CAS-44115-R8N0

Ombudsman's Determination

Applicant	Ms R
Scheme	NHS Superannuation Scheme (Scotland) (**the Scheme**)
Respondent	Scottish Public Pensions Agency (**SPPA**)

Outcome

1. I do not uphold Ms R's complaint and no further action is required by SPPA.

Complaint summary

2. Ms R's complaint concerns SPPA's decision to award her a Lower Tier ill health retirement pension (**IHRP**). She believes she should be awarded an Upper Tier IHRP.

Background information, including submissions from the parties

3. Ms R worked part time as a Medical Secretary Band 3. In 2012, she underwent brain surgery. Throughout 2012 and 2013 and February 2015, Ms R was seen by Occupational Health (**OH**) for assessments. In the latest report dated 17 February 2015, OH physician, Dr Blair concluded:

> "I am therefore of the opinion that you need to decide whether you can accommodate Ms R's disability within the workplace. My personal opinion is that she is able to do the full range of duties of her job but not at the same pace nor at the same level of confidence as previously."

4. From October 2017, Ms R went on sickness absence and requested a mutual termination of her employment on the grounds of capability due to ill health. On 30 October 2017, her employer referred her for an assessment for an IHRP and asked her to complete the relevant application form.

5. In March 2018, Ms R applied for an IHRP due to cognitive impact related to her brain surgery in 2012. In her submissions, Ms R provided medical evidence dating back to 2012, relevant sections of which are set out in Appendix 2.

6. Ms R's application was subsequently referred by SPPA to the Scheme's Medical Adviser (**MA**).

7. The relevant regulations are The National Health Service Pension Scheme (Scotland) Regulations 2015 (SSI2015/94) (as amended) (the **2015 Regulations**). Regulations 89 and 90 contain the conditions for payment of an IHRP. Extracts from the 2015 Regulations are set out in Appendix 1.

8. Briefly, the 2015 Regulations provide for two tiers of IHRP; the Lower Tier and the Upper Tier. The conditions for payment of the Lower Tier are:

   - the member has not attained normal pension age;
   - the member has ceased to be employed in NHS employment;
   - the Scheme Manager[1] is satisfied that the member suffers from physical or mental infirmity as a result of which s/he is permanently incapable of efficiently discharging the duties of her/his employment.
   - the member's employment is terminated because of the physical or mental infirmity; and
   - the member claims payment of the pension.

9. The conditions for payment of an Upper Tier IHRP are that the Lower Tier conditions have been met and the member is "permanently incapable of engaging in regular employment of like duration". "Permanently" is defined as lasting until the member's prospective normal pension age. In Ms R's case, this is age 67.

10. In his report dated 4 June 2018, an MA, Dr Williamson, concluded that Ms R was not yet permanently incapable of discharging the duties of her employment. It was therefore his opinion that the Scheme conditions, on the balance of probabilities, were not met. He said that "until and unless an up-to-date assessment of her condition is undertaken by the relevant specialist, it is not possible to conclude it is likely to permanently incapacitate her for work." Based on the MA's advice, SPPA declined Ms R's application.

11. On 13 June 2018, Ms R's employment terminated.

12. In January 2019, Ms R appealed SPPA's decision under the Scheme's one-stage Internal Dispute Resolution Procedure (**IDRP**). In her submissions, she provided a report, dated 20 December 2018, from her Consultant Neuropsychologist, Dr Swanson. All relevant medical evidence relating to Ms R's application for an IHRP is set out in Appendix 2.

13. On 15 January 2019, SPPA sent Ms R its IDRP response in which it awarded her a Lower Tier IHRP. It referred to another MA's advice and said in summary:-

    - The MA had considered the previous evidence and Dr Swanson's most recent report in detail.

[1] The Scottish Ministers

- The MA noted Ms R's cognitive deficits were likely to permanently impair her capacity for administrative work. Until such time as evidence was available regarding the implementation of compensatory strategies and the effects of those strategies, a psychological assessment, treatments advised and the effects of the those, it could not be concluded that reasonable therapeutic options had been exhausted.

- Should Ms R seek to challenge this view, detailed evidence would be required in the form of: (i) a report from the neuro rehabilitation service describing the compensatory strategies considered appropriate; and (ii) a report describing all the measures implemented to manage Ms R's anxiety, including a detailed description of any prescribed medication, talking therapy, psychological therapy or cognitive behavioural therapy (**CBT**).

- The MA would expect such treatments and interventions to be available to Ms R. In the absence of evidence that such treatments had been exhausted or any specialist opinion to explain why they might not be effective, the MA did not, yet, have evidence to suggest Ms R's current symptoms were likely to persist until her normal pension age in 16 years.

- In the MA's opinion, while it was clear that Ms R's condition had not improved sufficiently to allow her to return to work, the MA would anticipate that spontaneous improvement in her condition was likely.

- There was reasonable medical evidence that Ms R was permanently unfit for her NHS role, but the MA could not be persuaded, on the balance of probabilities, that she was permanently incapable of engaging in regular employment of like duration.

- In summary, the MA's opinion was that, on the balance of probabilities, the Scheme conditions had been met at the Lower Tier. However, the Upper Tier conditions were not yet met.

