CAS-86747-P1R3

Ombudsman's Determination

Applicant	Miss N
Scheme	NHS Pension Scheme (**the Scheme**)
Respondents	NHS Business Services Authority (**NHS BSA**)
	King's College Hospital NHS Foundation Trust (**the Trust**)

Outcome

1. I do not uphold Miss N's complaint and no further action is required by NHS BSA and the Trust.

Complaint summary

2. Miss N has complained that NHS BSA incorrectly decided to decline her application for ill health early retirement (**IHER**) benefits from the Scheme.

3. She also says that the Trust:

   - following her workplace injury in 2001, originally redeployed her to an unsuitable role that involved heavy lifting; and

   - in 2013, failed to provide NHS BSA with all the information about her ill health held in its records so that a decision could be made on her IHER application.

Background information, including submissions from the parties

4. The relevant regulations are the National Health Service Pension Scheme Regulations 2008 (as amended) (**the Scheme Regulations**).

5. On retirement from active service, regulation 2.D.8[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:

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

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] .

6. 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 are enhanced by two thirds of his/her prospective membership up to Normal Retirement Age (**NRA**) of 65.

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

8. Miss N was previously employed by the Trust as a part-time clerical worker.

9. In 2013, Miss N applied for IHER benefits from the Scheme prior to leaving NHS employment. At the time she had been diagnosed as suffering from numerous medical conditions including: (a) Ehlers-Danlos syndrome; (b) stage 4 Hodgkin's lymphoma; (c) pelvic enterocele, cystocele and vaginal prolapse; (d) chronic right shoulder pain and weakness; (e) abdominal hernia with divarication of the rectus muscles; (f) hypertension; (g) vitamin D deficiency; (h) peripheral neuropathy; and (i) dyspepsia.

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

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

12. In its letter dated 24 December 2013, Atos Healthcare (**Atos**), the SMA at the time, informed Miss N that there was insufficient evidence for it to make a decision. It listed Miss N's currently diagnosed medical conditions as summarised in paragraph 9 above and also the medical evidence which it had considered, that is:

- AW33E completed by consultant occupational health (**OH**) physician, Dr Batty, dated 10 December 2013;

- a report from the consultant haemato-oncologist, Dr Marcus, dated 13 November 2013;

[2] "permanently" means the period until Normal Retirement Age of 65..

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

- a report from the General Practitioner (**GP**), Dr Howard, dated 1 November 2013;
- copies of various hospital correspondence from cardiology, rheumatology and gynaecology out-patients;
- copies of OH records and reports; and
- information provided by the Trust.

13. Atos explained in its letter that:-

- Miss N was diagnosed with Hodgkin's lymphoma in 2012. She was currently being treated for this condition and following discharge, she would be unable to work for four months. After that, she might be able to resume work on a part time basis.
- As treatment was ongoing, it was not possible to predict the outcome of this condition and its impact on her future functional capabilities at this stage.
- The clinical picture would likely be clearer in six months' time.
- So it would review her case in six months and contact her again at that time.
- It could review her case earlier if she provided further medical evidence that would enable it to do so.

14. Miss N voluntarily left NHS employment on 31 March 2014 for health reasons after a period of long term sickness absence.

15. Atos failed to review Miss N's IHER application in June 2014.

16. In its e-mail dated 4 March 2021 to Miss N, NHS BSA said that:-

- It would consider her IHER application retrospectively because the Trust had confirmed that she left NHS employment in 2014.
- It could only take into account: (a) any medical health issues that she was suffering from at the time she left NHS employment; and (b) any treatments that she had for these conditions and how they had impacted on her future functional capabilities.
- Regrettably, Atos did not carry out its review in June 2014.
- She should complete another form AW33E and submit it with any further evidence about the health conditions that caused her to leave her NHS role on 31 March 2014 and the outcomes of her ongoing treatments.

17. In August 2021, Miss N sent NHS BSA her completed form AW33E together with additional medical evidence for consideration. She also informed NHS BSA that she was surprised her original application in 2013 had been put on hold because her illness was not just down to her Hodgkin's lymphoma.

18. In its letter dated 23 November 2021, Medigold Health (**Medigold**), the current SMA, informed Miss N that her application for IHER benefits had been declined. It quoted from its medical adviser (**MA**):

> "This is an initial application for ill health retirement benefits under the Scheme.
>
> My understanding is that I am required to provide advice as to whether the member was likely to have met the pension scheme conditions at the time the member left employment on 31 March 2014.
>
> Permanent incapacity is assessed by reference to the normal benefit age of 65 years.
>
> The medical evidence considered:
>
> - The referral documents;
> - Personal statement dated 11 November 2013;
> - Personal statement dated 24 August 2021;
> - Form AW33E, part C, completed by Dr L Batty, consultant OH physician, dated 10 December 2013;
> - OH report[4], dated 2 January 2008, from OH advisor, A Ike;
> - OH report, dated 25 July 2008, from OH physician, Dr O Elekima;
> - OH reports[5], from consultant OH physician, Dr J Wilford, dated 7 July 2011 x 2;

[4] In her report dated 2 January 2008 to the Trust, Dr Ike said that:

"As seen today, she (Miss N) should be fit to continue in her substantive post, provide that she has been signed back to work by her GP. However, I would recommend a graduated return back to work…I would advise that she should not carry out work that involve heavy manual handling and/or strenuous pushing or pulling…

Furthermore, please carry out a risk assessment of her job role as soon as she returns back to work in view of the recent operation and her general state of health and also to ensure compliance with the Health & Safety Executive guideline and the Trust's policy/protocol on manual handling…"

[5] In her reports dated 7 July 2011, Dr Wilford said that:

""Clinically she exhibits signs of Ehlers-Danlos Syndrome…The increased elastin is probably largely responsible for the surgical problems she has suffered in the past. Gastrointestinal motility problems are also linked to the syndrome…

- Report from department of colorectal surgery, dated 21 July 2011, Mr J Nunoo-Mensah, consultant colorectal surgeon;
- OH reports, from Dr L Batty, dated 1 November 2011, 28 November 2011, 22 February 2012[6], 18 December 2012 and 9 April 2013;
- Report from hypermobility clinic, rheumatology department, dated 6 October 2011, from Dr H Kazkaz, consultant rheumatologist;
- Letter from department of cardiology, dated 1 February 2012, Dr S Karla, specialist registrar in cardiology;
- MRI scan, dated 24 April 2012, reported by Dr P Peddu;
- OH report[7], dated 25 April 2012, Dr J Gration, OH physician;
- Letter from haematology department, dated 24 July 2013, from lymphoma clinical nurse specialist, E Wellving;

…if this does turn out, as I suspect, to be the key unifying factor in her medical history, it will greatly simplify management and particularly be encouraging future prognosis. There is nothing in her job at present requiring heavy lifting, and once investigations are completed and diagnosis confirmed, she should be able to increase her working hours and thus earn herself both a decent wage and a proper pension. Prof Grahame's view is that most ED patients remain active and untroubled by symptoms well into old age, unless they fall into the category who are more than usually vulnerable to pain. This is not her case at least at present…"

"Unfortunately some years ago, prior to implementation of Picture Archive and Communication Systems (**PACS**), some of her job tasks (involving lifting of heavy packets of X rays) were likely to impact adversely on her underlying condition.

