PO-15256

Ombudsman's Determination

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

Outcome

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

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Mrs E is unhappy with the decision made by NHS BSA in relation to her application for ill health early retirement (**IHER**).

Background information, including submissions from the parties

4. Mrs E worked as a midwife at Birmingham Hospital.

5. In April 2011, Mrs E was involved in an accident at work where a fire door came off its hinges and landed on her leg.

6. I understand that she attempted to continue working after this but suffered pain in her back.

7. On 15 March 2012, Mrs E attended a hospital appointment at a Chronic Pain Management clinic. The follow-up letter to this noted that she had been suffering from lower back pain and right leg pain since the accident in 2011.

8. On 7 August 2012, Mrs E applied for IHER. Mrs E's employment ceased with effect from 26 October 2012 on the grounds of capability.

9. On 20 August 2012, a doctor from Mrs E's GP surgery responded to an information request concerning her condition by a Specialist Occupational Health Physician. He said that all investigations, including MRI scans and those of the bladder, had been normal. He considered that she had suffered an injury which had developed into a "reflex dystrophy-type pain reaction." He said he had injected her back but this had caused significant pain and discomfort.

10. On 28 September 2012, an Occupational Health Doctor completed Part C of the IHER form. In this, the reported reasons for current incapacity were “persistent back and leg pain” and “unexplained falls.” The symptoms noted included: needing a stick to walk when outside the house, standing being limited to 5 minutes maximum, not being able to reach above shoulder height, finding it hard to tolerate hard surfaces when sitting and being able to drive for short journeys only.

11. Another question on this form asked the Occupational Health Doctor to comment on the likelihood of an improvement in functional abilities with normal therapeutic intervention, before the normal benefit age. The response given was “recovery is not anticipated.”

12. On 16 November 2012, Mrs E’s employment was terminated on the grounds of capability.

13. On 21 November 2012, NHS BSA sent Mrs E a letter explaining that her application for IHER had not been successful. It said: -

    - The information did not indicate that, on the balance of probabilities, Mrs E was permanently incapable of performing the duties of her NHS employment.
    - Dr Nixon, the Consultant Occupational Physician, had described significant levels of pain and functional impairment. Mrs E was presently unable to cope with the physical demands of her midwife role.
    - There remained scope for further treatment options and therefore permanency of her present incapacity could not be confirmed.
    - There was no evidence of a serious spinal condition. The evidence suggested that further damage to the spine would not occur as a result of a return to work, provided appropriate measures were put in place to meet the Manual Handling at Work Regulations.
    - Pain control was the main issue; addressing negative perceptions with psychotherapy together with effective analgesic treatment could resolve problems otherwise thought to be insurmountable.

14. In April 2013, Mrs E began to experience symptoms associated with what would later be diagnosed as Fibromyalgia.

15. On 29 January 2015, in a follow-up letter to Mrs E’s GP, an Associate Specialist in Rheumatology said he was inclined to agree that Mrs E appeared to be suffering from Fibromyalgia.

16. On 17 July 2015, Mrs E’s Pain Management Consultant wrote to her GP clarifying the procedures she had undertaken. The Consultant said Mrs E’s first caudal epidural resulted in a 40-50% reduction in pain for five to six months. The second epidural performed recently gave her a 60-65% reduction in pain overall. Although there was no limit on one having a caudal epidural, having it more than twice a year was not advised. Multiple neuropathic pain management agents had been tried by Mrs E in the past but she had not been able to tolerate most of these.

17. On 18 August 2015, a Consultant Psychiatrist sent Mrs E a follow-up letter following her appointment the previous month at the Young Onset Dementia Assessment Clinic. This noted that Mrs E reported "forgetting conversations, shopping lists, has to write everything down and forgets to write things down." It was stated that she was impatient and "always on the go", and had a mild cognitive impairment secondary to her physical problem. A low dose antidepressant was recommended and she was discharged from the clinic.

18. In September 2015, the above Pain Management Consultant wrote that Mrs E had reported an 80% reduction in pain, was walking unaided and was able to do more inside and outside her house. It also mentioned that Mrs E had not found any psychology based therapies useful.

19. On 3 December 2015, Mrs E's GP, Dr Swaebe, wrote a letter to NHS BSA in which she said:

> "[Mrs E] is currently in constant discomfort and is unable to do much walking or general activity…
>
> She currently has pain in her right sacroiliac joint area and down into her right leg but also has other joint and body pains which have been put down to fibromyalgia…
>
> I can't see that [Mrs E's] problem is likely to suddenly improve and I suspect her pain will continue and need to be managed over the coming years. I would be happy to provide further information should it be felt useful but I think it would be better for [Mrs E] if she was able to retire."

