PO-14333

Ombudsman's Determination

Applicant	Mr S
Scheme	BAE Systems Pension Scheme (the Scheme)
Respondent	BAE Systems Pension Fund Trustees Limited (the Trustees)

Outcome

1. I do not uphold Mr S' complaint and no further action is required by the Trustees.

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

Complaint summary

3. Mr S' complaint is about a decision by the Trustees to cease payment of his chronic ill-health pension.

Background information, including submissions from the parties

4. Mr S suffered a heart attack in 2001. In 2005, he submitted an application to the Trustees for a chronic ill-health pension, on the basis that he had been diagnosed with unstable angina.

5. The Trustees assessed Mr S's application under section 5.3 of the BAE Systems Pension Scheme Rules 2002 (**the Scheme Rules**) and determined that he was entitled to a chronic ill-health pension. A relevant extract from the Scheme Rules is provided in Appendix 1, and extracts from the available medical evidence are provided in Appendix 2.

6. In line with a provision in the Scheme Rules which permitted them, from time to time, to obtain evidence that Mr S continued to suffer from chronic ill-health, the Trustees requested a medical review in 2008.

7. Dr Kellerman, the then Pension Trustee Medical Adviser and a cardiologist at Bangkok Heart Hospital, examined Mr S, and provided a medical report to the Trustees. He reached the conclusion that Mr S no longer met the criteria, laid out in the Scheme Rules, for payment of a chronic ill-health pension.

8. Unhappy with this outcome, Mr S wrote to the Trustees in November 2008 to appeal. The Trustees forwarded a copy of Mr S' letter to Dr Kellerman, who provided his comments on 2 December 2008. Dr Kellerman noted that investigations, which Mr S had undergone in Thailand earlier that year, had included an ECG and chest x-ray, as well as an echocardiogram; none of which confirmed any form of unstable angina. Dr Kellerman recommended the Trustees obtain more detailed medical information concerning Mr S' cardiac and respiratory functions before reaching a final decision as to the outcome of the appeal.

9. Accordingly, the Trustees instructed Medigold Health, a company specialising in occupational health medicine, as to what additional information would be required to fully assess Mr S' appeal. The papers were reviewed by Dr Goldsmith, Senior Occupational Physician and Pensions Medicine Specialist, who concluded that Mr S should be examined by a cardiologist in London. However, due to transport difficulties, and Mr S' medical history, he was ultimately reviewed by Dr Kitiporn at Bangkok Heart Hospital.

10. Mr S was seen by Dr Kitiporn on 21 July 2009, when he had a resting ECG, a resting echocardiogram and a stress echocardiogram; all of which indicated that there was no active heart disease.

11. On the basis of the information contained in Dr Kellerman's report, Dr Goldsmith wrote to the Trustees on 23 July 2009 recommending that Mr S' appeal should not be upheld. Accordingly, the Trustees maintained their decision to cease payment of Mr S' chronic ill-health pension.

12. Mr S submitted a complaint to the Trustees on 9 May 2016. He said he had suffered a major heart attack in Thailand in April 2016 and that an angiogram confirmed that he had unstable angina. He also noted that an echocardiogram he had in July 2016 did not reveal coronary heart disease and, on that basis, questioned the validity of the echo cardiogram he underwent in Thailand in 2008. In addition, he related that in 2016, staff at the hospital had told him that an echocardiogam would not reveal coronary heart disease. On this basis, he argued that the evidence the Trustees were given in 2009 was flawed and incomplete. He submitted that there was a high likelihood he was suffering from unstable angina at the time of the review in 2008/9 and, as such, his ill-health pension should be reinstated.

13. The Trustees considered Mr S' complaint under the Scheme's internal dispute resolution procedure (**IDRP**). As part of this process, they obtained the opinion of a medical professional who had not been involved previously in Mr S's case, Dr Williams, Consultant Occupational Physician and Medigold Medical Director. On 11 October 2016, Dr Williams provided a report to the Trustees, in which he made the following points:-

- Dr Goldsmith had not said Mr S did not have any coronary heart disease. He had only stated that the investigations carried out in Thailand in 2008 had not revealed any

notable heart abnormalities at that time, notwithstanding Mr S's past history of heart problems.

