The Pensions Ombudsman

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Mrs N has complained that her application for the early payment of her benefits from active status on the grounds of ill health has not been considered in a proper manner.

Background information, including submissions from the parties

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

4. The relevant regulations are the NHS Pension Scheme Regulations 1995 (SI1995/300) (as amended). Regulation E2A provides for "Ill health pension on early retirement" as follows:

"(1) This regulation applies to a member who -

(a) retires from pensionable employment on or after 1st April 2008;

(b) did not submit Form AW33E (or such other form as the Secretary of State accepted) together with supporting medical evidence if not included in the form pursuant to regulation E2 which was received by the Secretary of State before 1st April 2008, and

(c) is not in receipt of a pension under regulation E2.

(2) A member to whom this regulation applies who retires from pensionable employment before normal benefit age shall be entitled to a pension under this regulation if -

(a) the member has at least 2 years qualifying service or qualifies for a pension under regulation E1; and

(b) the member's employment is terminated because of physical or mental infirmity as a result of which the member is -

(i) permanently incapable of efficiently discharging the duties of that employment (the **"tier 1 condition"**); or

(ii) permanently incapable of regular employment of like duration (the **"tier 2 condition"**) in addition to meeting the tier 1 condition."

5. Further extracts from the regulations are provided in Appendix 2.

6. Mrs N had been employed by the NHS since 1988, latterly as a full-time research nurse with Newcastle Hospitals NHS Trust (the **Employer**), until 9 March 2012 when she went on long term sick leave. Her contract was terminated mutually in September 2013. At the time she was aged 43 and her 'normal benefit age' was 60.

7. Mrs N's period of sickness absence began in March 2012 when, following complaints of fatigue, swallowing problems, loss of vision and loss of balance, her GP referred her to Neurology as an emergency (although she was treated as a non-emergency case). She was put on a reduced dose of steroids and her symptoms improved. She was also referred to Ophthalmology for a review of her visual disturbance. In June 2012, her steroids were stopped altogether and her symptoms then re-emerged and worsened.

8. On 15 June 2012, Mrs N attended an appointment with Dr Paterson, a Consultant Occupational Health Physician with Newcastle Occupational Health Service (**OHS**), who concluded that she remained not well enough to return to work. Further OHS reports in August and October 2012 confirmed that she remained unfit to return to work.

9. On 20 December 2012, Mrs N had an MRI scan arranged by Dr Dorman, Consultant Neurologist. Following this she was diagnosed with an Epidermoid Tumour on a Right Cerebellopontine Angle with Invasion to Trigeminal Nerve and Pons. As a result she was referred to Mr Crossman, Consultant Neurosurgeon.

10. In January 2013, at the request of Mr Crossman she saw Professor Wilson, Consultant ENT Surgeon. Professor Wilson said, in a letter dated 11 February 2013, that "in addition to the dysphagia she has a number of very disabling generalised symptoms". A copy of the medical reports can be found in Appendix 1.

11. On 11 January 2013, Dr Paterson wrote to the Employer to say that he had received an update from Mrs N's specialist advising that she was awaiting plans for further treatment and was unfit for "any form of work at the moment".

12. On 23 January 2013, Mrs N attended a Human Resources (**HR**) review meeting with the Employer at which ill health retirement was discussed. Mrs N was asked to consider this and was given pension adviser contact details. An application form AW33E (the **Application**) for Ill Health Retirement Benefit (**IHRB**) was requested from Payroll. The Application consisted of three parts: Part A was to be completed by the Employer, Part B was to be completed by Mrs N and Part C was to be completed by OHS.

13. During February and March 2013, Mrs N's line manager contacted OHS to ask it to carry out a review of her case. OHS requested reports from the specialists involved with her case. Dr Dharmadhikari, a Specialty Registrar with OHS, reported, on 19 April 2013, that reports from neurologists remained outstanding and that the ophthalmology report was not conclusive enough on its own to support Mrs N's claim for IHRB.

14. On 3 June 2013, Dr Dharmadhikari wrote to the Employer to confirm that further investigations were scheduled and that Mrs N remained unwell and unable to return to work.

15. On 12 July 2013, Mrs N was given the partly completed Application and asked to complete Part B before passing it to OHS. Part A of the Application noted that "[Mrs N] is in receipt of [Employment and Support Allowance] – terminal pathway."

16. Much of the Application noted that Mrs N was not fit to return to work at that time in any capacity as a result of which no type or period of rehabilitation had been considered.

17. On 26 September 2013, the HR Officer emailed Dr Dharmadhikari to ask whether Mrs N's application for IHRB could continue following the decision to terminate her contract and, if so, if it could be processed faster by NHS BSA as her consultant had submitted a form DS1500[1].