14. On 13 February 2019, Ms R wrote to SPPA saying she understood she could not appeal further as the IDRP had now been completed. She said in summary:-

- She was not happy with being awarded a Lower Tier IHRP. She provided a report dated 31 July 2014, from her Consultant Neurologist, Dr O'Riordan, showing her medication had been altered due to behavioural problems.

- Regarding being referred to talking therapy, it would be a waste of NHS resources as her stress and anxiety had greatly reduced since she retired.

- She had had extensive occupational therapy in hospital, at home and in the workplace.

- The MA said they would anticipate that a spontaneous improvement in her condition was likely. However, it had been six years since her brain surgery and her brain function had not improved and her sight loss would never return.

- She questioned the independence of the MA who had considered her application.

15. SPPA referred Ms R's points to the MA for comments. In May 2019, SPPA provided an updated stage one IDRP response in which it concluded:

    - The provided report of 31 July 2014 was not contemporaneous and described changes to Ms R's medication which had previously been implemented to good effect.

    - There remained no evidence that Ms R had engaged with any form of psychological support to manage the effects of her cognitive difficulties. Until such evidence had been presented that Ms R had been afforded the opportunity to engage in suitable psychological support, it could not be concluded that reasonable therapeutic options had been exhausted.

    - The decision to award Ms R a Lower Tier IHRP remained unchanged.

16. Ms R provided to SPPA a further report from Dr Swanson, dated January 2019, for consideration. In its final revised stage one IDRP decision, dated 25 July 2019, SPPA quoted from the MA's advice. Relevant sections of the MA's advice are set out in Appendix 2. SPPA said in summary:-

    - The MA had not had any previous involvement with the case. The MA during the appeal process was a different MA to the MA who considered the initial application.

    - It had considered the following questions:

        - whether or not Ms R was permanently incapable by reason of physical or mental infirmity of efficiently discharging the duties of her NHS employment (Lower Tier); and, if the answer was yes,

        - whether or not Ms R was permanently incapable by reason of physical or mental infirmity of engaging in regular employment of like duration (Upper Tier); and

        - whether or not she was so incapacitated when her employment ended on 13 June 2018.

    - It had considered all the available evidence and it had determined, on behalf of the Scottish Ministers, that Ms R did not meet the conditions for an Upper Tier IHRP. She was eligible for a Lower Tier IHRP.

17. In its submissions to The Pensions Ombudsman (**TPO**), SPPA said in summary:-

- The Scheme operated a one-stage IDRP, which complies with pensions legislation and Citizen's Charter guidelines and was supported by TPO.

- Ms R could not appeal against the outcome of SPPA's one-stage decision. However, if there was further medical evidence available, which had been highlighted by the MA as being material to the outcome of her appeal, then SPPA would be willing to review that evidence.

- Ms R provided further evidence and her case was reviewed by the MA, but the advice was that the conditions for an Upper Tier IHRP were not met.

- Ms R's current state of wellbeing of her cognitive abilities as a result of stress or anxiety does not present a barrier for her return to alternative work. If she did develop deterioration of her cognitive abilities, then there are therapeutic options which could be explored; for instance, adjusting her medication, talking therapy, psychological therapy or cognitive behavioural therapy. Currently, there was no evidence that these therapeutic options had been exhausted.

18. In her submissions to TPO, Ms R said that SPPA did not consider all her medical evidence from Dr Swanson. Specifically, she wanted SPPA to review Dr Swanson's report of 25 September 2019, that said she would not anticipate that there would be any improvement in Ms R's cognitive impairments, which would support her application.

19. Following TPO's involvement, SPPA referred Dr Swanson's 25 September 2019 report to the MA for consideration. On 12 July 2022, SPPA provided advice from the MA rejecting Ms R's application. The MA concluded that: "we, still, have no new (or old) medical evidence to suggest that Ms R cannot return to alternative regular employment" and there were further treatments available to her that she had not undertaken. Relevant sections of the MA's report are set out in Appendix 2.

20. In response to the MA's report, Ms R said in summary:

- She disagreed with SPPA that she could undertake work in hospitality, retail, catering or domestic services. The Rules state such reasonable employment as a member would be capable of engaging in, if due regard is given to mental capacity, physical capacity, previous training and practical, professional experience. She had never worked in any of these jobs. "Is it because [she is] a woman [she] should be able to cook and clean? Would the SPPA tell a man with the same disabilities as [her] that he could get a job cooking and cleaning."

- There were major health and safety issues in all these jobs for her. Her cognitive impairments are permanent, and the loss of her left peripheral vision is permanent.

Adjudicator's Opinion

21. Ms R's complaint was considered by one of our Adjudicators who concluded that no further action was required by SPPA. The Adjudicator's findings are summarised below in paragraphs 22 to 41.

22. Members' entitlements to benefits when taking early retirement due to ill health are determined by the scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members are eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

23. The relevant regulations were 89 and 90 in the 2015 Regulations (see Appendix 1). Under Regulation 89, in order to receive an Upper Tier pension, Ms R must satisfy the Lower Tier conditions and be considered permanently incapable of engaging in regular employment of like duration. "Regular employment of like duration" was defined in relation to the type of employment (full time or part time) which the member was undertaking. In Ms R's case, she was working part time and, therefore, the regular employment by reference to which she was to be assessed was also part time. It did not have to be the same or similar to her NHS role; it could be any type of employment.