…Since PACS has resulted in an absence of heavy lifting of X ray films in this post, she is fit for all tasks. Her current short hours have been organised to manage her surgical interventions (several operations) and investigations without incurring additional sick leave. It is important to understand Miss N clearly would be held to qualify under the Disability Discrimination Act now incorporated into the Equality Act 2010. The exacerbations due to her underlying medical condition were the recurrent hernias she suffered for which she required surgical repair…

In summary, Miss N is now nearing completion of medical investigations leading to a diagnosis of an underlying condition with a good prognosis. The only contraindications for her to successfully manage her work are that of heavy lifting and since the advent of PACS there is no heavy lifting requirement in her job."

[6] In her report dated 22 February 2012, Dr Batty said that:

"Despite having to deal with various health related issues, she (Miss N) assures me that, all is going well at work in relation to her fitness to work and no new adjustments are deemed to be necessary…"

[7] In his report dated 25 April 2012 to the Trust, Dr Gration said, following a face to face consultation with Miss N:

"From the work perspective, Miss N appears largely fit for work despite her health conditions, although she does feel that her chair at work is not supportive / adjustable enough….

"Overall, she feels somewhat better now than has in recent months…"

- Letter from urodynamics clinic, dated 14 May 2013, from senior clinical research fellow, Dr G Thiagamoorthy;
- Letter from department of surgery, dated 30 January 2012, from senior clinical research fellow, Mr S Nachimuthu;
- GP report[8], dated 1 November 2013, Dr K Howard;
- Letter from haematology department, dated 13 November 2013[9], from consultant haemato-oncologist, Dr R Marcus;
- Letters from haematology department, dated 5 March 2014[10], 22 July 2015 and 20 January 2016, from Dr S Kassam, consultant haematologist;
- GP reports, dated 9 November 2021 and 21 October 2021, Dr A Fernandes;
- Letters from department of colorectal surgery, dated 11 October 2011, from Mr J Nunoo-Mensah, consultant surgeon, and dated 23 November 2011 from Mr R Durai, colorectal surgical registrar;
- Letter from department of surgery, 30 April 2012, from Ms A Chang, consultant surgeon;
- Letters from haematology department, dated 7 September 2012, 23 November 2017 and 21 December 2017 x 2, Professor S Devereux, consultant haemato-oncologist;
- GP reports, dated 22 March 2013 and 1 April 2014, Dr S Parihar;

[8] In her letter dated 1 November 2013, Dr Howard said that:

"As her primary care physicians, we have not been actively involved in her care, this has been provided by the specialists. However, I would support her application for ill health retirement in view of her complex medical history."

[9]In his letter dated 13 November 2013, Dr Marcus said that:

"Miss N is currently being treated for Hodgkin's lymphoma…She is on her second course of therapy…and will be in hospital for four weeks. She will then be unable to return to work for four months. She may be able to resume work on a part time basis to start with after this time but please contact me again in February/March 2014 for another update on Miss N's condition."

[10]In his letter dated 5 March 2014, Dr Kassam said that:

"This lady is still not quite back to full functioning. Her main symptoms have been numbness in her hand and feet when it gets cold…On examination she has normal power in her arms and no sensory loss. There is no loss of function in her hands…I have said this lady should consider going back to work now…"

- Letter from department of haematological medicine, dated 26 November 2014, from specialist registrar in haematology, Dr C Graham;
- Letter from department of emergency and acute medicine, dated 3 September 2015, Dr M Kaminski, CMT Level 2;
- Letter from institute of liver studies, dated 20 January 2016, from Mr M Papoulas, senior clinical fellow;
- Letter from urogynaecology clinic, dated 9 January 2017, Dr E Johnson, specialist to Professor Cardozo;
- Discharge summary, dated 11 May 2017, day surgical centre;
- Letter from hepatology outpatient clinic, dated 25 September 2017, Dr P Harrison, consultant hepatologist;
- Letter from breast surgery care unit, dated 14 November 2018, Mr J Roberts, consultant breast surgeon;
- Letter from colorectal nurse specialist, W Ness, dated 6 February 2019;
- Letter from colorectal department, dated 15 July 2019, Mr V Alberto, registrar;
- Letter from diabetes and endocrinology department, dated 12 August 2019, Dr G Bano, associate specialist;
- Letter from department of haematology, dated 4 September 2020, Dr A Kuhnl, consultant haemato-oncologist;
- Letter from department of neurology, dated 30 October 2020, from Dr E Coutinho, consultant neurologist;
- Letters from department of surgery, dated 8 June 2021 and 13 September 2021, from Ms A Yi-Chien Tsai, specialist registrar;
- Report from department of endocrinology, dated 30 June 2021, Dr K Jeyaraman, consultant in diabetes and endocrinology;

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

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member’s incapacity was likely to have been permanent.

Miss N was diagnosed with Ehlers-Danlos syndrome (hypermobility) 10 years after having had an unusual injury in July 2001 whilst manhandling a patient. This was thanks to the recognition by the OH physician, Dr Wilford, who referred her on to the rheumatologist for confirmation. From the perspective of this condition the ongoing management would require pain killers and physiotherapy to prevent any further accelerated progression of the wear and tear type arthritis seen on x-rays of her knees and ankles. The OH advice was that her role should be adjusted to reduce manual handling and mobility requirements.

Miss N had a hysterectomy and posterior wall repair in 2007. She has had long term problems with constipation and urinary urgency and leaking. There was discussion by the GP and in the OH report that she was waiting for operations, but on subsequent specialist outpatients it has been determined that non-surgical treatments are required. Miss N has had abdominal wall hernias following her surgeries and these were repaired in 2007, 2010 and again in 2017. The associated advice is again in relation to any degrees of manual handling.

The main reason for Miss N's long term sickness absence in 2013 to the end of her employment was due to Hodgkin's lymphoma. She was initially diagnosed with this in 2012, had six rounds of chemotherapy ending in March 2013 with a relapse in July and a bone marrow transplant in November 2013. Miss N has been in remission for the Hodgkin's since then.

At the time of the end of her employment Miss N was experiencing ongoing fatigue and peripheral neuropathy from the treatment of her Hodgkin's and experiencing arm and leg pain from her Ehlers-Danlos syndrome. Dr Batty records that Miss N was waiting for pelvic operations and that she had doubts about Miss N's ability to return to employment.

I note the haematologist's report at the start of March of 2014 identifying that the main loss of function was due to the peripheral neuropathy in her hands and feet and that this occurred when it gets cold. However, on examination she had normal power in her arms, normal function of her hands and no sensory loss. The haematologist states an opinion that Miss N ought to think about returning to work "now".

At the time of leaving employment and therefore the consideration of the prognosis for the purposes of ill health retirement, Miss N had a diagnosis of Ehlers-Danlos syndrome which would explain the difficulties with tissue healing and the hernias following abdominal surgeries, her joint pains and in the absence of treatment the likelihood is that the pain and dysfunction that she had experienced would progress. As mentioned by the specialist, management of this would be through pain management and physiotherapy and prior to the onset of Hodgkin's lymphoma, the expectation of OH was that

she would be able to return into her job which had previously been successfully adjusted for.

