PO-25970

Ombudsman's Determination

Applicant	Mr Y
Scheme	Local Government Pension Scheme (**LGPS**) - Leicestershire County Council Pension Fund (**the Fund**)
Respondent	Leicester City Council (**the Council**)

Complaint Summary

1. Mr Y's complaint concerns the Council's decision to refuse his application for early payment of retirement pension on ill health grounds.

Summary of the Ombudsman's Determination and reasons

2. The complaint is upheld because the Council did not fully satisfy the requirements of the Local Government Pension Scheme Regulations (**the 2013 Regulations**) and the Statutory LGPS Ill Health Retirement Guidance (**the Guidance**).

3. The Council shall make a new decision and record whether Mr Y was permanently incapable of discharging efficiently the duties of the employment in which he was engaged. Also, if necessary, the Council shall consider whether Mr Y was immediately capable of undertaking any other form of gainful employment.

Detailed Determination

Material facts

4. 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.

5. Mr Y was an active member of the Fund, which is part of the LGPS. Leicestershire County Council is the administering authority and the Scheme employer.

6. In 1998, Mr Y was diagnosed with depression.

7. The relevant regulations are The Local Government Pension Scheme Regulations 2013 (SI2013/2356) (as amended) (**the 2013 Regulations**).

8. Regulation 35 of the 2013 Regulations, provides that a member is entitled to a pension if the member's employment is terminated by a Scheme employer on the

grounds of ill health and the member satisfies both the first condition and the second condition.

9. The first condition is that the member is, as a result of ill health or infirmity of mind or body, permanently incapable of discharging efficiently the duties of the employment in which the member was engaged.

10. Schedule 1 of the 2013 Regulations, states:

> ""permanently incapable" means that the member will, more likely than not, be incapable until at the earliest, the member's normal pension age [**NPA**]".

11. The second condition is that the member, as a result of ill health or infirmity of mind or body, is not immediately capable of undertaking any gainful employment.

12. Schedule 1 of the 2013 Regulations, states:

> ""gainful employment" means paid employment for not less than 30 hours in each week for a period of not less than 12 months".

13. Regulation 36 (1) of the 2013 Regulations, provides that a decision as to whether a member is entitled to a pension under Regulation 35, is for the Scheme employer to make after it has obtained a certificate from an Independent Registered Medical Practitioner (**IRMP**).

14. A member is entitled to Tier 1 benefits if that member is unlikely to be capable of undertaking gainful employment before NPA. A member is entitled to Tier 2 benefits if that member is not entitled to Tier 1 benefits; and:

    14.1. is unlikely to be capable of undertaking any gainful employment within three years of leaving the employment; but

    14.2. is likely to be able to undertake gainful employment before NPA.

15. Relevant extracts from the 2013 Regulations are set out in Appendix C.

16. Paragraph 36 of the 2013 Regulations, describes the role of the IRMP. Paragraph 36(4) provides that:

> "**the Scheme** employer and **IRMP** must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation and regulations **37** (special provision in respect of members receiving **Tier 3 benefits**) and **38** (early payment of **retirement pension** on ill health grounds: deferred and deferred pensioner members)".

17. In September 2014, the Department for Communities and Local Government (**the Department**) issued the Statutory LGPS Ill Health Retirement Guidance (**the Guidance**) under regulation 36(4), in respect of ill health retirements on or after 1 April 2014.

18. The Guidance is aimed at Scheme employers and IRMPs when carrying out their functions under regulations 36, 37 and 38 of the 2013 Regulations. Paragraph 20 of Part III of the Guidance, which covers the role and status of the IRMP, states:

> "Further, the independent registered medical practitioner may be asked to sign the certificate required under regulations 36(1), 37(6) and (10) or 38(3) and (6) and it is recommended that the independent registered medical practitioner complies with this request. **The Scheme employer will need to understand the reasoning of the independent registered medical practitioner when making their decision. So it is, therefore, recommended that the independent registered medical practitioner provides a narrative report to accompany the certificate.** Further, where the independent registered medical practitioner is of the opinion that the applicant could work in their current role with adjustments, or in an alternative role that is likely to be available with that employer, it is appropriate to include advice on this in the narrative report if such advice has not already been given to the Scheme employer previously." [Emphasis added in bold].