24. The Adjudicator noted Ms R's objection to the suggestion, by the MAs, that she might be capable of employment in hospitality, retail, catering or domestic services. Ms R's objection appeared to be based on a perception that such employment had been suggested by reference to her gender. The Adjudicator saw no evidence of this in the MAs' reports. The suggested employment appeared to have been put forward on the basis that they required less administrative and figure work than Ms R's former NHS role; that is, they were within the capacity of someone (of either gender) with her cognitive difficulties.

25. Decisions as to entitlement under Regulation 89 were to be made by the Scheme Manager, which was defined as the Scottish Ministers. SPPA made the decision on behalf of the Scottish Ministers. Decisions under Regulation 89 were not discretionary. In other words, SPPA was simply required to determine whether Ms R satisfied the Upper Tier conditions. If she did, she was entitled to an Upper Tier pension.

26. SPPA agreed that Ms R satisfied the Lower Tier conditions. The disagreement lay in its decision that Ms R was not permanently incapable of engaging in regular employment of like duration.

27. Regulation 90 set out the factors which SPPA must have regard to or ignore when making a decision under Regulation 89. Briefly, for the purposes of determining whether Ms R was permanently incapable of regular employment of like duration, SPPA must consider: (a) whether she had received appropriate treatment; (b) what reasonable employment she would be capable of; (c) the type and period of rehabilitation it would be reasonable for her to undergo; and (d) the type and period of

training it would be reasonable for her to undergo. It was to ignore Ms R's preferences and her location.

28. The 2015 Regulations did not specifically require SPPA to seek medical advice before making a decision under Regulation 89. The 2015 Regulations did provide SPPA with the option to require a member applying for an ill health retirement pension to submit to an examination by a medical practitioner chosen by it. If it did so, it must also allow the member to submit a report from her/his own doctor. SPPA did seek medical advice before making a decision, which was good practice. It also obtained evidence from Ms R's own medical practitioners. Again, this was good practice.

29. One of the specific obligations on SPPA was to consider all the relevant information which was available to it and ignore any irrelevant information. However, the weight which SPPA attached to any of the evidence was for it to decide; including giving some evidence little or no weight. It was open to SPPA to prefer the advice it received from its own medical advisers, unless there was a good reason why it should not do so or should not do so without first seeking clarification. The kind of things the Adjudicator had in mind were errors or omissions of fact or a misunderstanding of the regulatory requirements.

30. When reviewing the medical evidence, SPPA was only expected to look at the evidence from a lay perspective. It would not be expected to challenge a medical opinion. If there was a significant difference of opinion between its advisers and the member's own doctors, it could be expected to seek an explanation if this had not already been provided. A difference of opinion between the medical practitioners was not usually sufficient reason for the Ombudsman to ask for a decision to be retaken. So far as their medical opinions were concerned, the medical advisers did not come within the Ombudsman's jurisdiction. They were answerable to their own professional bodies and the General Medical Council.

31. In Ms R's case, SPPA had accepted the advice it received from its own medical advisers that she was not permanently incapable of regular employment of like duration. It would, therefore, be appropriate to consider this advice in detail.

32. The report provided for SPPA dated 4 June 2018 concluded, on the balance of probabilities, that, until and unless an up-to-date assessment of Ms R's condition was undertaken by the relevant specialist, it was not possible to conclude it was likely to permanently incapacitate her for work. Based on this advice, SPPA declined Ms R's application.

33. Following Ms R's appeal, SPPA wrote to her quoting from its MA who had explained what would be considered in order to assess her for an Upper Tier IHRP. SPPA gave Ms R the opportunity to submit further evidence.

34. The advice SPPA subsequently received from the MA was more detailed and, in particular, included details of the treatment options the MA thought would help Ms R recover sufficiently to undertake regular employment of like duration. The MA said

s/he would expect such treatments to be available to Ms R and did not anticipate that they would have a negative impact upon her well-being. S/he concluded that, in the absence of evidence that such treatments had been exhausted or a specialist opinion to explain why they might not be effective, s/he did not have evidence to suggest that Ms R's current symptoms were likely to persist until her normal pension age. The MA acknowledged that Ms R's cognitive impairment had not improved despite her compliance with her medical management to date. S/he said s/he would, nevertheless, anticipate that spontaneous improvement in Ms R's condition was likely. The MA later clarified that their reference to spontaneous improvement assumed that the therapeutic options they had described had been implemented.

35. SPPA offered Ms R another opportunity to provide further medical evidence to the MA.

36. The Adjudicator noted Ms R had told TPO that she wanted SPPA to consider the report from Dr Swanson dated 25 September 2019.