At the time she left employment, Miss N was recovering from the bone marrow transplant treatment following the relapse of the Hodgkin lymphoma. The normal ongoing treatment is watchful waiting for the consideration of any further relapse. At that time, the 10 year survival rate was greater than 50%. The haemato-oncologist's opinion was that her level of functioning should continue to improve and they explicitly stated that she should consider returning to work.

The medical evidence contains considerable amounts of information relating to the progression of her health status and disorders following the end of her employment which has clearly seen her not recover, however I cannot take these into account as it is the prognosis at the point at the end of her employment, not the subsequent progression of her condition that is being assessed.

The AW33E part C from Dr Batty does contain an inconsistency. At paragraph G4 she states that she is unsure of the prognosis, but that Miss N will be unable to return to her role and then at G5 again that the prognosis is unclear with regards to her Hodgkin's (this is at variance to the haemato-oncologist's opinion) and that she was waiting for other operations for her pelvic wall condition. This opinion is not supported by the haemato-oncologist nor from the management of her hypermobility syndrome and there was no evidence at the time that she required surgical intervention.

The consideration is certainly finely balanced and indeed subsequently Miss N has not gone on to recover levels of functionality that have allowed her to return to work. But I reiterate that the consideration for ill health retirement is whether or not the medical evidence at the time of the end of employment supports a likelihood of permanent incapacitation to normal pension age and in my opinion, the medical evidence at that time was still of an expectation of recovery from her Hodgkin's lymphoma treatment and pain management and physiotherapeutic management to the extent that would allow her to return to the previous agreed levels of adjustments in her role.

In my opinion, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. This incapacity was unlikely to have been permanent. The tier 1 condition was unlikely to have been met for the reasons given above…"

19. Miss N was dissatisfied with the outcome of her IHER application and made a complaint under the Scheme's Internal Dispute Resolution Procedure (**IDRP**).

20. At both stages of the IDRP, NHS BSA informed Miss N that her complaint was not upheld because it agreed with the medical advice given by its MA that she did not satisfy the Tier 1 condition at the time she left NHS employment on 31 March 2014.

21. The MAs at each stage of the IDRP did not have any previous involvement with Miss N's case.

22. Relevant paragraphs from the Stage One and Stage Two IDRP decision letters dated 19 January 2022 and 2 March 2022, including the opinions expressed by the MAs, are set out in Appendix Two.

23. Following the complaint being referred to The Pensions Ombudsman (**TPO**), Miss N and NHS BSA made further submissions that have been summarised in paragraphs 24 to 34 below.

Miss N's position

24. She has experienced financial difficulties after leaving NHS employment.

25. After sustaining a workplace injury in July 2001, the Trust caused her "pain and suffering" through its "mismanagement"[11] of her injury by originally redeploying her into an unsuitable role that involved heavy lifting.

26. She should be awarded IHER benefits from the Scheme to compensate her for the damage the Trust has caused her both mentally and physically.

27. In 2013, the Trust failed to provide Atos with all the information it held about her ill health in order that a decision could be made on her IHER application.

28. The Trust had only "highlighted" to Atos her Hodgkin's lymphoma and not her workplace injury.

29. Despite providing NHS BSA with extensive medical evidence in support of her IHER application, she is disappointed that it still cannot see that her work injury caused: (a) a prolapse to her bladder and rectum; and (b) a subluxation to her collarbone.

30. Miss N also says that:-

- She had an unsuccessful hysterectomy surgery for the prolapse in 2007.

[11] Miss N filed a claim against the Trust with the London Soutth Employment Tribunal (**the Tribunal**).

In 2013, the judgement of the Tribunal was as follows:-

a) The Trust had discriminated against Miss N by treating her unfavourably in consequence of something arising from her disability, contrary to Section 15 Equality Act 2010;
b) The Trust discriminated against Miss N by failing to comply with a duty to make reasonable adjustments, contrary to section 21 Equality Act 2010;
c) The Trust indirectly discriminated against Miss N in relation to disability, contrary to Section 19 Equality Act 2010.
d) The claims for direct disability discrimination, indirect sex discrimination and under the Part Time Workers Regulations failed and were dismissed.

- She developed a hernia in 2008 that had to be repaired surgically. She became sick with helicobacter twice after this operation.
- She was disciplined by the Trust for “high level of sickness at work”.
- She suffered an internal injury from “the mesh coming away” in her stomach area and had to have another hernia operation in 2010.
- Shortly after this operation, she developed bowel obstruction / enterocele.
- In 2011, she was diagnosed as suffering from Ehlers Danlos syndrome.
- She subsequently developed Hodgkin’s lymphoma and following a stem cell transplant, the side effects caused an infection.

NHS BSA’s position

31. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Miss N’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.

32. 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.

33. Evidence which post-dates a member’s last day of employment will be taken into consideration but only to the extent that it relates to or provides an insight into the medical condition and circumstances as at the date the member’s employment terminated. Any deterioration in a medical condition after this date cannot be taken into consideration.

34. 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 Miss N 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

35. Miss N’s complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA and the Trust. The Adjudicator’s findings are set out below.

36. Under regulation 2.D.8 of the Scheme Regulations, Tier 1 IHER benefits were available to Miss N if NHS BSA, acting on medical advice, decided that her medical conditions would prevent her from permanently discharging the duties of her NHS employment efficiently. Its decision was made on the balance of probabilities.

37. So, for Miss N to meet the criteria for Tier 1 IHER benefits, she must be considered by NHS BSA to be permanently incapable of undertaking efficiently the duties of her NHS post until her NRA of 65.

38. If NHS BSA considered that Miss N was, more likely than not, also permanently incapable of regular employment of "like duration" to her NHS role, she would be entitled to Tier 2 IHER benefits.

39. 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 Miss N's eligibility for IHER benefits from the Scheme.

40. The PO is primarily concerned with the decision-making process. Namely, whether NHS BSA's decision is supported by the available medical evidence and any other evidence relevant to the case. The PO would consider: (a) whether the applicable scheme rules or regulations have been correctly interpreted, (b) whether appropriate evidence has been obtained and considered, and (c) whether the decision is supported by the available relevant evidence.

41. If the PO finds that the decision-making process was flawed, or that the decision reached by NHS BSA was not supported by the evidence, the case is normally remitted to NHS BSA to reconsider. The PO cannot overturn the decision just because he might have acted differently when presented with the same evidence.

42. 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. The reason would have to be obvious to a lay person; NHS BSA was not expected to challenge medical opinion. It might, however, be expected to seek an explanation if its own MA's opinion was at variance to that held by OH physicians and Miss N's own doctors, if one had not already been provided.

43. The Adjudicator noted that Medigold acknowledged in its decision letter dated 23 November 2021 that its views differed to that given by Dr Batty, OH physician, and it explained why this was. Similarly, the MAs at both stages of the IDRP explained why their views were different to those expressed by some of Miss N's treating doctors who supported her IHER application.

44. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to decline Miss N's IHER application, was taken after its MA had carefully considered the medical evidence provided with the application, which it listed in its decision letter.

Medigold had to weigh the medical evidence and take a decision based on the balance of probabilities.