19. In addressing questions concerning whether a member is "permanently incapable," paragraph 23 of Part V of the Guidance states:

> "…consideration must, therefore, be given not to the immediate or foreseeable future, but to the date when the member attains their normal pension age. The independent registered medical practitioner should also consider whether the member would be capable following further treatment. Consideration should include whether that treatment is readily available and appropriate for the member and whether, with treatment, the member is likely to become capable before normal pension age. The fact that the member might choose not to accept such treatment should not be a relevant factor. Treatment can include lifestyle changes such as weight loss and stopping the use of harmful substances such as tobacco and alcohol. It would not be appropriate to consider the release of ill health retirement benefits for a reason other than when the member was genuinely medically incapacitated from undertaking their current employment or any other employment at the point of departure".

20. Mr Y was employed by the Council as a full time Riverside Ranger, a role that involves the maintenance and management of riverbanks. He was diagnosed with Hand Arm Vibration Syndrome (**HAVS**), a collective term for disorders of the upper limbs associated with hand-transmitted vibration. According to the Health and Safety Executive's (**HSE**) website, HAVS is caused by exposure to vibration and is permanent.

21. Following a meeting with Mr Y on 4 November 2014, Dr Maimbolwa, a Consultant Occupational Physician employed by Health Management Ltd, the Council's Occupational Health (**OH**) provider at the time, gave his assessment of Mr Y's fitness for work.

22. Dr Maimbolwa acknowledged that the Council had referred Mr Y because of upper limb symptoms, which he had attributed to HAVS. Dr Maimbolwa's comments are summarised below:-

22.1. Mr Y had been restricted from using vibrating tools since being diagnosed with HAVS. "Previous OT reports showed an established diagnosis of HAVS stage 3 vascular on right, stage 2 vascular on left; and stage 1 sensorineural in both hands".

22.2. Mr Y had reported ongoing symptoms of pain in his hands, elbows and arms going up to his shoulders. "The neuralgia, or nerve tablets, he takes for pain makes him feel tired. The pain in his arms is constant and "feels like someone is trying to pull his tendons out of his hands."

22.3. The pain Mr Y had reported was not consistent with a diagnosis of HAVS. His symptoms were also not characteristic of Carpel Tunnel Syndrome.

22.4. The pain in Mr Y's upper limb had been investigated by his doctor, this included x-rays and blood tests: Everything was clear. Hand arm exposure to significant vibration can cause arthritis.

22.5. He had reviewed the OH reports; Mr Y had not reported pain at the time. Minor damage to muscles, joints, and bones may cause pain in the hands and lower arms with exposure to vibration. These should ease when the exposure ceases.

22.6. Mr Y's grip strength was poor in both hands. He had reported reduced finger dexterity and used Dragon software at work because he found it difficult to type. He also used an active pen for dictation.

22.7. Based on the level of pain Mr Y had reported, he was temporarily unfit to undertake manual type work until the pain was better controlled and his grip strength had improved.

22.8. He could not identify a medical reason why Mr Y could not undertake sedentary or office work when the pain improved. The characteristics and degree of the pain suggested some form of neuralgia pain. Mr Y should consult his General Practitioner (**GP**) about seeing a pain specialist or neurologist to investigate the pain in detail. If the current medication is not helping to ease or control his pain, it may be appropriate for him to attend the Pain Clinic.

22.9. Mr Y had become depressed as a result of the pain and was under the care of a Psychiatrist. Mr Y had been seen by Dr Yew, a Consultant Occupational Physician, concerning his psychological symptoms and Dr Yew had provided a report.

22.10. Raynaud Phenomenon symptoms in Mr Y's feet should not be related to hand arm vibration exposure.

23. Dr Maimbolwa noted that Mr Y had not used vibration tools for several years. Consequently, he said he would not have expected new symptoms related to hand/arm vibration exposure to occur, or for existing symptoms or conditions to worsen. Dr Maimbolwa said he would write to Mr Y's GP to clarify why the GP considered that the pain Mr Y was experiencing was related to HAVS.