37. In her report, Dr Swanson noted SPPA's suggestion of further talking therapy but considered that Ms R did not need psychological therapy at present. However, Dr Swanson said, if Ms R was in a position where she was able to find suitable employment, she may require extra support at that time. While Dr Swanson considered that Ms R was not fit to carry out an administration role anymore, she agreed that Ms R may be able to undertake another role where these skills were not required. She anticipated that this would be at a lower level than Ms R had previously been able to sustain and recommended that Ms R would require additional support and consideration of reasonable adjustments to fulfil that role.

38. SPPA referred Dr Swanson's report to the MA for a further opinion. The final MA's opinion concluded that the report did not have any bearing on the previous advice. S/he recommended alternative, regular employment of like duration with a lesser administrative requirement for example in hospitality, retail, catering or domestic services, given Ms R's distress and anxiety had improved on leaving her NHS work. S/he was not persuaded, even on the balance of probabilities, that Ms R was permanently incapable of engaging in regular employment of like duration.

39. The Adjudicator noted that the advice from the MA was more optimistic than Dr Swanson's, but both were of the opinion that it would be possible for Ms R to attempt alternative employment. In any event, the difference in medical opinion between Ms R's treating doctors and the MA was not sufficient for the Ombudsman to remit the case back to SPPA for reconsideration. The Adjudicator had not identified anything which should have prompted SPPA to seek further clarification from its MAs before relying on their final advice.

40. Having reviewed the medical advice provided for SPPA, the Adjudicator had not identified any reason why it should not have relied on the advice from the MA in reaching its decision. There appeared to be no error or omission of fact on the part of the MA. S/he appeared to have considered all of Ms R's conditions and the treatment

she had received to date. The MA appeared to have understood the Upper Tier conditions and to have had access to Ms R's job description. The Adjudicator was satisfied that SPPA had enabled Ms R to provide further evidence to support her claim. It had then referred such evidence to the MA who gave it consideration.

41. The Adjudicator realised that it would be disappointing for Ms R, but it was her opinion that her complaint could not be upheld.

42. Ms R did not accept the Adjudicator's Opinion and in response provided further points. She said in summary:-

- Her understanding is that she will need to see a psychologist to get treatment to cope with being in the workplace again.
- She has not worked for over four years and, as SPPA says, statistically a return to work is highly unlikely.
- She would like to know the period of rehabilitation and training she would have to undergo.

43. Ms R's complaint was passed to me to consider. I have considered Ms R's further comments, but I find that they do not change the outcome. I agree with the Adjudicator's Opinion.

Ombudsman's decision

44. Insofar as their medical opinions are concerned, the MAs do not come within my jurisdiction. They are answerable to their own professional bodies. The question for me to consider is whether there was any reason why SPPA should not have relied on the advice it received from its MAs in making its decision. The reason would have to be apparent to a lay person; SPPA cannot be expected to challenge a medical opinion. This might include, but is not limited to, errors or omissions of fact, failure to consider all relevant medical conditions or a misunderstanding of the Upper Tier conditions.

45. I appreciate that it must be extremely difficult for Ms R having to live with her condition. However, in order to receive an Upper Tier IHRP, Ms R must satisfy the conditions set out in Regulation 89. In particular, she must be considered "**permanently** incapable of engaging in regular employment of like duration" (emphasis added). "Permanently" means until Ms R attains her prospective normal pension age of 67. It is accepted that Ms R is currently unable to engage in regular employment of like duration because of cognitive impairment. The question is whether Ms R's incapacity for such employment is likely to last until she reaches age 67.

46. The advice which SPPA received was it was more likely than not that Ms R's condition would improve sufficiently before her 67th birthday for her to be able to engage in regular employment of like duration. The MAs referred to a number of

treatment options which they considered were likely to improve Ms R's condition. The MAs' advice also included the type of employment Ms R could undertake. Such employment would come with a lesser administrative requirement; for example in hospitality, retail, catering or domestic services. Ms R has said that she has not worked for over four years and her return to work is highly unlikely.

47. I find that that the advice received from the MAs was comprehensive and provided details of treatments and the type of employment Ms R may undertake. The fact that Ms R's condition has not yet shown any improvement does not, in and of itself, invalidate the MAs' opinions.

48. Ms R wants to know the period of rehabilitation and training she would have to undergo. These questions will need to be addressed to Ms R's psychologist and future employer once she has commenced new employment.

49. I find that SPPA was entitled to rely on the advice it received from its MAs in reaching its decision on Ms R's eligibility for an Upper Tier IHRP. Its decision is supported by that advice and is compliant with the 2015 Regulations.

50. I do not uphold Ms R's complaint.

Anthony Arter

Pensions Ombudsman

24 August 2022

Appendix 1

The National Health Service Pension Scheme (Scotland) Regulations 2015

1. As at the date Ms R's employment ceased, Regulation 89 provided:

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

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

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

(2) The Lower Tier conditions are that -

(a) M has not attained normal pension age;

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

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

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

(e) M claims payment of the pension.

(3) The Upper Tier conditions are that -

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

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

…

(5) In paragraph (3)(b), **"regular employment of like duration"** means -

(a) …

(b) in any other case, where prior to ceasing NHS employment M was employed -

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

(ii) on a part-time basis, regular employment on a part-time basis, regard being had to the number of hours, half days and sessions the M worked in the employment …"

2. Regulation 90 provided:

"(1) For the purpose of determining whether a member (M) is permanently incapable of discharging the duties of M's employment efficiently, the scheme manager must -

(a) have regard to the factors in paragraph (2), no one of which is to be decisive; and

(b) disregard M's personal preference for or against engaging in the employment.