20. On 21 December 2015, Mrs E wrote to NHS BSA saying that her overall circumstances since her IHER application had remained the same, although she had developed Fibromyalgia. She explained that due to this, she suffered "uncontrollable and debilitating migraines coupled with severe vomiting." She said it had been four and a half years since the accident at work, and it did not appear that she would be well enough to return to her job as a midwife or any other work. She wrote to NHS BSA asking it to reconsider her for IHER.

21. This letter was treated as an appeal against the 2012 decision in relation to her IHER application, and was therefore considered under the Scheme's Internal Dispute Resolution Procedure (**IDRP**).

22. On 15 January 2016, NHS BSA wrote to Mrs E under stage one of the IDRP saying that her application had been successful under tier one conditions. The main points made by the medical adviser were: -

    - Piriformis syndrome was stated to be the relevant medical condition. Mrs E's pain consultant had noted that she had lower right back pain radiating to her right leg, which interfered with her daily activities. She had been prescribed

strong analgesics, been given various spinal injections and attended a pain management programme in 2013.

- On 6 March 2012, a Consultant Spine Surgeon wrote that Piriformis injection was worth trying.
- On 20 August 2012, the GP Dr Gravestock had said Mrs E's investigations had been normal and she had developed a reflex sympathetic dystrophy pain reaction; she was under the pain clinic.
- On 13 June 2014, the Pain Consultant had said Mrs E was taking Amitriptyline and was keen to have sacroiliac joint injections.
- Dr Arthanari, an Associate Specialist in Rheumatology, said that Mrs E had recently benefitted from an epidural injection and was having physiotherapy for her sacroiliac joint.
- Dr Swaebe had said she suspected that Mrs E's pain would continue and would need to be managed over the years.
- Only conditions which contributed to incapacity at the cessation of NHS employment could be taken into account – Polymyalgia, migraine and Fibromyalgia were conditions which were diagnosed after Mrs E ceased her NHS employment.
- Mrs E was unlikely to recover capacity for the significant physical demands of her NHS role. However, it was more likely than not that she that she would be "capable of low physical demand, regular employment, 22.5 hours per week, within the period to normal benefit age, especially if this is semi-sedentary and allows regular change of posture."
- Accordingly, the tier one condition had been met; but the tier two condition had not been met.

23. On 18 January 2016, Mrs E wrote to NHS BSA saying: -

- NHS BSA suggested she was capable of working 22.5 hours a week in another capacity, and that she could be offered a job where she could walk around regularly. However, she was not able to physically get to work on her own and there was no one who could take her.
- She was on medication which affected her concentration and made her tired.
- Regular migraines made working impossible, as well as painful muscle spasms and "fibro-fog", an inability to think or make a decision.
- She did not feel there was any job which she could fulfil in a professional manner.
- NHS BSA failed to take her medication, inability to drive and the lack of public transport into consideration, or that Fibromyalgia was linked with a traumatic event.

24. On 6 February 2016, Mrs E forwarded information on the payment she received from the Department for Work and Pensions; which said that from October 2014, she was

awarded a personal independence payment. She also highlighted the issues she experienced because of Fibromyalgia.

25. On 9 May 2016, Mrs E's pain management consultant sent her GP a letter saying that Mrs E had already been on the pain management programme, and that she had requested another epidural.

26. On 15 September 2016, Mrs E's GP, in relation to her IDRP appeal, sent NHS BSA a letter which said: -

- Mrs E's incapacitating medical conditions predominantly stemmed from an injury at work in 2011.
- She had various treatments but pain continued to limit her mobility very significantly. The distance she could walk was very limited and she had to use a stick.
- She could only do small amounts of work around the house and quite frequently was unable to do anything through the day. On days where she could do a little more, she understood that on the following day the pain would be more severe and she would be more restricted than normal.
- She did seem to benefit from epidural injections and demonstrated trigger points for Fibromyalgia. She may benefit from further injections and continued assessment of chronic pain and treatment.
- Over the last five years there had been no improvement in her mobility or pain, which had been fully investigated and managed, but she continued to suffer significant discomfort and limited mobility.
- In order to improve her memory, her medication had been reduced and she had been working hard on this.

27. On 16 November 2016, NHS BSA sent Mrs E its stage two IDRP response. This said: -

- Mrs E suffered from low back pain of uncertain origin. Pain relieving medication had caused a degree of poor cognition so she had been advised to reduce her painkilling medication.
- The GP report indicated that Mrs E used a stick to walk and was sometimes unable to do things at all through the day. However, other evidence presented pointed to a recent improvement in function following successful injection therapies.
- Improved self-management of chronic pain, comprising pacing of activity, avoidance of episodes of over-activity and graded exercise therapy were all likely to be of benefit. Mrs E needed to be encouraged to implement the advice she had been given and not spend all of her time "on the go." Reduction in analgesia would likely help her mood and cognitive function; this was ongoing.
- A combined approach of improved activity management, reduction in analgesia and six-monthly caudal injections were likely to result in her being fit for

alternative work of like duration, within a timeframe of three to five years from this date.
- The onset of Fibromyalgia was subsequent to her initial application so the impact of this condition was not considered.
- On the balance of probability, the tier 2 condition was not met and reassessment should not be allowed.