24. On 20 November 2014, Dr Maimbolwa wrote to the Council in response to a request for clarification on the following points:-

    24.1. The triggers or work-related duties that were causing Mr Y's pain and whether the pain was related to HAVS?

    24.2. Whether redeployment would be appropriate in the circumstances? The Council considered that all reasonable adjustments had been made.

    24.3. What further reasonable adjustments could the Council implement to enable Mr Y to return to work?

    24.4. The type of work Mr Y would be suited to, given his limitations due to his ill health.

    24.5. Whether Mr Y's symptoms of HAVS and depression were linked?

25. The Council requested an up-to-date prognosis and confirmation that Mr Y's medical conditions could be managed with support from his GP or medication while at work.

26. The Council also requested an update from the GP on the actions taken to identify the cause of Mr Y's pain and how it could be resolved.

27. Dr Maimbolwa said he had noted that Mr Y had completed a health and safety form in which he had simply reported pain. He said as far as he was aware from medical literature on HAVS, pain was not a feature of the condition. He explained that pain could occur with arthritis, which could be triggered by exposure to vibration. Dr Maimbolwa said that inflammation/swelling of tendons or ligaments could be triggered by exposure to vibration and could cause pain. He repeated that he would not have expected any new symptoms of HAVS to develop after exposure to hand-arm vibration had ceased.

28. Dr Maimbolwa questioned why the GP had signed Mr Y off work for a period of six weeks. However, he acknowledged that if the pain in Mr Y's arms was severe, this could affect his ability to work in an office or undertake any work involving the use of his hands and arms. Dr Maimbolwa said that he would support redeployment to a suitable alternative job. He recommended that Mr Y perform a role that did not require forceful use of his hands or arms.

29. Regarding Mr Y's symptoms of HAVS and depression, Dr Maimbolwa made the following comment:-

> "[Mr Y's] HAVS **will remain permanent at level 3 and is not likely to get significantly better**. It is not likely that it will get worse since he no longer uses vibrating tools. A slight improvement in symptoms can occur in some individuals upon cessation of exposure to hand arm vibration…I note that he has suffered with depression for a long time. **He is likely to be vulnerable to feelings of stress and anxiety. If specific triggers exacerbate the depression, avoiding the triggers may help improve his symptoms**." (Emphasis added in bold).

30. Dr Maimbolwa said that both medical conditions could be managed while at work, provided Mr Y's symptoms "are not severe to adversely impact on his duties or impair the [use] of his upper limbs because of pain".

31. Following his review of Mr Y on 3 January 2015, the GP provided Dr Maimbolwa with a medical report dated 20 November 2014. The GP said he would totally agree that a referral to the Pain Clinic would be of benefit to Mr Y. He would tend to agree that Mr Y could do office-type work.

32. Dr Maimbolwa advised that he had since discussed his report with Mr Y. Mr Y was content with the report apart from his comment concerning his ability to do office work, as repetitive use of his fingers and arms exacerbated his chronic pain.

33. On 15 January 2015, Dr Maimbolwa notified the Council that he had received the GP's medical report dated 20 November 2014 (**the GP's Report**). He said, in summary:-

    33.1. Mr Y was reviewed by the GP in October 2010; his HAVS was diagnosed elsewhere. The GP had found no evidence of Carpal Tunnel Syndrome.

    33.2. Mr Y was treated for depression because of his concurrent low mood. He improved on medication and was seen again in December 2011. At the time, Mr Y had expressed concerns about any association between Raynaud's, impaired blood flow to the fingers or toes, and SSRI medication. The GP could not find any evidence to support this, and he was advised to continue with the medication.

    33.3. In October 2012, Mr Y complained of increasing hand and wrist pain over a period of six months. The GP questioned whether he had osteoarthritis or whether the pain was related to his HAVS. The GP agreed that this would be unusual after exposure to vibration had ceased. X-rays and blood tests were unremarkable.

    33.4. The GP did not say that the pain Mr Y was experiencing was related to HAVS. He agreed that there could be other causes for Mr Y's symptoms of hand pain, and it would be beneficial for Mr Y to be referred to the Pain Clinic. Mr Y understands that the final decision cannot be made until he has seen the Specialist.