(2) The factors mentioned in paragraph (1)(a) are -

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

(b) M's mental capacity;

(c) M's physical capacity;

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

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

(3) For the purpose of determining whether M is permanently incapable of engaging in regular employment of like duration as mentioned in paragraph (3)(b) of regulation 89, the scheme manager must -

(a) have regard to the factors in paragraph (4), no one of which is to be decisive; and

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

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

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

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

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

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

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

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

(i) M's mental capacity; and

(ii) M's physical capacity.

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

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

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

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

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

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

(b) the geographical location of M.

(6) In this regulation -

"appropriate medical treatment" means such medical treatment as it would be normal to receive in respect of the infirmity, but does not include any treatment that the scheme manager considers -

(a) that it would be reasonable for M to refuse;

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

(i) discharging the duties of M's employment efficiently for the purposes of paragraph (2)(c) of regulation 89; or

(ii) engaging in regular employment of like duration for the purposes of paragraph (3)(b) of that regulation;

(c) that through no fault on the part of M, it is not possible for M to receive before M reaches normal pension age.

“permanently” means until M attains M's prospective normal pension age; and

“regular employment of like duration” has the same meaning as in regulation 89.”

Appendix 2

Medical Evidence

3. In his report dated 29 October 2012, Consultant Neurologist, Dr O'Riordan said:

> "The diagnosis in relation to these high signal changes is not certain and I think they are asymptomatic. In the first instance I have made arrangements for her to have a demyelinating blood screen and I have also scheduled repeat magnetic resonance imaging in 6 months and we will see her for review in 7 months."

4. In his report dated 8 November 2012, a GP, Dr Elliot said:

> "At present Ms R has been recently reviewed by Dr O'Riordan due to some minor changes on her MRI scan and I enclose a copy of his report. At present she is still awaiting an angiogram and then the further opinion of Mr Mowles regarding how we manage this problem further.
>
> As you are aware Ms R and I had a discussion about things on the 17/09/12 where she was very keen to at least try to return to work and I could see no reason that this was not a possibility and we therefore agreed that she would try returning to work on a part-time basis."

5. In his report dated 31 July 2014, Dr O'Riordan said:

> "…I would suggest changing from Levetiracetam to Lamotrigine in the following manner. Levetiracetam can certainly cause behavioural problems and may well be a factor."

6. In his report dated 21 November 2017, Dr Elliott said:

> "This 50 year old patient of mine has asked me to complete a medical report to support her claim for ill health retirement and early payment of her Royal Mail Statutory Pension.
>
> I can confirm that Ms R presented to ourselves back in 2012 having had a single seizure. Scanning of her brain confirmed that she had a right parietal cerebral arteriovenous malformation. She was started on anticonvulsive medication to control her epilepsy and following review by a neurosurgeon it was decided that she would benefit from neurosurgical repair of her aneurism to hopefully prevent further rupture in the future. She underwent repair of her aneurism in January 2013. Post operatively Ms R had further epileptic seizures and had some changes over the next number of months with her

anticonvulsant medication until something was found that both agreed with her and also controlled her symptoms. At present Ms R continues on lamotrigine 150mg twice daily and her seizures have been very well controlled with this.

Ms R had quite a bit of time off work when she was undergoing her surgical treatment and recovery though has been back at work for sometime.

Unfortunately since Ms R's brain issues, she has really struggled with performance at work and has found herself making simple errors, not passing on messages and struggling with changing IT systems. At times she has felt under severe pressure due to the supervision she has been put under and now has reached the stage where she feels she is unable to continue working.

I believe that Ms R has had support from her union Unison as they have supported her in applying for retiral on ill health grounds.

Without doubt Ms R was very unwell a number of years ago and recovered well from this though clearly has struggled with work since her return for the reasons stated above. I therefore support her application for early retirement on ill health grounds."

7. In his report dated 5 February 2018, Dr Elliott said:

"I can confirm that Ms R has had no contact with the Neurosurgical or Neurology Departments since 2015 and has not undergone any recent neuropsychometric assessment. Her main problems appear to be the increasing ability to cope with the stresses of work that she herself has concluded is the result of her previous brain surgery."

8. MA's report dated 4 June 2018, said:

"I note that Ms R works part time (18.75 hours/week) as a medical secretary in the setting of a child and adolescent mental health service. A job description has been provided and I have seen this sort of work which is to provide comprehensive secretarial and administrative support within the CAMHS. This will include a large amount of computer-based work requiring keyboard skills with a high degree of speed and accuracy. There is also the potential due to the patients served by CAMHS for the role to occasionally be emotionally distressing.

The sickness record identifies absence from 30/10/2017 for a non-specified reason.