18. Dr Dharmadhikari responded later the same day to say that if the specialist advised that Mrs N's condition was terminal NHS BSA would hopefully deal with her application as a priority.

19. In Part C of the Application Dr Dharmadhikari listed Mrs N's currently diagnosed medical conditions as:

   "Epidermoid tumour on right side April 2013;

   progressive dysphagia since few months;

   Labyrinthitis in Aug 2012

[1] The DS1500 form is used in circumstances where the employee's healthcare professional thinks they might have less than six months to live.

Myasthenia gravis 1999"

20. Under the section titled "Provide details of the reported reason(s) for current incapacity Dr Dharmadhikari said, "Reported symptoms from the tumour-complex unexplained symptoms." The symptoms were described as:

    "reduction of vision in left eye, loss of hearing in left ear, progressive dysphagia, weight loss, dizziness, seizures up to 3 episodes/day, loss of sensation on left side of face, bone pain on facial bones on left side, headaches".

21. In answer to the question "What is the likely future course of this member's health and function, with normal therapeutic intervention over the period to normal pension or benefit age" Dr Dharmadhikari said:

    "Unlikely to return to work at present due to level of symptoms, reports from specialists enclosed show that unable to explain above symptoms from the tumour, but symptoms persistent and therefore cannot comment on timescale for recovery."

22. Dr Dharmadhikari summarised his findings by saying:

    "I am unable to comment on prognosis based on the reports available to me. This member of staff (Mrs N) has now left the trust on grounds of ill health and I have been informed by HR that her GP has recently completed a DS1500 form – however I do not have any additional information available to me at the time of completion of this form".

23. He enclosed a copy of reports by Mr Crossman dated 28 January 2013, 29 April 2013 and 3 July 2013; a copy of a report by Professor Wilson dated 11 February 2013; a copy of reports by Dr Dorman dated 22 October 2012 and 5 November 2012 (with a copy of clinic letter dated 17 September 2012); and a copy of a report by Dr Miller dated 25 September 2012 (see Appendix 1).

24. Dr Dharmadhikari completed Part C of the Application on 8 October 2013.

25. At the time, the authority to make first instance decisions on ill health retirement had been delegated to the Scheme's Medical Adviser (SMA), Atos Healthcare. On 30 December 2013, the SMA wrote to Mrs N declining her application. It quoted from the doctor who had reviewed the case , Dr Fisher, who concluded that the available information did not tend to indicate that Mrs N was, on the balance of probability, permanently incapable of carrying out the duties of her NHS employment. Therefore, she did not meet the Tier 1 condition and, consequently, did not meet the Tier 2 condition. Based on this, NHS BSA wrote to Mrs N to tell her that her application had not been successful.

26. On 9 August 2018, Mrs N raised a complaint against the decision made in December 2013 under Stage 1 of the Scheme's Internal Dispute Resolution Procedure (**IDRP**). In support of her case she submitted:

- a Personal Independence Payment (**PIP**) notification, dated 27 October 2016, confirming she was entitled to the enhanced rate of payment;
- a letter from the Pain Management Unit at Chester le Street Community Hospital dated 21 March 2018; and
- a letter from Dr Laird, Pain Management Consultant dated 30 April 2018.

27. The Dispute Officer for NHS BSA issued its response to Mrs N's IDRP stage 1 complaint on 3 October 2018. In the response she said that she had undertaken a review of Mrs N's application together with a new SMA, Dr Evans, taking into account all the available evidence. The response quoted the SMA at length, saying that he had commented that in his opinion the relevant medical evidence had been considered and indicated that, on the balance of probability, at the time Mrs N left employment she was not permanently incapable of NHS employment, so that Tier 1 was not met. Furthermore, Mrs N was not permanently incapable of regular employment of like duration so that Tier 2 was not met.

28. On 22 May 2019, in response to an enquiry from Mrs N, Dr Murphy, a Consultant Occupational Physician with Newcastle OHS wrote to her. She said that she had reviewed all the available information in the OHS record, but the opinions Mrs N sought could not be answered by her or anyone in the current team as they were not her physicians at the time. She said that the usual process for progressing an application for IHRB appeared to have been followed and included specialist reports from Dr Crossman dated 3 October 2013.

29. On 7 June 2019, Mrs N appealed under Stage 2 of the IDRP via her MP's office. She said that the decision made in November 2013 was incorrect because it had been made with insufficient information and the evidence showed that on the balance of probability, she was suffering a permanent incapacity and therefore did meet Tier 1 and Tier 2.

30. Specifically, she submitted that throughout 2013 her line manager was writing to Dr Dharmadhikari for the necessary forms to progress ill health retirement. It was therefore clear that her line manager believed the criteria were met as Mrs N had been told by her consultant, as did Dr Dharmadhikari who had sought reports from specialists. Dr Dharmadhikari had said in a letter in March 2013 that she had been reviewed by Mr Crossman and been advised that she had a clear prognosis and that she would remain permanently unfit for work. It was therefore clear that the termination of employment was agreed by her in expectation of ill-health retirement and access to her pension.