45. At the time her NHS employment ended, Miss N suffered from several medical conditions as shown in paragraph 9 above. The MA was required to consider whether Miss N's incapacity for her NHS role at that time was likely to be permanent; that is, whether it was likely to last until her NRA of 65.

46. In Miss N's case, it was the MA's medical opinion that:-

- Her diagnosis of Ehlers-Danlos syndrome would explain: (a) the difficulties with her tissue healing; (b) the hernias following abdominal surgeries; and (c) her joint pains. In the absence of treatment, the pain and dysfunction that she had experienced would likely progress. Specialist management of this condition would be through pain management and physiotherapy.

- The main reason for her long term sickness absence until the end of her NHS employment was, however, due to Hodgkin's lymphoma. Miss N had chemotherapy for this until March 2013 and a bone marrow transplant in November 2013 following a relapse in her condition. She had been in remission for Hodgkin's lymphoma since then.

- It was the haemato-oncologist's opinion that Miss N's level of functioning should continue to improve and she should consider returning to work.

- According to the letter dated 5 March 2014, Dr Kassam, consultant haematologist, said that Miss N's main loss of function was due to the peripheral neuropathy in her hands and feet from the treatment of her Hodgkin's lymphoma and this occurred when it was cold. However, on examination Miss N had normal power in her arms and hands with no sensory loss. It was Dr Kassam's view that Miss N ought to think about returning to work "now".

- The view expressed by OH physician, Dr Batty, that she was doubtful about Miss N's ability to return to employment was not supported by the haemato-oncologist or from "the management of her hypermobility syndrome". Furthermore, there was no evidence to support Dr Batty's statement that Miss N was waiting for other operations for her pelvic wall condition.

- The medical evidence contained a lot of information relating to the progression of Miss N's conditions following the end of her employment. This showed that she had not yet recovered sufficiently in order to return to work. This evidence could not, however, be taken into account in its decision because it was the prognosis at the point her NHS employment ended and not the subsequent progression of her conditions that was being assessed.

- At the time Miss N left NHS employment, there was still an expectation of recovery from: (a) her Hodgkin's lymphoma treatment; (b) pain management; and (c) physiotherapeutic management in order to allow her to return to the previous agreed levels of adjustments in her role.

47. Based on the evidence presented, the MA concluded, on the balance of probabilities, that:-

- Miss N's conditions did not permanently prevent her from efficiently discharging the duties of her NHS employment up to her NRA of 65; and so

- the Tier 1 condition for IHER had not been met.

As Miss N did not meet the Tier 1 condition the Tier 2 condition was not met.

48. Miss N was dissatisfied with the outcome of her IHER application and appealed it twice under the IDRP. On each occasion, after carrying out a thorough assessment, NHS BSA informed Miss N that her appeal had been unsuccessful because it accepted the view of its MA.

49. There was a difference between disregarding medical evidence and attaching little or no weight to it. NHS BSA listed the medical evidence which its MAs had considered in its IDRP decision letters. The medical evidence submitted by the OH physicians and Miss N's treating doctors were on these lists. The Adjudicator was satisfied that all the medical evidence was considered that pertained to Miss N's conditions at the time her NHS employment ended.

50. 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 their employer.

51. The Adjudicator noted that in December 2013, Atos, the former SMA, informed Miss N that there was insufficient evidence for it to make its decision on her IHER application. Miss N alleged that it was as a consequence of the Trust's failure to provide Atos with all the information about her ill health held in its records that it could not do so.

52. The Adjudicator had seen no irrefutable evidence that corroborated Miss N's allegation though. What was clear was that Atos had been made aware of all Miss N's medical conditions and it could have sought further information from the Trust, if it deemed necessary.

53. Atos, however, considered that the main reason for Miss N's long term sickness was her Hodgkin's lymphoma diagnosed in 2012. As treatment for this condition was ongoing, Atos' view was that it could not predict its impact on her future functional capabilities at the time.

54. Atos notified Miss N that it would review her case in June 2013 when the clinical picture would likely be clearer. In the Adjudicator's view, it was reasonable for Atos to defer making its decision. Regrettably, it failed to consider her application again in June 2013.

55. This resulted in NHS BSA having to apologise to Miss N for Atos' mistake and retrospectively consider her IHER application as at her date of leaving NHS employment on 31 March 2014.

56. The Adjudicator was 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, Miss N's condition rendered her permanently incapable of discharging the duties of the NHS employment she was engaged in.

57. At the time Miss N left employment in 2014, she was around 12 years from her NRA. The MA's opinions were that there was more likely than not, ample time for Miss N to be rehabilitated back to her normal role before she reached NRA.

58. The Adjudicator had also 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.

59. 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 in reaching its decision in Miss N's case.

60. The fact that Miss N was still suffering from the same medical conditions did not, in and of 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 pertaining to Miss N's health when her employment ended. NHS BSA chose to give more weight to the opinion of its MAs, who are occupational health experts.

61. That Miss N's condition might not have followed the course anticipated at the time she left employment did not in itself provide evidence that the original decision made in November 2021 was incorrect.

62. 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. The Adjudicator was also satisfied that NHS BSA: (a) gave proper consideration to Miss N's application at the time by assessing all the relevant medical evidence available, and (b) acted in accordance with the Scheme Regulations and the principles outlined in paragraph 40 above.

63. In the Adjudicator's view, NHS BSA's decision not to award Miss N Tier 1 IHER benefits from the Scheme was consequently supported by the available evidence and within the bounds of reasonableness.

64. The complaint which Miss N had made against the Trust that it originally redeployed her to an unsuitable role that involved heavy lifting following her workplace injury was

a matter of employment law that had already been considered in her Employment Tribunal. It was not in the jurisdiction of the PO to also investigate this issue.

65. Miss N said that NHS BSA should award her IHER benefits from the Scheme to compensate her for the damage the Trust had caused her both mentally and physically.

66. The Scheme Regulations govern the payment of benefits from the Scheme. In its capacity as the administrator of the Scheme, NHS BSA must act in accordance with these regulations and within the framework of the law.

67. Consequently, NHS BSA had to follow the relevant provisions of the Scheme Regulations when assessing Miss N's application for IHER benefits from the Scheme. It could not award Miss N compensation in the way she would have liked.

68. Miss N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Miss N and NHS BSA provided further comments which do not change the outcome.

Miss N's comments

69. In December 2013, Atos said that there was insufficient evidence for it to make a decision on her IHER application while she was ill in hospital for cancer treatment. In her view, all her health conditions should have been medically assessed by a doctor when she was discharged from hospital following the stem cell transplant to treat her stage four Hodgkin's lymphoma.

70. There is no information in the medical evidence about: (a) the side-effects of her stem cell transplant; (b) the medication that she took after the transplant; (c) her blood tests and transfusions carried out after surgery at the hospital for about a year; and (d) how the mesh in her stomach was affecting her on a day-to-day basis.