33.5. The GP had advised that Mr Y had been referred to the Psychiatric team in December 2013 because of low mood.

33.6. In January 2014, Mr Y again saw his GP complaining of upper limb pains and the GP wondered about a neuropathic cause or whether these were from his neck. He was treated by the local Psychiatrists with medication for recurrent depression.

33.7. When the GP reviewed Mr Y in May 2014, his mood had improved. The GP considered that Mr Y had neuropathic pain in his hands and was hopeful that this would improve with the Pregabalin medication used for this type of pain.

33.8. Mr Y was seen on two occasions by other partners at the GP surgery because of increasing upper limb pain. Mr Y was taking strong medication for the pain. The dose could be adjusted, or his medication changed, if his current medication was not helping.

33.9. In his opinion, Mr Y should be able to perform duties in his adjusted role with good pain control.

34. Dr Maimbolwa said that the pain in Mr Y's arms/hands should be investigated further and treated appropriately before they could conclude that he was permanently incapacitated from performing the duties of his adjusted role. He recommended that Mr Y discuss with the GP whether he could be referred to the Pain Clinic.

35. In conclusion, Dr Maimbolwa said that his professional opinion remained the same; pain was not a feature of HAVS. He said this was made clear at the HAVS Refresher Course he attended in 2014.

36. On 31 March 2015, Dr Macheridis, an OH Physician, issued his report to the Council after Mr Y attended his clinic on 30 March 2015.

37. Dr Macheridis explained that physical and psychological restrictions affected Mr Y's ability to attend and perform at work. Consequently, he was very restricted. He said he was not in a position to advise how quickly Mr Y's current circumstances were likely to change.

38. Regarding Mr Y's fitness for his current post, Dr Macheridis made the following observation:

> "[Mr Y] is experiencing very significant physical and psychological problems. **His long term prognosis appears very uncertain at this stage**. We are currently awaiting a report from Dr Lin [Consultant in Pain Management] with regards to [Mr Y's] physical difficulties and pain. At this stage I do not recommend further occupational health reviews until we have all medical evidence available to enable us to advise accordingly." (Emphasis added in bold).

39. On 22 April 2015, after receiving a medical report from Dr Lin on 9 April 2015, Dr Maimbolwa wrote to the Council. He said, in summary:-

    39.1. Dr Lin reports that Mr Y's pain symptoms are due to neuropathic pain secondary to central sensitization of his pain system. Dr Lin says that these reproduce somatic signs of sympathetic dysfunction in his hands and potentially such signs and symptoms can progress to chronic regional pain syndrome (**CRPS**).

    39.2. Dr Lin saw Mr Y for the first time in March 2015, and plans to proceed with Lignocaine infusion treatment. Mr Y has been placed on a day care waiting list. At this stage, Dr Lin cannot provide any meaningful advice on Mr Y's prognosis.

    39.3. Although Mr Y was no longer working with vibrating tools, Dr Lin said it was unlikely he would experience any significant improvement in his symptoms within the next six months.

    39.4. He understood, from the information Dr Lin had provided, that Mr Y had developed a condition “where his brain perceives pain due to sensitization…where there is no specific pathology causing pain at that time”.

    39.5. Dr Lin could not answer all his questions and had only seen Mr Y on one occasion. Although Dr Lin did not expect a significant improvement in Mr Y’s symptoms, it may be appropriate to wait and see how he responded to the treatment.

    39.6. He could not provide an opinion on Mr Y’s eligibility for ill health retirement because he had previously dealt with his case.

40. The paperwork relating to Mr Y’s case was referred to Dr Haseldine, (an IRMP), to advise on whether Mr Y satisfied the definition for ill health retirement under the LGPS Regulations.

41. In his report dated 18 May 2015, Dr Haseldine explained that, to qualify for ill health retirement under the LGPS, the member must be permanently incapable of discharging his Local Government employment, as a result of ill health or infirmity of mind or body.

42. Dr Haseldine also explained that under the first Tier of the LGPS ill health provisions, the member is deemed permanently incapable of discharging his Local Authority employment and is unlikely to be capable of undertaking gainful employment before NPA.

