tinnitus involving both ears. She tells me her emotions have become quite labile in recent times. Her headaches are quite persistent and occasionally is associated with malaise and generalised ill feeling. She gives history of inability to concentrate while reading. There are no other constitutional symptoms. The weakness on the left side is being followed up with Physiotherapy but she has not had any formal Ophthalmology assessment and antalgic assessment for bilateral tinnitus. She currently has Gabapentin 300mg once a day for neuropathic pain and paracetamol also.
>
> …
>
> We have gone through her symptoms together and I am quite suspicious that this might be some form of post-concussion syndrome. The plan of action would be to have a functional MRI of the brain concussion sequence done. She would also benefit from a Neuropsychology, an ophthalmology and formal audiology/vertigo assessments done review which we will organise…"

Dr Falope's (Consultant in Rehabilitation Medicine) report dated 20 January 2022

> "[Mrs S] has been reporting persistent pain, subjective weakness on the left side of the body, fatigue, word finding difficulties, poor concentration and low mood. She often reports feeling anxious and panicky and being unable to go out and also unable to cope with noise and bright light. She feels that her memory has not been right. She has been assessed by different experts and referred to Neurosurgeon who then informed her she does not need to see a Neurosurgeon and she was referred to a Neurologist.
>
> …
>
> She is receiving psychological talking therapy from a Clinical Psychologist … She is finding it hard to accept her current situation.
>
> …
>
> The other party has admitted liability for her injuries, but things are yet to be settled.
>
> Overall, we believe that [Mrs S] would benefit from future rehabilitation to help her cope with her current difficulties and help her to adjust to her injuries and manage fatigue and her emotional and cognitive difficulties…

> In the meantime, we have suggested that [Mrs S] continues with her 1:1 support from the Clinical Psychologist”