31. Mrs N said that many of the comments made by Mr Crossman appeared to be tentative suggestions rather than definitive diagnoses. Following her discharge from hospital in August 2013 she was referred to MacMillan and Alnwick Hospice. There was also reference to form DS1500 and the need for her case to be expedited due to terminal illness.

32. She argued that Dr Evans had misread the evidence relating to the epidermoid cyst. He had said that this was not thought to be the cause of her symptoms and noted that no intervention was planned. She says that Mr Crossman had said the tumour did not explain all her symptoms and that the reason no intervention was planned was that none was possible. Mr Crossman had explained to her that the tumour was inoperable.

33. She also disputed Dr Evans' findings with regard to future treatments generally and specifically with regard to migraines. She also pointed out that she had never been diagnosed with chronic fatigue and that no further investigations were carried out. Similarly, functional neurological disorder had only been tentatively mentioned and, although it was stated that the majority of people do not recover from it, the conclusion reached was still that any incapacity in her case was not likely to be permanent. She said the opinion of specialists at the time was that her collection of symptoms was very disabling and was unexplained.

34. She asserted that with such uncertainty, NHS BSA should not have reached the conclusion that it did and that it should have sought more detailed medical evidence from Mr Crossman to ascertain whether a diagnosis of terminal illness had been made and what investigations and future treatments were planned.

35. On 30 July 2019, NHS BSA issued its response to Mrs N's Stage 2 complaint. The letter was similar to the one issued in response to the Stage 1 response. The writer said that she had undertaken a thorough review of Mrs N's application taking into account all the available relevant evidence including the latest information provided. She said that NHS BSA took advice on medical matters from professionally qualified, experienced Occupational Health doctors. The SMA considering Mrs N's case, Dr Rooms, had recommended that she did not satisfy the Tier 1 conditions laid down in Regulation E2A.

36. Again, the SMA's report was quoted at length. It said that all the contemporaneous evidence (see Appendix 1) had been considered together with the recent submissions made by Mrs N. Based on this, the SMA concluded that Mrs N, on the balance of probability, did not meet the Tier 1 condition of permanent incapacity at the time of leaving employment and the Tier 2 condition was therefore also not met. He said that while there was reasonable medical evidence that, at the time of leaving employment, Mrs N had a physical or mental infirmity as a result of which she was unable to efficiently discharge her duties, the key issue was whether that incapacity was likely to have been permanent. Where evidence had subsequently been submitted it would only be taken into account where it provided data as to the likely prognosis at the time Mrs N's employment finished.

37. NHS BSA's position:-

- It submits that it has properly considered Mrs N's application, taking into account and weighing all relevant evidence. It has taken advice from the SMAs,

considered and accepted that advice and arrived at a decision that it believes is not perverse.

- It does not accept that Mrs N meets the Tier 1 condition for IHRB; it considers that before she reaches normal retirement age, she will be capable of the duties of her NHS employment as a Research Nurse. Having taken advice from the Scheme's medical adviser it has concluded that at the date of severance of her NHS employment Mrs N did not meet the Tier 1 condition.

- In considering Mrs N's application for IHRB, the medial adviser's recommendations and rationales are founded on the correct interpretation of the appropriate Regulations.

38. It refutes any allegations of maladministration and submits that it has correctly considered Mrs N's application for IHRB, taking into account all available relevant evidence and weighing it appropriately. In reaching its conclusion it has sought and considered the advice of its SMAs.

Adjudicator's Opinion

39. Mrs N'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 below:-

- Having reviewed the advice provided by NHS BSA's medical advisers, the Adjudicator saw no evidence of any misunderstanding of the Regulations. Nor was there any evidence of an error or omission of fact on the part of the OHS doctors.

- In addition, the views expressed by the OHS doctors did not appear to be at odds with the opinion given by Dr Anderson in October 2013. She supported the diagnosis of myasthenia and noted Mrs N had longstanding symptoms of fatigue. She also noted Mrs N remained under the review of Mr Crossman for monitoring of an epidermoid tumour but said that neither she nor Mr Crossman felt that this was contributory to Mrs N's problems at the time. Dr Anderson did not feel Mrs N was permanently incapable and supported a phased return to work.

- The evidence provided by Mr Crossman, Professor Wilson and Dr Dorman confirmed that Mrs N's condition was complex and remained unexplained. However, the indications were that future treatment options existed. While there was a suggestion that Mrs N's GP considered her condition to be terminal, there was no evidence to show that form DS1500 was completed or submitted to NHS BSA.