43. Dr Haseldine clarified that under the second Tier, the member is deemed permanently incapable of discharging his Local Authority employment but is likely to be capable of undertaking gainful employment after three years and before NPA.

44. Dr Haseldine advised that under the third Tier, the member is deemed permanently incapable of discharging his Local Authority employment. However, the medical evidence indicates that gainful employment could be undertaken within three years of leaving employment.

45. Dr Haseldine concluded that Mr Y did not satisfy the criteria for early payment of retirement pension on ill health grounds. He advised that:

> "For both conditions Mr Y is still under active treatment that "**may allow sufficient improvement"**…**to allow him to return to his previous, adjusted, duties**. It is therefore not possible to say that his conditions cause him, on the balance of probabilities, to be permanently incapable of discharging his Local Government employment as a result of ill health or infirmity of mind or body." (Emphasis added in bold).

46. Dr Haseldine confirmed that he had reviewed the following documents:-

46.1. The referral letter from the Council.

46.2. Letters following Mr Y's consultation with Dr Philips, a Consultant Occupational Physician, dated 24 November 2011 and 10 April 2013.

46.3. Letters following Mr Y's consultation with Dr Ephraim, a Consultant Occupational Physician, dated 23 September 2013.

46.4. Letters following Mr Y's consultation with Dr Yew, a Consultant Occupational Physician, dated 27 October 2014.

46.5. The GP's Report.

46.6. Letters from Dr Maimbolwa dated 5 November 2014, 20 November 2014, 15 January 2015, and 22 April 2015.

46.7. A letter following Mr Y's consultation with Dr Macheridis, dated 31 March 2015.

46.8. A letter from Dr Lin, dated 9 April 2015.

46.9. A letter following Mr Y's consultation with Dr Farmah, an Occupational Physician, dated 13 May 2015.

47. Regarding the medical evidence, Dr Haseldine explained that before supporting early payment of retirement pension on ill health grounds, there should be clear evidence that the member has been fully investigated and treated without effect. Namely:-

47.1. The member has a recognised medical condition. The diagnosis of this condition must be supported by appropriate clinical evidence.

47.2. The member has failed to respond to evidence based treatments, or the treatments are unlikely to result in sufficient improvement for the member to

discharge his duties. All the standard treatments currently readily available in the UK are considered.

48. Dr Haseldine said that the medical evidence was clear that Mr Y was currently unfit for work because of ill health. However, "Further improvement in his arm pain and depression is possible as he is still undergoing investigations and treatment".

49. Dr Haseldine considered that there was reasonable medical evidence that Mr Y was currently prevented from discharging his duties. The key issue was whether Mr Y's health problems were likely to cause permanent incapacity. In his opinion, the definitions of incapacity under the LGPS Regulations, which he had outlined in his report, were unlikely to be met in Mr Y's case on the balance of probabilities.

50. Dr Haseldine explained his reasoning as follows:

> "Mr [Y] has ongoing upper limb [pain] of uncertain cause causing him difficulty with many activities of daily living. He reports generalised upper limb weakness due to his symptoms and had a reduced range of movement of his arms but had a full range of movement in his wrist and hand with normal grip strength when recently examined. He has been extensively investigated and no cause has been found for his pain. He is under the care of a Pain Clinic and is taking Pregabalin. He is under review and is awaiting lidocaine infusion to manage his pain. Mr [Y] has a well documented history of mental health difficulties for which he is under the care of his GP and Psychiatrist. He is taking Venlafaxine and is awaiting further treatment in the form of Cognitive Behavioural Therapy [(**CBT**)] although he reports there is a long waiting list for therapy and that his Psychiatrist is awaiting treatment of his arm pain before considering altering any treatment for his psychological illness. **For both conditions Mr [Y] is still under active treatment that may allow sufficient improvement for his health to allow him to return to his previous, adjusted, duties. It is therefore not possible to say that his conditions cause him, on the balance of probabilities, to be permanently incapable of discharging his Local Government employment as a result of ill health or infirmity of mind or body**." (Emphasis added in bold)

51. Mr Y was referred for a further OH assessment after he asked for the decision to be reviewed.

52. Following a meeting with Mr Y on 2 July 2015, Dr Crofts, an OH Physician, wrote to the Council on 3 July 2015. Dr Crofts advised that Mr Y would benefit from a re-assessment at a private centre to confirm whether his symptoms of pain were due to HAVS and the staging. If the Council was willing to pay for the assessment, OH would make the referral. Dr Crofts confirmed that she would write to Mr Y's Psychiatrist for additional information.