71. She says that:

> "…from the first mesh operation, I started to suffer with Helicobacter twice and after the second hernia mesh repair, I developed bowel obstruction and then a (sic) enterocele causing stomachs and chest pains. Before I left work, I was already going through a grievance with my employers for the treatment regarding long-term sickness…I was suffering with was conditions from internal muscular injury at work, at some point I would needed to have surgery to sort out the prolapses. I had.
>
> Weakness to my bladder and weakness to my rectum, which caused me to not have proper bowel control or bladder control…after all these surgeries OH doctor realise I was showing an underlying medical condition and it was then I was diagnosed with Ehlers-Danlos syndrome type three which is a lifelong condition. I have a connective tissue disorder, it affects my joints and my bones. I had a minor disc bulge in my lower back before I left work, pains in my joints, severe gastro problems in in my stomach…my Ehlers-Danlos

> syndrome cause you to have internal skin tissue easily to tear and bruising and early disease of the bone Osteoarthritis…and then became ill with Hodgkin lymphoma which are all the side-effects of having a second operation regarding my hernia mesh repair plus the hysterectomy and the H Pylori infection in the biliary system has been reported suggesting a potential relationship with biliary disease….I developed biliary sepsis with Hodgkin lymphoma when I was admitted at hospital, since leaving work, I have been off sick and not able to work. I have suffered twice with sepsis and neutropenic which are side effects from having a stem cell transplant many infections and I am immunosuppressive and once you develop sepsis, you can develop sepsis again, so I am high risk of being around people as I have caught the H1N1, sepsis, MRSA and C diff all from staying in a hospital and also to be sick for six weeks on antibiotics just because I had a biopsy."

72. She has letters from her GP, OH and the DWP[12] that say she is unfit for work.

73. She also says that:

> "…I suffered with low white blood count /neutrophils well before I became ill with Hodgkin lymphoma, the hernia mesh repair is still giving me pains, and sickness, I have tried to have the mesh removed because I have realised, it's the mesh that's been making me sick all this time. I have been advised they wouldn't want to remove it as it's become a part of me so I could be even more worse (sic) …"
>
> "I now know the mesh is causing me to have a dilated bile duct and I have had 2 cancers scares because of dilated bile ducts and dilated pancreas and shadow on my liver…I was not aware mesh could cause so much problems… bearing in mind all my surgery have failed in the past…for you to say I can go and have more surgeries is unbelievable..".

NHS BSA's position

74. NHS BSA says that:

> "During Medigold's investigation on whether Miss N met the ill health criteria, Medigold had available Miss N's application that she submitted in late 2013 prior to the end of her employment. This detailed her musculoskeletal symptoms later diagnosed as hypermobility type 3 Ehlers-Danlos syndrome which also contributed to her surgical hernia, enterocele, cystocele and prolapse. She was diagnosed with Hodgkin's lymphoma in July 2012, had brief remission with chemotherapy and had repeat chemotherapy prior to bone marrow transplant.

[12] Miss N has submitted copies of DWP's letters dated 28 September 2012 and 15 February 2013 concerning her Disability Living Allowance as evidence.

> Following on from this, Medigold had further information about Miss N's health however the documentation pack only contained a few documents from 2011 to 2013 and then a further set of documentation from 2017 onwards.
>
> In order for Medigold to provide appropriate advice, Medigold requested further medical evidence (**FME**) regarding Miss N's medical records and requested Dr Fernandes to provide a report relating to Miss N's health status and care that she received in 2014. This was so any new diagnoses made since then could be taken into account, but only if it related to insight on the prognosis as at 31 March 2014…."

75. I note the additional points raised by Miss N and NHS BSA but agree with the Adjudicator's Opinion.

Ombudsman's decision

76. 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 Miss N should in fact receive a pension – that decision is made by NHS BSA (as set out in paragraph 10 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.

77. 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.

78. 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 Miss N's eligibility for IHER benefits from the Scheme. I am primarily concerned with the decision making process.

79. NHS BSA was required to assess Miss N's IHER application in accordance with the Scheme Regulations, and to do so in consultation with its MAs.

80. Miss N feels that more weight should have been given by NHS BSA to the medical view expressed by her GP and OH that say she is unfit for work.

81. She also contends that it was improper for NHS BSA to accept the advice of its MA when they had not medically examined her.

82. Miss N also says that no medical evidence was obtained by the MA about: (a) the side-effects of her stem cell transplant; (b) the medication that she took after the

transplant; (c) her blood tests and transfusions carried out after surgery at the hospital for about a year; and (d) how the mesh in her stomach was affecting her on a day-to-day basis.

83. However, there is no requirement in the Scheme Regulations for an applicant to be seen by the MA. Moreover, the MA's remit is not to add to the weight of medical evidence but to objectively assess the evidence presented in support of any application or subsequent dispute. It was open, however, to the MA to request further medical evidence should the need arise.

84. So it is for the MA to exercise their professional judgement in deciding whether they: (a) needed to see Miss N, and (b) obtain further medical evidence from her various treating doctors, OH, or the Trust before providing their advice to NHS BSA

85. In Miss N's case, the MA decided that it already had sufficient evidence to form their medical opinion after receiving further medical information from Dr Fernandes in late 2021 at its request and obtaining additional information would not significantly add to their understanding of Miss N's medical conditions.

86. Moreover, I note that, in March 2021, NHS BSA informed Miss N that she should provide further evidence about her health conditions causing her to leave NHS employment on 31 March 2014 and also the outcomes of her ongoing treatments with her new completed form AW33E. So I consider that it had been open to Miss N to provide the missing information if she deemed it pertinent prior to the consideration of her IHER application by Medigold in the first instance and by NHS BSA on appeal under IDRP.

87. That the MA was able to advise NHS BSA based on the available evidence did not consequently mean that it had failed to properly assess Miss N's IHER application.

88. Furthermore, it is for NHS BSA to decide, within the bounds of reasonableness, the weight which is attached to any of the medical evidence. 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.

89. By way of example, this might include such things as an obvious error or omission of a fact or a misunderstanding of the relevant rules by the MA, neither of which I consider has occurred in this case.

90. 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. It is clear that the medical evidence submitted by her GP and OH was provided to the MA for consideration.

91. Both IDRP decision letters also said that NHS BSA, together with the MA, had taken into account all the available evidence when carrying out a comprehensive review of Miss N's application and there is no evidence to suggest that was not the case.

92. It is consequently clear that NHS BSA had given most weight to the MA's detailed opinion that, at the time of leaving employment, Miss N's condition did not permanently prevent her from regular employment before her NRA of 65.

93. I find that NHS BSA did give proper consideration to Miss N'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.

94. I consider its decision not to award Miss N IHER benefits was not one that no reasonable body would make, and it was within the bounds of reasonableness.

95. The fact that Miss N is still suffering from the same medical conditions does not impact upon the validity of the original decision. NHS BSA could only be expected to make its decision 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.

96. That Miss N's condition may not have followed the course anticipated at the time she left employment does not in itself provide evidence that the original decision made in was incorrect.

97. Miss N has provided evidence of her Disability Living Allowance payments from DWP. Receipt of these benefits does not, however, mean that Miss N would automatically qualify for IHER benefits from the Scheme because the criteria used to determine whether or not she qualified for Disability Living Allowance are different and less stringent.