- The findings of an investigation done in 2016 are not relevant to a decision made in 2008/9, since the blockages discovered then would have developed over several years. Dr Williams noted that Mr S suffered from a number of risk factors for heart disease, which would result in an increased likelihood that he would develop further heart problems in the future.

- Mr S had a dobutamine stress echocardiogram in 2008, not a simple echocardiogram. The former procedure involved drug-induced stress which produced a similar effect to a treadmill stress test. If Mr S's coronary heart disease was as severe in 2008/9 as it was in 2016, he would have expected the dobutamine stress echocardiograph to have identified some abnormalities.

14. The Trustees issued their stage 2 IDRP decision on 21 November 2016, maintaining that the decision to cease payment of Mr S's chronic ill-health pension in 2008/9 had been properly reached.

Adjudicator's Opinion

15. Mr S' complaint was considered by one of our Adjudicators, who concluded that no further action was required by the Trustees. The Adjudicator's findings are summarised briefly below:-

- Dr Williams' report provided several reasons as to why the evidence Mr S submitted to the Trustees in 2016 does not mean Dr Goldsmith's report was flawed. For example, he explained the difference between a simple echocardiogram and a dobutamine stress echocardiogram and that, had Mr S' coronary heart disease been as severe in 2008/9 as it was in 2016, the latter investigation could be expected to have revealed heart abnormalities. Further, that Mr S suffered from several health problems, which would have resulted in a worsening of his coronary heart disease between 2008/9 and 2016.

- Dr Williams did not criticise any aspect of Dr Goldsmith's report.

- In these circumstances, there was no reason to remit the decision reached in 2016 to the Trustees for reconsideration.

16. Mr S did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr S provided his further comments, which do not change the outcome. I agree with the Adjudicator's Opinion, summarised above, and I will therefore only respond to the key points made by Mr S for completeness. In summary, these are:-

- His angina attacks became more severe from 2007 onwards. This is reflected in the evidence from the angiogram which he had in 2016, which revealed that the original

blockage had lengthened to two inches. The angiogram also showed that, due to the severity of the original blockage, a second obstruction had developed over time.

- Dr Goldsmith did not mention the original blockage and asserted that there was no heart disease of any sort.
- All of the doctors he spoke to during his hospitalisation in 2016 were of the opinion that an echocardiogram would not establish the presence of coronary heart disease. Had he had an angiogram in 2008, the blockage(s) would have been found.

Ombudsman's decision

17. It is not my role to review the medical evidence and substitute the decision reached by the Trustees in 2016 with my own. I am primarily concerned with assessing the Trustees' decision-making process. I examine the available medical evidence only in order to establish whether it supported the decision reached by the Trustees. The issues considered include: whether the Trustees applied the Scheme Rules correctly; whether they obtained and considered relevant and appropriate evidence; and whether their decision was supported by the available evidence.

18. It is for the Trustees to determine what weight (if any) to ascribe to any of the available evidence. It is also acceptable for the Trustees to prefer evidence provided by their own medical adviser(s), unless there is a forceful reason they should not, or should not without seeking clarification. In the event that the decision-making process is found to be flawed, the decision will be remitted to the Trustees for reconsideration.

19. After receiving Mr S' complaint in 2016, the Trustees obtained the professional opinion of Dr Williams, who was a medical adviser not previously involved with his case.

20. Dr Williams was asked for his view as to whether the findings of the investigations in 2016 should invalidate the decision reached in 2008/9 to stop paying Mr S' chronic ill-health retirement pension. In his report dated 11 October 2016, Dr Williams clarified that Dr Goldsmith's conclusion was that the investigations in 2008 did not reveal significant heart problems, or heart failure, *at that time*, and not that he had no history of heart disease or heart failure.