53. On 17 July 2015, Dr Hunt (an IRMP) advised the Council that a review would be undertaken in connection with Mr Y's appeal once OH had received additional information from the doctors treating him.

54. Regarding Dr Crofts' recommendation that Mr Y undergo a further assessment at a private centre, Dr Hunt said that a referral would not be made unless requested by the Council. Dr Hunt also said that she did not think it would impact the decision-making process in respect of his application for early payment of retirement pension on ill health grounds.

55. On 30 July 2015, Dr Lin wrote to Dr Hunt and confirmed that Mr Y had been diagnosed with peripheral sympathetic disturbance. Dr Lin restated that Mr Y's symptoms would likely be longstanding and he did not anticipate being in a position to give any meaningful prognosis within the next six months. Dr Lin confirmed that he had performed a lignocaine infusion. However, it was too early to assess the results; he had not yet had a follow up consultation with Mr Y. If the infusion did not produce any significant benefits, he would proceed with other interventions. For example, stellate ganglion block. In the meantime, Mr Y continues on Pregabalin.

56. Dr Lin said he anticipated at this stage that Mr Y's symptoms could persist for a period of years rather than resolve over the course of months. He acknowledged that this would not assist in deciding whether to allow Mr Y early payment of retirement pension on ill health grounds. However, in his experience, this is the likely course of events for Mr Y's condition.

57. On 6 August 2015, Dr Imam, Mr Y's Psychiatrist, provided Dr Crofts with his report based on previous psychiatric notes and a review of Mr Y on 5 August 2015. In summary, he said:-

    57.1. Mr Y was first seen by the service in March 2014. At the time, he was on Fluoxetine for his depression. He has been followed up in the outpatients' department since March 2015.

    57.2. His medication has been changed due to non-response. He now takes Venlafaxine XL 75mg once a day, Pregabalin 100mg three times a day in addition to Amitriptyline 10mg at night, prescribed by the Pain Clinic.

    57.3. Mr Y has also been referred for psychological input and has been assessed by a Psychologist. It was concluded that he needed CBT. The waiting list was likely to be between 12 and 18 months.

    57.4. At the present time, he did not consider that Mr Y would be able to work and would not benefit from returning to work activities as he was unlikely to be able to do any kind of work. The possibility of returning to any form of employment would depend on his medical condition and a further assessment at the time. However, in his view Mr Y was unlikely to be able to return to work in the foreseeable future.

58. On 17 August 2015, Dr Hunt concluded, on the basis of the available medical evidence, that Mr Y did not have a medical condition that rendered him permanently incapable of performing the duties of his post.

59. Dr Hunt said that it was often difficult to conclude that an illness will not resolve or improve until all evidence-based treatments widely available for the illness had been completed. In most circumstances, it is expected that the remaining treatment options would improve symptoms and functional capabilities sufficiently to enable a return to work.

60. Dr Hunt explained that in cases where applications are considered before all evidence-based treatments have taken place, consideration would be given to:-

    60.1. The likely effect of treatment options on the incapacitating effects of the individual's medical condition.

    60.2. The likely outcome of treatment or the prospect of treatment taking place before NPA. Also, whether it would result in improved functional capability for work.

61. The evidence, Dr Hunt said she had considered, is set out in Appendix A.

62. Dr Hunt acknowledged that Mr Y had several health issues and was diagnosed with HAVS years earlier. She noted that Mr Y's role at the Council was primarily physical and manual. However, this had been adjusted to a ratio of 80% office work and 20% site work. Dr Hunt said that due to Mr Y's underlying health problems, office work has been difficult to establish for him.

63. Dr Hunt observed that in some cases, the neurological symptoms of HAVS can be such that dexterity is affected and this can be permanent, despite ceasing exposure to vibration. Dr Hunt acknowledged that Mr Y had described difficulties with manual dexterity and had developed significant pain affecting his upper limbs and involving the whole of his upper arm.