98. Finally, the IHER pension is a contingent benefit payable under the Scheme Regulations where the Tier 1 or Tier 2 test is met. It is not compensation for personal injury or for any employment complaint against the Trust and whether or not her redeployment by the Trust to a particular role in 2001 caused her mental or physical injury is not relevant to the tests which NHS BSA was required to apply to determine her entitlement to IHER benefits.

99. While I sympathise with Miss N's circumstances, the evidence does not support a finding of maladministration by NHS BSA in coming to the decision it did.

100. I do not uphold Miss N's complaint.

Camilla Barry

Deputy Pensions Ombudsman
21 October 2025

Appendix One

The National Health Service Pension Scheme Regulations 2008

At the time Miss N's NHS employment ended, Regulation 2.D.8 provided:

Early retirement on ill-health (active members and non-contributing members)

(1) A pension payable under this regulation shall be known as an ill-health pension and may be paid at two different tiers known as a tier 1 ill-health pension and a tier 2 ill-health pension.

(2) An active member or a non-contributing member who has not reached the age of 65 and who has ceased to be employed in NHS employment is entitled to immediate payment of a tier 1 ill-health pension that is payable for life if—

(a) in the opinion of the Secretary of State the member suffers from physical or mental infirmity as a result of which the member is permanently incapable of discharging the duties of the member's employment efficiently,

(b) the member's employment is terminated because of that physical or mental infirmity,

(c) the member has at least 2 years of qualifying service, and

(d) the member has claimed the pension.

(3) An active member who has not reached the age of 65 is entitled to immediate payment of a tier 2 ill-health pension if—

(a) in addition to meeting the condition in paragraph (2)(a), in the opinion of the Secretary of State the member suffers from physical or mental infirmity as a result of which the member is permanently incapable of engaging in regular employment of like duration,

(b) the member's employment is terminated because of that physical or mental infirmity,

(c) the member has at least 2 years of qualifying service, and

(d) the member has claimed the pension.

(4) The annual amount of a tier 1 ill-health pension (disregarding any additional pension is calculated as specified in regulation 2.D.1(4).

(5) The annual amount of a tier 2 ill-health pension (disregarding any additional pension) is calculated as specified in regulation 2.D.1(4), but on the assumption that the member's pensionable service—

(a) is increased by the enhancement period where the member—

(i) has not had a break in pensionable service of 12 months or more; or

(ii) has returned to pensionable 12 months or more after having a break in such service and it would be more favourable to the member to treat the member's pensionable service before and after the break, and all such other breaks (if any), as continuous;

(b) is not increased by the enhancement period in the circumstances referred to in (a) (ii) if—

(i) the member's pensionable service before and after the break is treated separately under regulation 2.G.2; or

(ii) the member's pensionable service in respect of an earlier service credit is treated separately under regulation 2.K.7.

(6) In this regulation "the enhancement period" means two-thirds of the member's assumed pensionable service…

Appendix Two

Relevant excerpts from the Stage One IDRP decision letter dated 19 January 2022

> "In my role as Dispute Officer, I have undertaken, together with the SMA, a very full and thorough review of your application taking into account all the available evidence...
>
> The MA…has commented:
>
> I note Miss N comments that her application should be considered on the basis of her circumstances on 24 December 2013 and not on the basis of her circumstances as of her last day of service on 31 March 2014. My colleague… considered this application on the basis that it was a retrospective application for ill health retirement and the question to be determined was whether Miss N met the pension scheme criteria as of her last date of service. I note that I have been requested to provide advice on the same basis. I will therefore do so…
>
> My understanding is that I am required to provide advice as to whether the applicant was likely to have met the tier 1 condition at the time the applicant left employment on 31 March 2014 and, if so, to also advise on whether the applicant also met the tier 2 condition…
>
> **Medical Evidence**
>
> I have considered the documents submitted in respect of this first stage IDR review, specifically:
>
> - The referral documents;
> - Hospital discharge summaries, dated 3 December 2013, 15 January 2020 and 15 November 2021;
> - Report from Dr Balachandran, registrar in urogynaecology, dated 28 March 2019;
> - Report from Professor Heaton, consultant transplant surgeon, dated 3 March 2016;
> - Report from Dr French, specialist registrar in haematology, dated 30 July 2014;
> - Report from Dr Roomallah, specialist registrar in haematology, dated 4 June 2014;
> - Report from Miss Stewart, lymphoid clinical nurse specialist, dated 28 May 2014;

- Report from Dr Wykes, specialist registrar in haematology, dated 12 December 2012. Although Dr Wykes report is dated 2012, I think this is a typographical error as the report refers to events that took place in 2013. I think it is most likely that this report was written in December 2013;
- Report of PET CT scan dated 15 July 2013;
- Reports from Mr Thiagamoorthy, clinical research fellow in urogynaecology, dated 11 April 2013;
- Report from Dr Tindall, specialist registrar in haematology, dated 19 September 2012;
- Report from Mr Nunoo-Mensah, consultant colorectal surgeon, dated 23 May 2012;
- Report from Dr Emslie, consultant occupational physician, dated 22 April 2002;
- Email from applicant dated 26 November 2021;
- Employment tribunal judgement[13];
- Form MED3, dated 6 February 2014.

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

- The referral documents submitted with the original application;
- Reports from GP, Dr Fernandes, dated 17 May 2021, 21 October 2021 and 9 November 2021;
- Reports from GP, Dr Parihar, dated 22 March 2013 and 1 April 2014;
- Report from GP, Dr Howard, dated 1 November 2013;
- Joint report from Miss Yi-Chien Tsai, specialist registrar in surgery, and Ms Chang, consultant surgeon, dated 13 September 2021;
- Report from Dr Jeyaraman, consultant in diabetes and endocrinology, dated 30 June 2021;
- Report from Miss Yi-Chien Tsai, dated 8 June 2021;
- Report from Dr Coutinho, consultant neurologist, dated 30 October 2020;

[13] Details of the outcome of the Employment Tribunal are set out in footnote 11 to paragraph 25 above.

- Report from Dr Kuhnl, consultant haemato-oncologist, dated 4 September 2020;
- Report from Dr Bano, associate specialist in diabetes and endocrinology, dated 8 August 2019;
- Report from Dr Alberto, registrar in colorectal surgery, dated 8 July 2019;
- Report from colorectal clinical nurse specialist Ness, dated 6 February 2019;
- Report from Mr Roberts, consultant breast surgeon, dated 14 November 2018;
- Reports from Professor Devereux, consultant haemato-oncologist, dated 7 September 2012, 23 November 2017, 21 December 2017 and 21 March 2018;
- Report from Dr Harrison, consultant hepatologist, dated 25 September 2017;
- Hospital discharge summaries, dated 21 August 2013 and 11 May 2017;
- Report from Dr Johnson, specialist registrar in urogynaecology, dated 9 January 2017;
- Reports from Dr Kassam, consultant haematologist, dated 5 March 2014, 22 July 2015 and 20 January 2016;
- Report from Mr Papoulas, hepatobiliary fellow, dated 24 December 2015;
- Report from Dr Kaminski, CMT2 in medicine, dated 3 September 2015;
- Report from Dr Graham, specialist registrar in haematology, dated 26 November 2014;
- Report from Dr Marcus, consultant haemato-oncologist, dated 13 November 2013;
- Report from Ms Wellving, lymphoma clinical nurse specialist, dated 24 July 2013;
- Report from Mr Thiagamoorthy, research fellow in urogynaecology, dated 14 May 2013;
- Joint report from Mr Singh, clinical fellow, and Ms Chang, consultant surgeon, dated 30 April 2012;