21. Having examined Dr Goldsmith's report dated 23 July 2009, which formed the basis of the decision made in 2008/9 to cease payment of Mr S' chronic ill-health retirement pension, I note that it is indeed the case that he did not say Mr S did not have heart disease. What Dr Goldsmith said was that there was no evidence of active heart disease at the time he wrote his report. That Dr Goldsmith did not deny Mr S' history of heart problems is further illustrated by his reference, in his report, to Mr S' "myocardial infarction eight years ago". Accordingly, I find there was no inconsistency there which the trustees needed to consider further.

22. Dr Williams also explained the substantive differences between the simple echocardiogram Mr S underwent in 2016 and the dobutamine stress echocardiogram he had in 2008; notably, that the former simulated the heart's response to exercise-related stress, while the latter did not. Dr Williams' opinion was that, had Mr S' coronary heart disease been as severe in 2008 as it was in 2016, a dobutamine stress echocardiogram could be expected to have revealed some heart abnormalities. Dr Williams also noted that Mr S suffered from several medical complaints, which presented an increased likelihood that he would develop further heart problems in the future. As such, he concluded that the second blockage is likely to have developed after 2008/9.

23. As such, Dr Williams provided substantive reasons as to why the medical evidence Mr S submitted in 2016 cannot reasonably be said to invalidate the decision reached in 2008/9.

24. Furthermore, Dr Williams' report provides a detailed background, including references to the evidence Dr Goldsmith relied on in 2009 when he recommended Mr S' appeal should not succeed. As such, I am satisfied that the medical evidence which the Trustees made available to Dr Williams was sufficient to enable him to reach an informed judgment as to whether the information Mr S submitted in 2016 invalidated the decision made in 2008/9.

25. In these circumstances, I see no reason the Trustees should have sought further evidence or clarification before reaching the decision that the evidence Mr S submitted in 2016 did not call into question the decision made in 2008/9. Accordingly, I find no evidence that the decision arrived at by the Trustees in 2016 was improperly reached.

26. Therefore, I do not uphold Mr S' complaint.

Karen Johnston

Deputy Pensions Ombudsman
28 September 2017

Appendix 1

BAE Systems Pension Scheme Rules effective from 1 May 2002

27. Section 1 ("Meaning of words used") defines "Chronic ill-health" the following way:-

> "**Chronic Ill-health**" means physical or mental deterioration or any other condition which, in the opinion of the Trustees:
>
> results in a Member's being permanently unable to undertake any regular work for an Employer or any other employer; or
>
> seriously impairs the Member's earning capacity.
>
> In forming their opinion the Trustees will have regard to (but will not be bound by) reports submitted by the Employer's medical adviser and/or the Member's general practitioner and/or to such other medical evidence as they think fit".

Appendix 2

Medical evidence

28. On 23 July 2009, Dr M J Goldsmith issued a report to the Trustees, in which he concluded:-

> "I am now in a position to report back to the Trustees, having received very promptly the reports from Dr Kitiporn Angkasuwapala, the Consultant Cardiologist at Bangkok Heart Hospital as we arranged last month.
>
> The results are in some ways surprising, in that they show that there is no active heart disease at the current time with this man, but in other ways not so surprising because we were very doubtful that this man is anything like as ill as he maintains. Dr Renee' Kellerman was also of the view that this man has done extremely well since his myocardial infarction eight years ago and lives a normal lifestyle.
>
> Dr Kitiporn's findings in detail are that this man gave a history of his current illness of frequent chest pain, which has increased in severity. He also gave a past medical history of chronic obstructive pulmonary disease and also coronary artery disease. Amazingly, the full examination and vital signs were utterly normal. Blood pressure was 103/61, the pulse was 60, the temperature was 36.5 and respirations were 18/min. The head and neck examination, heart examination in full, lungs examination and abdomen, all were normal. Dr Kitiporn also said that the extremities showed no edema at all, which means there is no heart failure of any sort.

The next day Dr Kitiporn carried out a Dobutamine Stress Echo examination, which is an echocardiogram of the heart performed under stress situations, where drug induced stress is produced, which produces a similar affect to a treadmill stress test. The results of this are equally amazing in that it showed absolutely no sign of a blockage or problems with any of the ventricles and the resting ECG was normal sinus rhythm with no sign of any scarring.