64. Dr Hunt highlighted that Dr Lin said it was too early to determine whether Mr Y would gain significant benefit from the lignocaine infusion. She also highlighted that Dr Lin had indicated that there were other interventions available. Although Dr Lin had advised that Mr Y's symptoms could persist for some years, improvement in the longer term is to be anticipated. Dr Hunt made the following comments:-

    64.1. Mr Y also suffers with recurrent impairment of psychological wellbeing and had received treatment intermittently for this over some period of time. He has been referred again to specialist psychiatric services since March 2014 because of the severity of his psychological issues. He has been prescribed several antidepressants which have been changed due to non-response. He was currently taking a combination of three different medications to try to improve his mood. The Psychiatrist had recommended CBT. Unfortunately, the waiting list was between 12 and 18 months. "The Psychiatrist is of the view that the mood issues are aggravated by the ongoing chronic pain that [Mr Y] experiences in his limbs. There appears to be fluctuations in his mood which vary in parallel with the level of pain that he is experiencing in his arms, as well as concerns about his work situation".

64.2. “The Specialist is of the view that he is likely to continue to suffer depressed mood for the foreseeable future and likely to continue to need antidepressant treatments. The Specialist does not believe that he is currently fit for work, nor does he think he would be able to return to work for the foreseeable future. It is clear from the evidence available to me, that Mr [Y] is significantly incapacitated with regard to the pain he is experiencing in his arms, and the use of his hands”.

64.3. Mr Y has trouble with gripping and repetitive tasks. He has problems with day to day activities. For example, buttoning shirts, cleaning shoes, and showering. His symptoms worsened in 2012. Mr Y was clearly suffering significant symptoms, which were impacting on his functional capacity outside of work.

64.4. “His physical health problems are limiting and aggravating his significant psychological problems. Unfortunately, the two are closely related and individuals with reduced psychological wellbeing often find it harder to cope with chronic pain”.

64.5. Mr Y remained under the care of two specialists, who were attempting to improve the situation for him. It was clear that Mr Y was currently unfit for any work. However, he was 47. Dr Lin had indicated that there were outstanding treatment options available to him that could be tried if the recent treatment was unsuccessful. Although the time period for this was likely to be years, rather than months, Dr Lin had not indicated that this was a permanent situation and treatment options had not been exhausted.

64.6. Although Mr Y was currently significantly depressed, he has had recurrent episodes of depression, on and off since 1999 and had responded to treatment previously and been able to work with his condition when in remission.

64.7. “It is reasonable to anticipate that if the physical symptoms that he is experiencing improve, that the depression will equally lift and there is, on the balance of probabilities, a likelihood that Mr [Y] would be able to return to work in due course”.

64.8. Mr Y has not worked with vibrating tools for years; it appeared that this had been accommodated by his employers. It was likely that Mr Y would be able to perform other duties if his pain was better controlled. Consequently, on the balance of probabilities, Mr Y did not have a medical condition that would render him permanently incapable of the duties of his current post. Should Mr Y's situation change, and in particular if the outstanding treatments referred to by his Consultant do not improve his symptoms and function, they would be pleased to review his case in light of any new information.

65. At a meeting on 8 September 2015, the Council decided to terminate Mr Y’s employment taking into account the medical advice that it had received and Mr Y’s absence from work since November 2014. In a letter notifying Mr Y of its decision dated 8 September 2015, headed “RE: DISMISSAL ON THE GROUNDS OF ILL

HEALTH (following second medical opinion)" the Council said that his current period of absence, which had prevented him from attending work since November 2014, was not sustainable by the service.

66. The Council has subsequently advised that as part of the dismissal process, it decided not to grant Mr Y early payment of retirement pension on ill health grounds based on the medical advice from Dr Hunt. While minutes were not taken at the meeting when his case was discussed, the details were confirmed in the Council's letter dated 8 September 2015. There is a reference to Mr Y's application for a review of the decision on his ill health retirement in the Council's letter and the opinion and decision expressed by Dr Hunt.