- Report from Dr Peddu, consultant radiologist, dated 24 April 2012;
- Report from Dr Karla, specialist registrar in rheumatology, dated 1 February 2012;
- Report from Mr Nachimuthu clinical research fellow in surgery, dated 30 January 2012;
- Report from Mr Durai, registrar in surgery, dated 18 November 2011;
- Reports from Mr Nunoo-Mensah, consultant colorectal surgeon, dated 21 July 2011 and 5 October 2011;
- Report from Dr Kazkaz, consultant rheumatologist, dated 6 October 2011;
- Joint report from Mr James, clinical fellow, and Ms Chang, dated 2 August 2010;
- Report from Dr Utting, SHO in obstetrics and gynaecology, dated 18 October 2007;
- Notes from consultants with Dr Gration, consultant occupational physician, dated 25 April 2012;
- Report from Dr Batty, occupational physician, on Form AW33, dated 10 December 2013;
- Reports from Dr Batty, dated 1 November 2011, 28 November 2011, 22 February 2012, 18 December 2012 and 9 April 2013;
- Report from Ms Aderibigbe, specialist nurse advisor, dated 9 September 2012;
- Report from Dr Gration, dated 25 April 2012;
- Report from Dr Wilford, occupational physician, dated 7 July 2021;
- Report from Dr Elekima, specialist registrar in occupational medicine, dated 25 July 2008;
- Report from OH advisor Ike, dated 2 January 2008;
- Letter from applicant dated 24 August 2021;
- Email from applicant dated 11 November 2013.

I note that some of the medical reports post-date the applicant's last day of service. Changes in the applicant's health after the applicant left employment are not relevant to the determination whether the applicant satisfied the pension scheme definitions at the time of leaving employment. 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 at the time the applicant left employment.

The documents submitted with this application are extensive and include many medical reports that post-date Miss N's last day of service and which are related to changes that had occurred in her health after she left NHS employment. I confirm that I have reviewed the whole case file. However, I have not cited all of these documents in the list of evidence considered as many do not contain information that is relevant to the consideration of this application that is not already contained in the documents that I have cited above.

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, at the time of leaving employment, the applicant did not meet the tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met.

The rationale for this is as follows:

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the applicant had a physical or mental infirmity as a result of which the applicant was incapable of efficiently discharging the duties of their NHS employment. The key issue in relation to the application is whether the applicant's incapacity was likely to have been permanent.

The medical evidence is that, at the time she left employment, Miss N was unfit for her normal NHS role. At that time Miss N had a number of medical conditions, some of which were permanent, that were contributing to her difficulties.

It may help Miss N if I begin by pointing out that the key consideration is not the permanence of her medical condition; rather it is the permanence of any incapacity arising from that condition.

In summary, by the time Miss N left employment, she was known to have a condition called Ehlers-Danlos syndrome (EDS). EDS is a generic term used to describe a number of inherited disorders that involve a genetic defect in the production of a structural protein called collagen. This protein is widespread throughout the body. The effects of collagen production can therefore have protean manifestations, in part dependent upon the specific genetic defect the individual has. In Miss N's case, she had increased laxity of her joints and hypermobility. This would have been contributing to her musculoskeletal

symptoms. However, there is no indication that her musculoskeletal symptoms were a cause of incapacity at the time Miss N left employment. EDS is a genetic disorder. It had therefore been present since conception. The report appertaining to the musculoskeletal consequences of this condition that is most contemporaneous with Miss N leaving NHS employment is Dr Gration's report from April 2012 in which he advised that Miss N was fit for her normal role. There are no subsequent reports to indicate a significant change in Miss N's musculoskeletal problems resulting from her EDS between then and when she left employment. In my opinion, on balance of probability, at the time Miss N left employment, the musculoskeletal consequences of her EDS were not a cause of incapacity for work.

Miss N did have other difficulties to which her EDS was probably contributing. There are multiple reports attesting to gynaecological problems for which Miss N first had surgery in 2007. She had a number of issues and symptoms related to problems with her pelvic floor and, at the time of leaving employment, was awaiting surgery for a condition called a cystocele. The cystocele would not have been expected to resolve spontaneously and so, without intervention, any symptoms and incapacity arising from it would have been likely to be permanent. It would have been reasonable to have anticipated that surgery would resolve those problems, most probably once Miss N had convalescenced from surgery. The timing of surgery had not been decided by the time Miss N left employment. However, it appears from Dr Kassam's report of 5 April 2014 that surgery in the summer of 2014 would have been feasible. The benefits of surgery would therefore have been expected to come about well before Miss N reached scheme pension age which, at that time, was over a decade away.

Miss N also had a type of hernia affecting her abdominal wall. The EDS may also have contributed to this hernia. This had required both primary surgery and subsequent revision surgery. At the time of leaving employment Miss N still had a defect in her anterior abdominal wall. However, this defect was not the result of a recurrence of the hernia but was the result of a condition called divarication of the recti, which is a separation of the muscles in the abdominal wall. The documents provided confirmed that surgery for this was not required. It is unlikely that this condition would have been a cause of incapacity for Miss N's normal role.

Miss N was also experiencing abdominal pain. The cause of this was unclear, though it is certainly plausible that EDS was a contributory factor as it is known to be associated with gastrointestinal dysmotility.

Unrelated to the EDS, Miss N was diagnosed with Hodgkin's disease in 2012 and treated with chemotherapy. The condition relapsed, necessitating further treatment and a bone marrow transplant towards the end of 2013. At the time of leaving employment, Miss N probably did have residual symptoms as a consequence of the treatment she had been given for Hodgkin's disease. She

did have some sensory symptoms that were considered to be a side effect of her chemotherapy (a peripheral neuropathy). However, Dr Roomallah's report of 4 June 2014 indicates that Miss N's neuropathic symptoms were predominately brought on by exposure to cold environments. This suggests that these symptoms would have been unlikely to have been a major obstacle to Miss N undertaking her normal role, which was in an indoor environment. In any event, the symptoms would have been expected to improve with the passage of time, even if they did not fully resolve. I am conscious that Dr Kassam specifically confirms in her report of 5 March 2014 that Miss N had normal power in her upper limbs and no demonstrable sensory loss.

Miss N probably did have some ongoing fatigue following her chemotherapy. This would have been expected to resolve with the passage of time, most probably within a few months.

At the time of leaving employment, Miss N did have high blood pressure. However, this was not requiring treatment at that time. High blood pressure generally gives rise to no symptoms unless complications of the condition occur. It would not have therefore been contributing to any incapacity for employment at the time Miss N left NHS service.