The resting echo revealed a normal size of both left and right cardiac chambers with normal left ventricle contraction and an ejection fraction of sixty six percent, without any sign of abnormal contraction. There was possible trivial mitral regurgitation, but this is not significant. After infusion of the dobutamine stressor, wall motion and wall thickness were increased appropriately. At peak dose of the various drugs there was an increase that showed absolutely normal changes, without any abnormal “ST” changes and without angina or chest pain of any sort. This means that there was no sign of any ischaemic heart disease when the heart was raised to high levels and put under load.

Dr Kitiporn’s impression therefore of the cardiac test was that the stress echo test was completely normal and negative with only very trivial mitral valve disease.

As a result of receiving this report, I sent a message back to Dr Kitiporn because he had not actually specifically answered the questions I had asked in my referral. I asked the following three questions:

i. Do you believe in the light of his normal exam that he really has the amount of coronary artery disease that he complains of?

ii. Do you think he is fit to do non-physical sedentary work (and if not why not)

iii. Do you think he would be fit enough to fly either to Dubai or to the UK?

By return I received answers to all three questions as follows:

i. The diagnosis of coronary disease was given by history. He had previously had a coronary angiogram but the doctor has never seen it or the results.

ii. He could find no limitations at all of his heart and no problems with his heart.

iii. He believes Mr S is fit to fly both to Dubai and the UK.

In the light of this examination by an eminent Consultant Cardiologist, I am very satisfied that there is no active ischaemic heart disease going on at the moment.

The symptoms complained of by Mr S are not linked to any physical findings in a thorough examination and test. Mr S appears to be cardiologically recovered from his previous heart attack and there were no physical signs of

uncontrolled respiratory disease. Clearly his current treatment has resolved his heart disease and appears to control his respiratory problems too.

This man was examined fully and there were no indications that anything significant was found wrong with him. In my opinion there is, therefore, no medical evidence that would support ongoing payment of his early ill-health retirement pension at this time. Furthermore, he is fully fit to fly to Britain for a full examination and therefore, if there is an appeal of your decision, I would recommend he comes to Britain and we examine again".

29. On 27 July 2016, Dr G Williams produced a report for BAE, in connection with Mr S' stage 1 IDRP complaint. He wrote:-

"To briefly summarise the background history, Mr S suffered from a heart attack back in 2001. He was subsequently granted ill-health retirement in about 2005, which was subject to review. In September 2008, Dr Kellerman, the then Pension Trustee Medical Adviser, provided a medical certificate indicating that Mr S no longer met the criteria for ill-health retirement.

Mr S subsequently appealed against that decision in a letter from November 2008. Dr Kellerman responded to that appeal on 2 December 2008. Dr Kellerman outlines that the original investigations of Mr S' atypical chest pain, which he was suffering from subsequent to his heart attack back in 2001, included undergoing coronary angiography and echocardiography, which "confirmed a generally reassuring picture". Recent investigations that were carried out in 2008 included an ECG, cholesterol and chest x-ray, along with a troponin negative episode of chest pain and a normal echocardiogram, which I understand Mr S had in Thailand. Dr Kellerman indicates that this did not confirm any form of unstable angina. Dr Kellerman concluded and advised the Pension Trustees at the time that more detailed cardiac and respiratory information would be needed to support Mr S' appeal.

At that stage, I understand Dr Goldsmith at Medigold became involved, with an initial recommendation that Mr S be seen by a cardiologist in London. Due to difficulties in transport and Mr S' perceived health problems at the time, eventually a compromise was made, whereby Mr S was seen by Dr Kitiporn at Bangkok Heart Hospital.

Reviewing Dr Kitiporn's report, I note that investigations were undertaken on 21 July 2009, with Dr Kitiporn indicating that a resting ECG was normal, a resting echo revealed normal size of left and right cardiac chambers, with normal left ventricular contraction and an ejection fraction of 66 per cent (good functioning of the heart). A dubutamine stress echo was then performed, with Dr Kitiporn reporting that at peak dose of dobutamine and 0.6 milligrams of atropine, wall motion and wall thickness were increased without regional wall hypokinesia, and without abnormal ST changes and without angina. Dr Kitiporn concluded that this was a negative dobutamine stress echo test.