- The PIP assessment in 2016 and letters from Dr Laird and the Pain Management Unit in 2018 related to Mrs N's condition as it then presented and, as such, were

not relevant to his consideration of NHS BSA's decision refusing her ill health retirement from active status.

- The Adjudicator recognised that Mrs N did not agree with the views expressed by the OHS doctors and he acknowledged that she was still experiencing significant issues with her health. However, he did not believe that there were grounds for finding that NHS BSA should not have accepted the advice it received from OHS and its SMAs.

- In his opinion, there were no grounds for finding maladministration on the part of NHS BSA and Mrs N's complaint should not be upheld.

- He noted that Mrs N may apply for ill health retirement from deferred status. This would consider the medical evidence pertaining to her current health.

40. Mrs N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mrs N provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Mrs N.

41. Mrs N has made the following points set out in Paragraphs 42 to 54 below.

42. She understands that in 2013 nobody could have predicted how her illness was going to develop, however she believes there have been discrepancies and additional information missing.

43. On diagnosis of her first brain tumour her professional licence with the Nursing and Midwifery Council was removed and her driving licence was revoked by DVLA. She is still unable to drive indefinitely.

44. In 2013, OHS was advised that form DS1500 had been completed by her GP but it never arrived.

45. In October 2013, she signed a document agreeing to terminate her employment on a mutual arrangement as she was advised her in-service ill health pension would be paid on signing the form. At this point, she had recently been discharged from the neurosurgery ward and was on various medications including Oramorph (a liquid form of Morphine) and was probably not competent to sign any documents.

46. From some months before her diagnosis she had been suffering from severe headaches. She suffered vomiting, dizziness, visual disturbances, numb face and 'absent moments'. The onset of this had occurred while she was inputting data into a computer in the presence of her work colleagues. Yet her GP ignored all these symptoms saying it was 'all in her head' and suggested she needed to see a psychiatrist. She was upset by this, hence she paid privately for an MRI scan at the Nuffield hospital in Newcastle. This resulted in the first diagnosis of a brain stem tumour in the right Cp angle, affecting pons and strangulation of trigeminal nerve, which accounts for the headaches, dizziness, unbalance and no feeling in her face.

47. OHS had also written and telephoned her GP surgery on a number of occasions requesting them to order an MRI scan, which they refused to do as they considered it was a waste of money.

48. After undergoing various tests, treatments and medications she was advised the tumour was inoperable due to its location. She was then placed on a 'wait & watch' list.

49. Throughout 2014/15, her symptoms continued: daily vomiting; unable to lift her head off the pillow due to dizziness and headaches; and an increased number of falls. She was also now deaf in the right ear and had no vision in her left eye.

50. Following media coverage of the successful treatment of Ashya King[2], she sold her home and arranged private treatment at the proton beam centre in Prague. Here she was advised to take Tetrahydrocannabinol (**THC**) oil and to never stop it or the tumour would grow and more would develop. This assisted her with managing her condition on a daily basis, although symptoms continued.

51. On return from Prague, she needed daily assistance, but after an episode of her nearly drowning in the bath it was decided she required full time care. At this point although she remains mobile she requires aids and a wheelchair for outside. She also requires help on stairs following several falls.

52. She was referred to a Consultant, Dr Laird, at the Pain Management team to deal with her head pain and vomiting. She was prescribed a trial drug 'Nabilone' capsules which is a synthetic THC treatment. She was told these are only prescribed in Terminal cases. Her weight increased from six stone to eight stone, the vomiting was less although she still had nausea and balance issues with falls continuing. After 18 months on this medication the NHS stopped the trial as it was too expensive.

53. All her symptoms continue as at first diagnosis. She lies in bed most days unable to lift her head off the pillow and vomiting into bowls next to her. She suffers choking several times a day. This can be caused by food, drink and even just her own saliva.

54. Regular MRIs continue. A second brain tumour has developed, Meningioma, in upper right of head. She has a lack of ability to understand written comprehension and is now unable to read. This is deteriorating at a rapid rate. The most recent MRI scan indicates the first tumour has increased in size again. She has a forthcoming appointment with Mr Crossman to discuss her options.

55. She feels she has fought the system to no avail. Maybe it is because the NHS refuses to accept real life situations and continues to give to the members with 'bad

[2] The well publicised case of Ashya King concerned a boy who suffered from a brain tumour. His parents wanted their son to be treated with proton therapy, which they felt was less harmful than conventional radiotherapy. At that time, the NHS did not provide proton therapy in the United Kingdom. The issues about treating the boy were brought to the High Court to be resolved, and on 5 September 2014, the Court ruled that Ashya could receive proton therapy in Prague.

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backs' who then go on to get other jobs after being awarded NHS pension. This will never happen in her case. She was told to go and get a job a few years ago, she applied but OHS asked what she was doing and said she could never work again in any capacity. That was documented from 2013.