Looking at Miss N's circumstances holistically, at the time she left employment she undoubtedly had multiple medical issues, and her EDS was undoubtedly a permanent medical condition. However, the obstacles to Miss N working at that time were most probably the side effects of the treatment she had received for her Hodgkin's disease and, possibly, symptoms resulting from the cystocele. The side effects of treatment would have been expected to at least improve, if not fully resolve, spontaneously over time. The cystocele would have been expected to be amenable to surgical intervention. It follows from this that the obstacles to employment would have been expected to resolve either with time, or in response to future treatment, most probably within a year or so of Miss N leaving employment, depending upon the timing of surgery. She would then have required a period of vocational rehabilitation, most likely lasting several months, given the length of time she would have, by then, been away from work. However, given that Miss N will not reach scheme pension age until 2026, at the time she left employment in 2014 there was ample time for her to be rehabilitated back to her normal role before she reached scheme pension age.

In my opinion, on balance of probability, at the time Miss N left employment, her incapacity for her normal role was unlikely to have been permanent.

In my opinion, at the time of leaving employment, the applicant did have a physical or mental infirmity as a result of which the applicant was incapable of efficiently discharging the duties of their NHS employment. This incapacity was unlikely to have been permanent. The tier 1 condition was therefore unlikely to have been met for the reasons given above.

I note that my advice is in agreement with that of my colleague. My advice is also consistent with the opinion of Dr Kassam who, writing in early March 2014, wrote that Miss N was not quite back to full functioning, but that she should consider going back to work.

A number of the medical reports do attest to the uncertainty regarding Miss N's prognosis around the time she left employment. There was undoubtedly some uncertainty. Predicting the future course of any illness is not an exact science and there is an inherent element of uncertainty in attempting to predict any aspect of the future. However, a decision has to be made, one way or the other, based on what would have been expected to be the most likely course for Miss N's health to follow, using information that was, or could have been, available at the date she left employment. While the future course of Miss N's health may not have followed the course that would have been anticipated in 2014, this does not in itself demonstrate that the decision was wrong, as the decision could only be based on information that would have been available in March 2014. The actual course Miss N's health was to follow could not have been known at that time and therefore cannot be taken into account.

While the authors of some of the medical reports have expressed their support for Miss N's application for ill health retirement, this support has been given without reference to the requirements of the regulations. I have taken this into account in deciding how much weight to give to such statements when formulating my advice."

Relevant excerpts from the Stage Two IDRP decision letter dated 2 March 2022

"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 including the latest information you kindly provided.

The MA considering your case has recommended that you do not satisfy the Tier 1 conditions laid down in Regulation 2.D.8 of the NHS Pension Scheme Regulations 2008 (as amended) for payment of ill health retirement benefits and I have accepted that recommendation…

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

Medical Evidence

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

- The referral documents;
- Emails from member dated 29 January 2022 and 31 January 2022;
- Letter from Dr Emslie, consultant occupational physician, dated 22 April 2002;
- MRI scan of abdomen dated 10 April 2012;
- Letters from Mr Nunoo-Mensah, consultant colorectal and laparoscopic surgeon, dated 1 June 2012 and 30 May 2012;
- Proctogram reports dated 27 June 2011;
- Letters from G Thiagamoorthy, senior clinical research fellow - urogynaecology, gynaecology clinic, dated 11 April 2013 and 14 May 2013;
- Report of CT scan of sternoclavicular joints (date not clear);
- Report of ultrasound of abdomen dated 28 November 2015;
- Discharge summaries dated 3 August 2012, 21 August 2013, and 3 December 2013.

I have also considered the documents submitted in respect of the first stage IDR review and the original application, specifically…

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, at the time of leaving employment, the applicant did not meet the tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met.

The rationale for this is as follows:-

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent.

In her appeal Miss N refers to her permanent medical conditions of Ehlers-Danlos syndrome and her permanent condition of divarication of the rectus muscles. It is not disputed that Miss N has permanent medical conditions. However, the key consideration for an application for ill health retirement is not the permanence of medical conditions it is the permanence of any incapacity arising from those conditions.

Miss N has Ehlers-Danlos syndrome (EDS). The issue of incapacity resulting from EDS at the time Miss N left employment was addressed at her stage 1 appeal. It was advised that the most contemporaneous report with Miss N leaving NHS employment was Dr Gration's report. This report advised that Miss N was fit for her normal role. None of the documents that Miss N has submitted with her stage 2 appeal provide any evidence that, at the time she left employment, the musculoskeletal symptoms of her EDS were causing incapacity for work.

The MRI scan of abdomen of April 2012 indicates divarication of rectus muscles and scarring from previous surgery. There is no indication from this or any of the other documents submitted with the stage 2 appeal that the divarication of the rectus muscles would have resulted in incapacity for her NHS role.

The letters from Mr Nunoo-Mensah indicate that investigations suggested a rectocele (a type of prolapse where the rectum bulges into the vagina) and obstructive defecation syndrome (ODS) (a condition causing the patient difficulty in emptying the rectum normally). Mr Nunoo-Mensah indicated that he would discuss the findings in the next multi-disciplinary team meeting to see if she would benefit from a rectocele repair. It is reasonable to assume that surgical repair of the rectocele, if deemed appropriate, would have been successful and that the benefits of surgery would have come before Miss N reached her normal scheme pension age.

Of the two letters from G Thiagamoorthy submitted with the stage 2 appeal, the later letter of 14 May 2013 had been submitted and reviewed at the time of her stage 1 appeal. Mr Thiagamoorthy indicated that urodynamic studies were normal but in view of symptoms they would refer Miss N for bladder retraining and pelvic floor exercises. In relation to her prolapse, she was placed on the waiting list for anterior repair plus or minus vaginal hysterectomy. Again, the benefits of surgery would have been expected to come about before Miss N reached her normal scheme pension age.

Miss N was diagnosed with Hodgkin's lymphoma in 2012 and was treated with chemotherapy and, after relapse, a bone marrow transplant. At the time she left employment, there was no evidence that residual symptoms from Hodgkin's lymphoma would have prevented Miss N undertaking her normal NHS role. In her stage 2 appeal she refers to a biopsy in 2017 for a suspected relapse and subsequent treatment and admission to hospital for a skin infection. She also refers to antibiotic and steroid treatment for lung infection/breathing problems in 2017 and further problems with regards infections in January 2020 and November 2021. Changes in Miss N's health after she left employment are not relevant to the determination of whether she satisfied the pension scheme definitions at the time of leaving employment. I have therefore not taken the subsequent course of her illness into account. Miss N did not submit any new documentation in relation to her Hodgkin's

lymphoma and there are therefore no documents that relate to or provide insight into her circumstances in relation to this condition at the time she left employment.

In my opinion, taking all the available evidence into account, on balance of probability, at the time she left NHS employment, Miss N's incapacity for her normal role was unlikely to have been permanent.

In my opinion, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. This incapacity was unlikely to have been permanent. The tier 1 condition was unlikely to have been met for the reasons given above.

My advice is in agreement with that of my colleagues who advised on Miss N's initial application and stage 1 appeal and also consistent with Dr Kassam's opinion. Some of the authors of medical reports have indicated support for the application for ill health retirement. However, this support has been given without reference to the requirements of the NHS pension regulations.

It is my opinion that relevant medical evidence has been considered in this case and, on the balance of probabilities, indicates that the applicant is not permanently incapable of the NHS employment; the tier 1 condition is not met. That the applicant is not permanently incapable of regular employment of like duration; the tier 2 condition is not met.

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