28. Mrs E subsequently referred the matter to this Office for an independent review.

29. On 17 January 2017, NHS BSA sent this Office its formal response. In summary, it said it had properly considered Mrs E's application and the medical adviser's recommendation was founded on the correct interpretation of the appropriate scheme regulations.

30. On 18 January 2017, Mrs E informed this Office that she had recently been diagnosed with Chronic Fatigue Syndrome, also known as Myalgic Encephalomyelitis (ME).

Adjudicator's Opinion

31. Mrs E'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 summarised briefly below: -

- For Mrs E to be eligible for tier 1 IHER benefits, NHS BSA would need to be satisfied that she was permanently incapable of efficiently discharging the duties of her NHS employment. In terms of tier 2 IHER benefits, Mrs E needed to first meet the criteria for tier 1, and also be deemed to be permanently incapable of regular employment for a comparable number of hours as worked previously.
- The above was considered by all three of the medical advisers and therefore the correct test was applied.
- The factors which the medical advisers were required to consider fell within E2A(15) of the NHS Pension Scheme regulations 1995 (**the Regulations**), which concerned whether the member had received appropriate medical treatment and their mental and physical capacity. The medical adviser in the second stage IDRP decision (which overrode previous decisions), gave due regard to these factors.
- The symptoms for Mrs E's Fibromyalgia did not arise until April 2013, and it was not diagnosed until at least 2014. Mrs E considered that all of her symptoms came about as result of the accident at work so any distinction made between her symptoms pre and post November 2012 was arbitrary. This was a judgment for a medically qualified person to make, however as the condition presented to NHS BSA in 2012 was Piriformis Syndrome, this was the condition which must be assessed in her IHER application.

- Mrs E's GP had said her condition was unlikely to "suddenly improve" and she should be allowed to retire. However, the fact that NHS BSA's medical adviser's view differed to this opinion, this did not render it incorrect. Instead, the medical adviser needed to have taken into account all of the evidence available; Dr Swaebe's later letter of 15 September 2016, in which it was said "pain continued to limit her mobility," was referenced in the second stage decision. Nonetheless, the medical adviser concluded that a combined approach of improved activity management, reduction in analgesia and six-monthly caudal injections was likely to result in Mrs E being fit for alternative work of like duration.
- It would have been helpful if the medical adviser considered the average duration over which the positive effects of future injections might last, and how this treatment interacted with the other suggestions. However, this discrepancy, or NHS BSA's lack of questioning this, did not mean the overall conclusion was flawed. The medical adviser believed the injections were one part of an overall holistic approach, which was reinforced by the medical adviser saying that Mrs E needed to be encouraged to implement the advice given and not spend all her time "on the go."
- NHS BSA had acted in accordance with the Regulations in assessing Mrs E's IHER application.

32. NHS BSA accepted the Adjudicator's Opinion. Mrs E did not accept the Adjudicator's Opinion and made the following comments: -

- She felt that she was in the same position as seven years ago having done everything asked of her.
- She was no longer having pain injections as her pain consultant considered these were not working as expected.
- The additional conditions she had meant she felt more pain than she would normally, and she found the simplest of tasks difficult.
- In reading the Adjudicator's findings, she felt that certain notes had been carefully selected, leaving out the pain and struggle which she had endured over the last seven years.

33. The complaint has been passed to me to consider. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Mrs E for completeness.

Ombudsman's decision

34. I would firstly like to highlight that the Ombudsman's role is not to replace NHS BSA as the decision maker, but to decide whether NHS BSA has followed the correct process and reached a reasonable decision.

35. In NHS BSA's second stage IDRP decision, the medical adviser considered all of the relevant factors outlined in Regulation E2A(15) of the Regulations. Specifically, they

took into account the various symptoms pertaining to Mrs E's physical and mental capacity, and reached the view, partly on the basis of the treatments already tried, that injection therapies and graded exercise would help her to eventually become fit for alternative work. Whilst Mrs E, may disagree with this view, I cannot see that such a conclusion was inconsistent with the Regulations, or that the reasoning within this was inherently flawed or perverse.

36. Although Mrs E can, with the passage of time, say that medical adviser's prognosis has not proven correct, my assessment of NHS BSA's decision must be limited to the evidence considered in the IDRP. Equally, NHS BSA has acted in accordance with the Regulations by assessing the condition presented to it in 2012.

37. I have considerable sympathy for Mrs E and the conditions she has endured over the last seven years. However, I am unable to find that NHS BSA has made an administrative error in assessing her IHER application.

38. Therefore, I do not uphold Mrs E's complaint.

Anthony Arter

Pensions Ombudsman
23 March 2018