Ombudsman's decision

56. It may help if I explain that it is not my role to make a decision on Mrs N's eligibility for a pension under Regulation E2A. My role is to consider the decision-making process undertaken by the SMA, under a delegated authority, and NHS BSA.

57. The issues I need to consider include whether the relevant regulations have been correctly applied; whether appropriate evidence has been obtained and considered; and whether the decision is supported by the available relevant evidence.

58. Medical (and other) evidence is reviewed in order to determine whether it supports the decision made. However, the weight which is attached to any of the evidence is for NHS BSA to decide (including giving some of it little or no weight)[3]. It is open to NHS BSA to prefer evidence from its own advisers; unless there is a cogent reason why it should not or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the SMA. If the decision-making process is found to be flawed, the appropriate course of action is for the decision to be remitted for NHS BSA to reconsider.

59. Because Mrs N was applying for ill health retirement as an active member, under regulation E2A, she had to meet the criteria for payment at the time her employment ceased in September 2013. Namely, her employment had to be terminated on the grounds of ill health and she had to be deemed either permanently incapable, that is to age 60, of her NHS employment (the tier 1 condition), or regular employment of like duration in addition to her NHS employment (the tier 2 condition).

60. Mrs N says she signed a document agreeing to terminate her employment on a mutual arrangement as she was advised by her employer that her in-service ill health pension would be paid on signing the form. But the decision was not one for her employer to make.

61. I note Mrs N has continued to be under the care of Mr Crossman and continues to provide up to date medical evidence. But the decisions reached by the SMA and NHS BSA have to be assessed in the light of the medical evidence which was, or could have been, available at the time her employment ended, or later comments on her condition at that time. Any subsequent deterioration in Mrs N's condition is not relevant to this assessment; unless it could reasonably have been foreseen at the time of the decision. A report as to Mrs N's current condition would not help

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

determine whether there was any maladministration in the way in which her regulation E2A application was considered.

62. It seems clear it was accepted by NHS BSA that Mrs N was not capable of efficiently discharging the duties of her NHS employment in September 2013. However, to satisfy the Tier 1 condition, Mrs N had to be permanently incapable of doing so. In other words, NHS BSA and its medical advisers also had to consider how likely it was that Mrs N would recover, at some point before her 60th birthday, such that she would again be able to discharge those duties. If the medical evidence suggested that, on the balance of probabilities, Mrs N was going to recover sufficiently before her 60th birthday, the Tier 1 condition is not met. If the Tier 1 condition is not met, the Tier 2 condition need not be considered,

63. It is clear from Mrs N's submissions and her correspondence with my Office that she is still experiencing significant issues with her health and for that she has my genuine sympathy. However, the decision to award IHRB under the Scheme Regulations must meet a high bar and I cannot allow subsequent developments to influence my consideration of her case. It is not a question of applying hindsight.

64. As the Adjudicator said in his Opinion, the consensus view of Mrs N's treating doctors was that hers was a complex case and it is clear from the contemporaneous medical evidence that the precise cause of many of her symptoms was not at all clear and that various treatments were being tried and further future treatments considered.

65. The developments that Mrs N refers to in her comments could not be foreseen when the SMA made its decision in 2013. I also cannot help but note that Mrs N did not appeal that decision until some five years later, which would suggest that she also believed that there remained a possibility of future improvement.

66. NHS BSA and its SMA reviewed Mrs N's case on several occasions and concluded that she did not meet the criteria for an IHRB. The SMA's advice does not appear to be inconsistent with the medical evidence submitted by Mrs N's treating doctors at that time. I find no reason why NHS BSA should not have accepted the advice from the SMA.

67. Clearly Mrs N does not agree with the conclusions reached by the SMA and NHS BSA. But, as I have said, it is not my role to make a decision on Mrs N's eligibility for a pension under Regulation E2A.

68. My review of the SMA's reports is to determine whether or not there was any reason why NHS BSA should not have relied on them in reaching a decision. This would include errors or omissions of fact, irrelevant matters taken into account or a misinterpretation of the relevant regulations.

69. The SMA's suggestions concerning treatment or its views on the likely outcome of treatment would not normally be something I would expect NHS BSA to query. But if, for example, there was an obvious disparity between the SMA's view and those of

Mrs N's treating doctors, I would expect this to be explained to NHS BSA and to Mrs N. However, I have seen no such obvious disparity in Mrs N's case.

70. In summary, I find that there was no reason why NHS BSA should not have relied on the advice it received from the SMA in reaching its decision. Its decision is supported by that advice and is compliant with the Regulations. The fact that Mrs N's condition since then has not progressed as might have been hoped for in 2013, does not undermine NHS BSA's decision.