…

The only recent medical evidence other than the above described GP reports from Dr Elliot consists of the information provided in the AW8/Med by Dr Lewthwaite, Consultant Occupational Health Physician. He notes that he undertook a telephone consultation 22/11/2017 to inform the completion of the

AW8/Med, but that other than that she had not been seen in occupational health since 2015. Dr Lewthwaite notes that Ms R reported struggling at work for some months particularly with multitasking or learning new skills and appeared to find change to computer systems et cetera difficult to get to grips with, hampered by reported short-term memory problems and problems with focus and concentration. She apparently reported making excessive errors such as getting numbers mixed up and that when she made errors her anxiety would increase further. She also noted her impaired vision [is] such that she might stumble over items on the floor and had difficulty gauging distance. She reported three seizures to Dr Lethwaite's appearance [*sic*] in 2017 following a bereavement earlier in the year.

Dr Lewthwaite notes that with regards to the reported cognitive impact that may be related to the previous surgery and/or the resultant epilepsy, there has been no neuro psychometric assessment so additional information about cognitive functioning was not available other than that provided by Ms R on the telephone consultation and the earlier reports. Dr Lewthwaite also notes that the reported cognitive impacts may be contributed to by a perception of work stress although states that the referral received from line management in October 17 did not mention any overt concerns. Dr Lewthwaite goes on to say that a neuro psychometric assessment might have been of benefit to clarify the nature of her reported cognitive decline and that without such additional information it is very difficult to predict what her prognosis is for normal retirement age. He notes that the reported concerns would make it very difficult for her to continue in a patient-facing role with unpredictable and variable work demands and that her pace of work is likely to be slower than others, in part related to visual problems. He concludes that she might be able to function better in a non-patient facing role with more regular and structured, predictable work demands.

Rationale

There is clear evidence that Ms R has a degree of visual impairment to her peripheral vision and that the previous Occupational Health assessments suggested this might reduce her pace of work, particularly in terms of data entry. However, noting that her last occupational health review was in 2015 and she remained in work until late 2017 it would appear in the absence of evidence to the contrary that this particular impairment was not a bar to her remaining in employment.

At the time of the last occupational health assessment in 2015 there do not appear to have been any concerns about Ms R's cognitive performance. It is not clear from the evidence presented when Ms R first noticed these problems. It would appear from the GP reports that there has been no further investigation or assessment of the reported cognitive problems. As noted by Dr Lewthwaite in the AW8/Med it is entirely feasible that one could experience cognitive deficit as a result of the surgery Ms R underwent, as a consequence

of her necessary anticonvulsants medication or indeed as a combination of the both. Furthermore, it is possible that any such problems could be exacerbated if Ms R was subject to psychological ill-health relating to stress. As yet however there is no evidence that any assessment has been made or whether she is experiencing mental ill health. It would be useful for such an assessment be made and then, if appropriate, treatment given such that the question of whether psychological factors are affecting her cognitive performance could be better understood. It may well prove to be the case that Ms R is experiencing long term objective cognitive deficit as a result of her neurological medical condition, but until and unless an up-to-date assessment of her condition is undertaken by the relevant specialist, it is not possible to conclude that it is likely to permanently incapacitate her for work.

If Ms R wishes to dispute this advice new medical evidence which addresses the points outlined above, specifically to address the issue of the likely prognosis following appropriate assessment and/or treatment would be helpful.

In the circumstances while it is my opinion there is reasonable medical evidence that Ms R's health problems currently prevent her from discharging the duties of her employment and/or engaging in regular employment of like duration I do not, yet, have medical evidence that her medical condition will continue to prevent a return to the duties of the employment before she reaches age 67 years.

I conclude that on the balance of probabilities Ms R is not, yet, permanently incapable of discharging the duties of her employment and it is therefore my opinion that the scheme definitions as outlined above, are, on the balance of probabilities, not met."

9. In her report dated 20 December 2018, Clinical Neuropsychologist, Dr Swanson said:

"Presenting Problems

Ms R reported noticing a range of cognitive problems when she returned to work as a[n] administration assistant at …Health Centre following her haemorrhage in July 2013. She described specific difficulties with number recognition…She reported difficulty seeing numbers and noted she often made errors when entering data and writing phone numbers down. When reading she often needed to use her finger as a visual cue to keep track of her position on the page. She reported difficulty managing money for example could not work out what change she was due when making purchases at the shops. She found it very difficult to do sudoku which she had previously enjoyed. She did not describe difficulties spelling. She described some mild apraxic difficulties for example noted reduced motor skill for typing, making more errors and requiring to look at the keyboard more regularly. She also described dressing apraxia for example often puts tops on the wrong way

round and puts her shoes on the wrong feet…She reports her pain response is reduced for example she often burns her fingers and got her finger trapped in a door without realising…She described increased irritability and anger following her return to work and noted she often became annoyed with colleagues and lost her temper which was out of character for her. She was redeployed and became a medical secretary with CAMHS in July 2014. She had a period of sick leave due to seizures however continued to struggle with many aspects of the job…She reports a number of physical modifications were made to the workplace on her behalf for example she was given a chair with 2 handles, a sloped board below her computer screen and the office was rearranged on her behalf.