As a consequence of these investigations reported on by Dr Kitiporn, Dr Goldsmith provided the Pension Trustees with a report indicating that there was no active heart disease. I would concur with this conclusion, in that the investigations in 2009 revealed a satisfactory functioning of the heart, with no evidence of angina on the stress echo.

Reviewing Mr S' recent complaints, I note that he has unfortunately suffered a further heart attack recently, on 27 April 2016. Mr S, in his letter to BAE Systems Pension Trustees, has indicated that he has undergone an angiogram, at which time he had a conversation with the cardiologist, who indicated that an echo had its limitations in usage. Whilst a simple resting echocardiogram would have its limitations in evaluating the functioning of the heart, a stress echo, on the other hand, is commonly used for individuals who are too frail or, due to lower limb problems, are unable to undertake a stress exercise test. The heart is stressed in these circumstances with the infusion of a drug, dobutamine.

Whilst noting Mr S' dissatisfaction in the manner that his ill-health retirement pension benefit was initially suspended and declined, and then his appeal not upheld, I am satisfied that the correct decision was made at the time on the evidence available. I would also like to point out that this decision was made seven years ago and that Mr S has various risk factors, such as his diabetes, which would have resulted in the subsequent deterioration in his cardiac status. Investigative findings at this stage would not be relevant to the decision made back in 2008/2009".

30. On 11 October 2016, Dr Williams provided a report to the Trustees in connection to Mr S' stage 2 IDRP complaint. He said:-

"Further to previous correspondence, I note that Mr S remains dissatisfied regarding the advice given to date and that he has decided to appeal against the stage 1 decision. I note that Mr S has provided further information, which you have requested for me to review. I note some, if not all, of the information was previously available to me.

I have reviewed Mr S's file, noting the previous reports as outlined in previous correspondence. I did note Mr S's comment that Dr Goldsmith had indicated that in Mr S's words that he had "no heart disease whatsoever". I would comment that that is not exactly what Dr Goldsmith had indicated, but that Dr Goldsmith had stated that Mr S had "no active heart disease". This is not the same as Mr S's interpretation of the facts. I think it is accepted by all that Mr S had a past history of ischaemic heart disease which led to his initial heart attack, resulting in the initial granting of his ill-health retirement pension benefit. Dr Goldsmith's comments are a reflection of the findings of the various investigations carried out in Thailand in 2008, which included a stress echocardiograph. As I have previously commented, this is often used instead of an exercise stress test and Mr S's investigations in 2008 did not reveal any

major cardiac problems at that time. That is not to say that he had not had a past history of cardiac disease.

I note that Mr S has provided further evidence from May 2016, including the findings of an angiogram carried out by a cardiologist at Udonthani Hospital on 5 May 2016. I would comment that this is evidence that was not available in 2008 and, in fact, the findings in 2016 would not be relevant to a decision made back in 2008 as the "second blockage" that Mr S alludes to would have gradually developed over the intervening years, in particular as Mr S has various risk factors, including his diabetes, which would result in increased risk of him developing further cardiac problems in the future. I would have expected that if the severity of his coronary artery disease was the same in 2008 as it is currently, that the stress echocardiograph would have identified some abnormalities.

In his letter of appeal I note that Mr S maintains that an echocardiograph is limited in its use. He does not appear to understand that he did not just have a simple echocardiograph, but had a dobutamine stress echocardiograph carried out, which is different to a straightforward echocardiograph. The most recent echocardiograph, carried out in July 2016 I understand, was a simple, straightforward echocardiograph and not the dobutamine stress echocardiograph that was carried out in 2008.

Having reviewed all the additional evidence provided by Mr S, I do not feel that it alters the advice and recommendations that are made in my report to the Pension Trustees dated 27 July 2016 and that an appropriate decision was made in 2008/2009 on the evidence available at that time".