71. As the Adjudicator has suggested, Mrs N may wish to consider submitting an application for an early payment of deferred benefits on the grounds of ill health, at which time she will be able to provide medical evidence reflecting her current health condition.

72. I do not uphold Mrs N's complaint.

Anthony Arter

Pensions Ombudsman
6 October 2022

Appendix 1

Medical Evidence

Letter from Dr Schaefer (Consultant Neurologist) to Dr Miller (Mrs N's GP) dated 17 August 2012

"…you will see from my letter dated 2nd May 2012 that [Mrs N] reported a number of episodes where her vision appeared transiently impaired and that I did not feel that they were likely to be neurological in origin. They certainly sounded too brief to be due to an optic neuritis, and one would certainly not expect them to recur if that were the case. One can see transient and recurrent visual symptoms due to uthoff's [sic] phenomenon in somebody who has previously suffered optic neuritis but there is no prior history of this and no signs of optic disc pallor on examination to support it…

…In summary my own thoughts having seen [Mrs N] was that there was no evidence of an optic neuritis based on the history or examination and no features that suggested multiple sclerosis. It does not sound as though her symptoms have changed significantly from that time. I therefore do not feel that an MRI brain scan is indicated unless something new has developed…"

Report from Dr Miller to Dr Hashtroudi (OHS) dated 25 September 2012

"…[Mrs N] continues to struggle with symptoms of fatigue and strange visual symptoms. I have performed screening tests on her prior to referring her to Immunology for a possible diagnosis of chronic fatigue syndrome. These bloods including U&E, LFT, Glucose, CRP, FBC, ESR and TFT's were all normal."

Dr Dorman's (Consultant Neurologist) report to Dr Miller dated 22 October 2012

"[Mrs N] presents with a history of headaches and episodes of visual disturbance. These date back about 14 months. She reports that the visual disturbance involves a "smoky" blurring of vision. She is not sure if it is binocular or not. However, she does state that it does seem to be mainly on the left side. This has occurred intermittently in the context of headache (which has been localised over the vertex). With the first episode of headache she felt sickly, but this is not been [sic] a consistent feature. She often has to lie down to manage the headache. The visual disturbance is usually episodic lasting about an hour. The headache has lasted longer at times.

She has other complex symptoms which remain unexplained. She described a tight sensation around her neck which feels like a scarf. She feels she cannot chew well. She said that she has been living off soup and reports about a stone of weight loss over the last year. She feels she cannot speak for too long as her voice becomes croaky. She also reported a two week period in which she was unable to speak at all.

She also complained of short term memory loss. Her husband stated that there was an occasion when they were by a swimming pool and [she] asked him the name of a little girl repeatedly. The memory disturbance does not seem to be a consistent problem. [She] feels that she "cannot take things in." She is currently off sick from her work as a

research nurse. She feels that she cannot concentrate well enough to take in documents at work. She reports that her legs are swollen at times and at times she finds it difficult to lie down because she feels that she might choke…

…She has been off work for about 30 weeks. Her main reason for being unable to work relates to constant fatigue as well as cognitive issues, particularly concentration. I note that she was able to drive herself from Belford to Newcastle Nuffield Hospital this afternoon…

She was alert and appropriate. She gave a clear history. Her vision and fields were full and fundi were normal. Her reading vision was N12 on the left and N6 on the right without correction. Eye movements were full and had no ptosis. There was a very mild symmetrical facial weakness. She had normal facial sensations. Her speech was normal. Palatal and tongue movements were normal. There was no tongue wasting.

In the motor system her gait was normal. Romberg's test was somewhat variable, but she finally managed it well after encouragement. She could walk well heel to toe. She could walk on her tiptoes and heels. She could rise from a squat without help. She could rise from the lying position without using her arms. Tone and power were normal all over. Reflexes were physiological and symmetrical and both plantars were flexor. She was normotensive.

OPINION

I note that her previous EMG investigations have shown some jitter and on this basis she has been diagnosed as suffering from a neuromuscular junction defect. The clinical signs today do not support anything more than very mild myasthenia and I do not think that this can account for much of her current symptomology.

Her episodes of visual disturbance sound quite migrainous. I suspect the associated headaches are also probably migrainous.

She has other symptoms which appear to be dominated by fatigue, as well as associated subjective cognitive concerns. She gave a clear history today. She was able to conduct a long car journey independently and indeed could give me a clear account of why she arrived late in clinic. In the informal assessment, I have found little evidence to support a significant cognitive disturbance. I think a significant neurological problem is unlikely. I wonder about a chronic fatigue syndrome or alternatively a functional neurological problem.