With regards to her mood, she described feeling depressed while she was still at work. Her mood has now improved and she is sleeping and eating well. She does not report any particular hobbies or interests but regularly goes out to see family and friends and is content spending time at home …

Summary & recommendations

To summarise this 51 year old right handed woman sustained a large intra-cerebral haemorrhage secondary to a right parietal lobe AVM. Following this she described a range of cognitive [problems] including altered number recognition, reduced calculation abilities, apraxia, and reduced left/right orientation. She also described a change in her emotional responses with reduced empathy and increased anger and irritability…

Neuropsychological assessment has demonstrated variable attention with specific deficits in spatial attention, visual attention and divided attention. These difficulties impacted on her performance on tests of other cognitive domains. There was evidence of reduced visual memory secondary to her hemianopia and performance was mildly reduced on tests of mental arithmetic and finger recognition. Given the results of her assessment she meets 3 of the 4 criteria for Gerstmann syndrome. This is a rare neurological disorder characterised by the loss of four specific neurological functions: inability to write (dysgraphia or agraphia), the loss of the ability to do mathematics (acalculia), the inability to identify one’s own or another’s fingers (finger agnosia), and inability to make the distinction between the right and left side of the body.

This disorder typically occurs following left sided parietal damage and her haemorrhage was on the right side, it may be that has atypical cortical organisation or that the damage to her right parietal lobe has disrupted bilateral cortical networks resulting in a mild presentation of this disorder.

Other aspects of her cognitive function remain intact. Thus her performance was satisfactory on tests of verbal memory, naming, visual perceptual and spatial skills and on tests of executive function. Her profile demonstrates

specific impairments in keeping with parietal lobe damage. There is therefore evidence of cognitive difficulties which would have a significant impact on her ability to work in an administrative role.

…

I do not have any further plans to see her again and she has now been discharged from the Department of Clinical Neuropsychology."

10. In her report dated 13 March 2019, Dr Swanson said:

"When you came to your appointment in December we discussed some strategies that might be helpful in managing these difficulties by making simple changes to how you do things day to day. These included:

- Using a calculator when having to complete mental arithmetic, such as working out what change you are due in a shop. This would be relatively easy using your phone.
- Removing distractions from the environment for example turning off the television or the radio when you are trying to do a task.
- Focus on one task at a time.
- Breaking tasks down into a step-by-step plan.
- See attached information sheet for further strategies for managing difficulties with attention and concentration.

We discussed that a lot of the problems you have with your thinking have become less bothersome for you since you stopped working. This is probably because you have reduced stress, reduced pressure upon you and you have more time to carry out tasks."

11. MA's advice in IDRP response dated 25 July 2019 said:

"[Ms R] has previously described, and Dr Swanson observed improvement in her cognitive abilities following her removal from the administrative role which she found to be stressful. I remain of the view that [Ms R's] current state of well-being does not represent a barrier for her to return to alternative work. Should she develop worsening cognitive abilities in response to experiencing stress or anxiety arising from such endeavours, I would anticipate that treatment of new onset anxiety symptoms would be considered clinically appropriate and would be likely to result in an improvement in her cognitive abilities.

As no attempt has been made, no symptoms have arisen and no intervention is clinically indicated at this time. In my opinion, this does not mean that [Ms R] has exhausted reasonable therapeutic options in the event she develops new or worsening symptoms.

[Ms R] has advised that she may be dissatisfied with the care she has received to date. I cannot comment on her satisfaction with her care to date but I can advise that in my opinion, further therapeutic options remain open to [Ms R] in the event that she develops symptoms in response to engaging in alternative work.

[Ms R] advises that she is surprised by my statement that spontaneous improvement in her condition is likely. To clarify, in making that statement I am assuming that the therapeutic options described in my report have been implemented. If the comment is assumed to mean improvement in the absence of the therapeutic interventions described, I apologise for any lack of clarity.

It remains my opinion that there is not, yet, evidence that [Ms R] lacks the capacity for a suitable alternative role with adjustments and support. There are a number of work activities and environments such as hospitality, retail, catering or domestic services in which the requirement to perform administrative duties can be significantly reduced or eliminated.

In my opinion, while it is clear that [Ms R] has been compliant with her medical management to date, that despite this her condition has not improved sufficient to allow her to return to her NHS duties or engage in regular employment of like duration, I would anticipate that improvement in her condition remains likely. In my opinion, there is reasonable medical evidence that [Ms R] is permanently unfit for her NHS role but I cannot be persuaded, even on the balance of probabilities, that she is permanently incapable of engaging in regular employment of like duration.

In my opinion, there remains reasonable medical evidence that [Ms R's] health issues permanently prevent her from discharging the duties of her employment. However, it remains the case that there is not, yet, reasonable medical evidence that her medical condition will continue to prevent her from engaging in regular employment of like duration.

In summary, I conclude on the balance of probabilities that the scheme definitions as outlined above are met at the Lower Tier. In my opinion, the Upper Tier and the HMRC (HM Revenue and Customs) Severe Ill Health Test are not, yet, met."