I think it would be reasonable to conduct further investigation to try and clarify the diagnosis. I will arrange an MRI scan of her brain and I will see her thereafter. If that proves normal, I would suggest that she engages with the chronic fatigue service to address her symptoms. In addition, it may also be helpful to seek an assessment / input from a speech and language therapist regarding her bulbar symptoms…"

Letter from Dr Dorman to Dr Dharmadhikari dated 5 November 2012

> "Thank you for requesting a report on this lady. I enclose my recent clinic letter.
>
> I had suggested further investigation, but she has cancelled the planned investigation. In the circumstances I can take matters no further."

Letter from Mr Crossman (Consultant Neurosurgeon) to Professor Wilson dated 28 January 2013

> "Over the past year [Mrs N] has noticed predominantly choking/tightness in her throat which has led to difficulty in eating solids. She also has increasing fatigue and dizziness and feels 'washy' with pain in her head.
>
> She has been reviewed by my colleague Dr Dorman, who arranged [for her] to undergo a MRI scan which demonstrated an epidermoid cyst. Dr Dorman feels that [her] symptoms are suggestive of a migraine and chronic fatigue type syndrome…"

Professor Wilson's (Honorary Consultant Department of Otolaryngology/head & neck surgery) report to Mr Crossman dated 11 February 2013

> "Thank you for referring [Mrs N] who has progressive dysphagia for eighteen months with choking on saliva and drinking fluid. She has more or less given up on solids and although initially lost two stone in weight has managed to regain half a stone so she is now back up to eight stone via supplements such as build up. She has been off work now…for some time and is imminently going to undertake an HR meeting in respect of early retirement through sickness.
>
> Her myasthenia gravis appears to be stable and not of any particular concern.
>
> As you know in addition to the dysphagia she has a number of very disabling generalised symptoms which Mr Mitchell does not feel are attributable to the epidermoid lesion which was discovered when she self funded an MRI scan at the Nuffield Hospital in December.
>
> The generalised symptoms include going dizzy, falling over, a noise of bees in the ears, transient visual disturbance, sometimes being confused and not knowing where she is, daughter reluctant to leave her alone, pins and needles in arms, numb face.
>
> She accepts that some of these symptoms have features of chronic fatigue and has a long standing lowish blood pressure.
>
> On examination oral mucosa unremarkable, neck showing no masses, flexible endoscopic examination of the laryngopharynx showed no obvious structural or functional abnormality at that level.
>
> In respect of the dysphagia I have copied this letter to our speech and language therapy team as it is up to them to decide whether or not a functional endoscopic evaluation of swallowing or a videofluoroscopy would be more productive under all these various circumstances.

In respect of her hypotension/chronic fatigue, I guess it is very much up to her general practitioner to decide whether an autonomic/fatigue investigation course of action via Professor Newton in the cardiovascular lab would be more productive, or at this stage whether a direct access to a cognitive Behaviour therapy would produce more symptomatic benefit for [her]."

Professor Wilson's letter to Dr Dharmadhikari dated 18 March 2013

"As you can see from the attached clinic letter of 11 February [2013], [Mrs N] has multiple unexplained persistent physical symptoms about which many questions remain unanswered".

Mr Crossman's report to Dr Dharmadhikari dated 29 April 2013

"[Mrs N] was referred to me by her GP Dr Miller in January this year after she had been investigated by Dr Dorman for fatigue, dizziness, headache and difficulty in swallowing.

Dr Dorman undertook an MRI scan which demonstrated an epidermoid tumour in the right posterior fossa with very mild indentation of the right side of the pons and displacement of the right trigeminal nerve.

In the past, in 1999 I understand [she] was diagnosed as suffering from myasthenia gravis following a respiratory arrest related to surgery. She remains on Pyridostigmine for this and also takes Paracetamol and Brufen.

Neurological examination was unremarkable.

I further reviewed the MRI scan which demonstrates a right epidermoid tumour. I feel this is unlikely to be the cause of all [her] symptoms, and referred [her] for a further opinion from Professor Janet Wilson."

Mr Crossman's report to OHS dated 3 July 2013

"I understand that in 1999 [Mrs N] was diagnosed as suffering from myasthenia gravis. She was on Pyridostigmine for this is (sic) January this year.

As part of investigations for her choking and swallowing problems and her dizziness and fatigue, she underwent an MRI of her brain at the Nuffield Hospital late last year which demonstrated an epidermoid tumour in the right cerebello-pontine angle region.

I reviewed this with my Neuroradiological colleagues and felt that this was unlikely to explain all of [her] symptoms and therefore referred her to Professor Wilson for advice on her symptoms.

[She] was subsequently reviewed in the Neurosurgical Department by myself in May 2013 when her symptoms were persistent rather than progressive. I requested a further MRI scan to see whether her radiological findings had altered. [She] was reviewed with the results of the MRI scan at the end of June. At this time she described new symptoms of popping and bubbling in both ears with possible reduced hearing and also reduction in her left eye vision.

The MRI scan obtained in June did not demonstrate any obvious change when compared to the study obtained at the end of last year of the epidermoid cyst in the right cerebello-pontine angle region."

Report from Mr Garvey (Optometrist) to Dr Dharmadhikari dated 11 August 2013

"[Mrs N] reported her L side visual field affected, and a blue tint to objects.

She reported a diagnosis of a brain stem tumour, awaiting further investigations…L eye peripheral field restricted, mainly temporal hemifield…

Action taken: No ocular pathology detected…

Future treatment to her neurological pathology will affect visual outcomes."

Letter from Dr Anderson (Consultant Neurologist) to Dr Jewell (independent medical adviser to NHS BSA) dated 25 October 2013

"At the stage at which I saw [Mrs N] she had migraine headaches and I have recommended a low dose of sodium Valproate as a preventative. We had no evidence that her myasthenia was causing significant symptoms and she has had longstanding symptoms of fatigue but my understanding that [sic] she had still worked during this time.

She is still under the review of Mr Crossman for monitoring of an incidental epidermoid cerebellopontine angle tumour which has not increased in size with repeat imaging and neither I or [sic] Mr Crossman felt that this was contributory to problems at the current time.

Therefore based on my single limited assessment, I would not feel that she was permanently incapable of efficiently discharging the duties of her job and we know that fatigue symptoms are often best managed with a graded and regular schedule and paced physical activity and a regular work schedule may provide some of this.

You may feel that you wish a report from Mr Crossman as well but my understanding is that he does not plan any neurosurgical intervention in the immediate future."

Appendix 2

The NHS Pension Scheme Regulations 1995 (SI1995/300) (as amended)

73. As at the date Mrs N's employment ceased, regulation E2A provided:

"E2A Ill health pension on early retirement

(1) [see Paragraph 6 above]

(2) [see Paragraph 6 above]

…

(13) For the purposes of determining whether a member is permanently incapable of efficiently discharging the duties of the member's employment under paragraph (2)(b)(i), the Secretary of State shall have regard to the factors in paragraph (15) (no one of which shall be decisive) and disregard the member's personal preferences for or against engaging in that employment.

(14) For the purposes of determining whether a member is permanently incapable of regular employment under paragraph (2)(b)(ii), the Secretary of State shall have regard to the factors in paragraph (16) (no one of which shall be decisive) and disregard the factors in paragraph (17).

(15) The factors to be taken into account for paragraph (13) are -

(a) whether the member has received appropriate medical treatment in respect of the incapacity;

(b) the member's -

(i) mental capacity; and

(ii) physical capacity;

(c) such type and period of rehabilitation which it would be reasonable for the member to undergo in respect of the member's incapacity, irrespective of whether such rehabilitation is undergone; and

(d) any other matter which the Secretary of State considers appropriate.

(16) The factors to be taken into account for paragraph (14) are -

(a) whether the member has received appropriate medical treatment in respect of the incapacity; and

(b) such reasonable employment as the member would be capable of engaging in if due regard is given to the member's -

(i) mental capacity;

(ii) physical capacity;

(iii) previous training; and

(iv) previous practical, professional and vocational experience,

irrespective of whether or not such employment is actually available to the member;

(c) such type and period of rehabilitation which it would be reasonable for the member to undergo in respect of the member's incapacity (irrespective of whether such rehabilitation is undergone) having regard to the member's -

(i) mental capacity, and

(ii) physical capacity:

(d) such type and period of training which it would be reasonable for the member to undergo in respect of the member's incapacity (irrespective of whether such training is undergone) having regard to the member's -

(i) mental capacity,

(ii) physical capacity,

(iii) previous training, and

(iv) previous practical, professional and vocational experience,

and

(e) any other matter which the Secretary of State considers appropriate.

(17) The factors to be disregarded for paragraph (14) are -

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

(b) the geographical location of the member.

(18) For the purpose of this regulation -

“appropriate medical treatment” means such medical treatment as it would be normal to receive in respect of the incapacity, but does not include any treatment that the Secretary of State considers -

(a) that it would be reasonable for the member to refuse,

(b) would provide no benefit to restoring the member's capacity for -

(i) efficiently discharging the duties of
the member's employment under paragraph (2)(b)(i), or

(ii) regular employment of like duration under paragraph (2)(b)(ii),

before the member reaches normal benefit age; and

(c) that, through no fault on the part of the member, it is not possible for the member to receive before the member reaches normal benefit age;

“permanently” means the period until normal benefit age; and

“regular employment of like duration” means -

(a) …

(b) in all other cases, where prior to retiring from employment that is pensionable the member was employed -

(i) on a whole-time basis, regular employment on a whole-time basis;

(ii) on a part-time basis, regular employment on a part-time basis,

regard being had to the number of hours, half-days and sessions the member worked in that employment.”