12. In her report dated 25 September 2019, Dr Swanson said:

"There was no evidence you were suffering from depression or an anxiety disorder. **It was therefore my opinion that you did not require any further psychological support or therapy**…The SPPA have suggested that you would benefit from psychological therapy or cognitive behaviour therapy to manage your anxiety…The crucial part of this statement is that [SPPA] states you would benefit from additional psychological support "**in the event**" that you experience further psychological difficulties when attempting to re-engage

in employment. This would suggest to me that you do not need psychological therapy at present. However if you are in a position where you are able to find suitable employment you may require extra support at that time.

…

I would not anticipate that there would be any improvement in your cognitive impairments. The use of simple compensatory strategies can help you to manage difficulties, and could lead to improvements in your *functioning* however the underlying cognitive impairments would remain unchanged.

…

The difficulties seen on cognitive assessment in particular would make it very difficult to carry out an administrative role due to difficulties with typing, working with numbers and written material. As [SPPA] states it may be possible for you to work in another role where these skills are not required. If you were to seek further employment I anticipate that this would be at a lower level than you have previously been able to sustain and I would recommend that you would require additional support and consideration of reasonable adjustments that may need to be made in order for you to fulfil that role. It is difficult for me to provide further advice on this without having specific type of employment in mind. If you are able to secure new employment I would be happy for you to contact me for further advice or support at that time." [original emphasis]

13. Following TPO's involvement, SPPA provided a further report from the MA in July 2022 that said:

"The new medical evidence identified by the Pension Ombudsman takes the form of a letter from Dr Swanson, the same clinical neuropsychologist, dated 25/09/2019.

On this occasion Dr Swanson comments on information from SPPA dated 25/04/2019 and 25/07/2019 and I understand this is likely taken from the detailed advice from the SPPA Medical Advisers.

Dr Swanson notes that [Ms R's] stress and anxiety levels are improved and that her sleep is better. She notes that when assessed there was no evidence that [Ms R] was suffering from depression or anxiety disorder and therefore, in her opinion, [Ms R] did not require any further psychological full support or therapy. In my opinion this conclusion seems reasonable, as by then [Ms R] had left her employment and her health had improved.

Dr Swanson goes on to discuss talking therapies and how these may have been useful to [Ms R] when she was still working and under significant stress but how they would not be required as she had left work.

Dr Swanson notes that SPPA have indicated that [Ms R] may benefit from additional psychological support "in the event you experience further psychological difficulties when attempting to re-engage in employment". Dr Swanson makes a similar statement in advising that were [Ms R] able to find suitable employment she may require extra support at the time but Dr Swanson notes that she does not anticipate there would be any improvement in her cognitive impairment but advises that use of simple compensatory strategies can help [Ms R] manage her difficulties.

Dr Swanson further notes that were [Ms R] to seek further employment she anticipates this would be at a lower level than she had previously been able to sustain and she recommends that [Ms R] may require additional support and consideration of reasonable adjustments to fulfil that role.

Dr Swanson devises [*sic*] it is difficult to provide further advice on this without having specific types of employment in mind. She notes that if [Ms R] is able to secure new employment she would be happy to be contacted for further advice or support.

Conclusions

Having considered all the evidence in detail it is my opinion that we, still, have no new (or old) medical evidence to suggest that [Ms R] cannot return to alternative regular employment of like duration.

It is accepted that [Ms R] has a chronic and enduring health condition that impairs her cognitive function for administrative tasks.

It is accepted that, on the balance of probabilities, this means she is now permanently prevented from discharging the duties of her employment. Ill-health retirement has been and can still be supported at Lower Tier.

However, no doctor (or other healthcare professional) has indicated that there is good medical evidence to suggest that [Ms R] lacks the capacity for suitable alternative regular employment of like duration. Dr Lewthwaite concluded that [Ms R] may be better able to function in a non-patient facing role with regular and structured predictable work demands. Dr Swanson notes that were [Ms R] to seek further employment this would likely be at a lower level then she had been previously able to sustain and that she may require additional support and consideration of reasonable adjustments to fulfil that role.

It is accepted that [Ms R] has now been absent from the employment market for some 4 1/2 years and so statistically a return to work becomes unlikely but I note that she does, however, still have more than 10 years to her normal pension age of 67 years.

It is accepted that [Ms R] may have some natural anxiety associated with returning to the employment market but, as indicated above, there are

opportunities for supportive arrangements, reasonable adjustments and if necessary "talking therapies" to support her in a return to alternative regular employment of like duration (51% wte).

In the absence of any definitive statement explaining why [Ms R] could not work in alternative, regular employment of like duration with a lesser administrative requirement for example in hospitality, retail, catering or domestic services et cetera given her distress and anxiety have improved on leaving her NHS work I am not persuaded, even on the balance of probabilities, that she is permanently incapable of engaging in regular employment of like duration.

It is my opinion there is reasonable medical evidence that [Ms R] is permanently unfit for her NHS role (and indeed any other role with significant administrative activity) but I cannot be persuaded, even on the balance of probabilities, that she is permanently incapable of engaging in regular employment of like duration in the many years to her Normal Pension Age.

In summary, I conclude on the balance of probabilities that the scheme definitions as outlined above are met at the Lower Tier only. It follows that the Upper Tier and HMRC (HM Revenue and Customs) Severe Ill Health Test are not, yet, met."