67. In December 2015, the Department of Work and Pensions (**the DWP**) awarded Mr Y the daily living component of the Personal Independence Payment (**PIP**) at the enhanced rate, which is the highest rate. The DWP's decision is summarised below:-

    67.1. The evidence indicated that Mr Y's medical conditions caused him substantial difficulties preparing food, taking nutrition, dressing, undressing, reading, understanding signs, symbols and words, and engaging with other people face to face.

    67.2. Mr Y said that he had difficulties with moving around. However, he reported that he was able to walk without an aid or assistance.

    67.3. Mr Y also said that he had difficulties planning and following journeys due to depression, anxiety, and needing support from his wife. It was reasonable to suggest that he would need prompting from another person to undertake a journey to avoid causing himself significant distress.

    67.4. On 14 February 2016, Mr Y appealed the Council's decision to refuse early payment of retirement pension on ill health grounds. In summary, he said:-

    67.5. Dr Crofts accepted that his recent treatment was unsuccessful. All treatment for pain had now been exhausted. There had been no improvement in his medical conditions.

    67.6. Dr Lin informed OH that ill health retirement was the likely path for his condition.

    67.7. Dr Imam was not sure why his pension had not been released and did not consider that he would be fit to work before NPA. His Psychiatrist also did not consider that he would be able to work for the foreseeable future.

    67.8. The IRMPs were influenced by the referrals and views that had been expressed by the Council.

67.9. He did not consider that Dr Crofts had interpreted the LGPS Regulations correctly and had failed to consider his eligibility for early payment of retirement pension on ill health grounds in the right way.

67.10. The Council amended his post of Riverside Ranger without consulting him. His application should have been assessed on his full job description, not his adjusted role.

67.11. His age should not be a consideration when deciding whether he is eligible to access his pension on ill health grounds. Dr Crofts' comments concerning his age amount to direct age discrimination and breaches equal opportunities.

67.12. Dr Lin and Dr Imam were willing to update the Council on his current situation and clarify what they meant by foreseeable future.

68. On 8 April 2016, the Council wrote to Mr Y and requested additional documentation in connection with his appeal.

69. In a letter dated 25 May 2016, upholding the original decision, the decision-maker listed the documents he had considered relevant to Mr Y's appeal. These are set out in Appendix B.

70. The decision-maker acknowledged that Mr Y's medical conditions had significantly impacted his attendance at work. Under the heading 'Medical Evidence', he made the following statement:

> "Dr Lin, in his letter to Dr Hunt dated 30 July 2015, confirms that although at the time of writing it was too early to assess the results of the lignocaine infusion he would be able to proceed with other interventions if it did not produce any significant benefits. Dr Lin further opines that your symptoms could well persist for a period of years rather than resolve over a course of months. Dr Lin states that whilst he recognises that his opinion would not assist in a decision regarding ill health retirement it is his experience that it is the likely course of events for your condition." [Emphasis added in bold].

71. The decision-maker pointed out that Dr Imam had advised that Mr Y required CBT for treatment of his depression. He said Dr Imam had concluded that a return to any kind of work would depend on Mr Y's medical condition and a further assessment at the relevant time was being considered. The decision-maker's further comments are summarised below:-

71.1. Dr Haseldine had concluded that it was not possible to say that Mr Y was permanently incapable of discharging the duties of a Riverside Ranger; he was still under active treatment for both conditions.

71.2. Dr Hunt said that Mr Y's conditions were closely related. It would be reasonable to anticipate that if his physical symptoms improved, his depression would also improve, and he would be able to return to work in due course. This was supported by the views expressed by Dr Imam.

71.3. In concluding that the available medical evidence did not support early payment of retirement pension on ill health grounds, Dr Hunt also relied on the Consultant's opinion that further treatment options were available.

72. On 27 August 2018, Mr Y complained under the Internal Dispute Resolution Procedure (**IDRP**) concerning the Council's handling of his application. He said that all medical professionals are aware that HAVS is a permanent condition, which cannot be reversed. Consequently, his pension should have been released on ill health grounds. He could not perform the duties of a Riverside Ranger and would be unable to do so in future. Mr Y subsequently complained to The Pensions Ombudsman (**TPO**).

73. Mr Y considers that his complaint shares similarities with Mr Williams' complaint [73307/1 24 August 2009] (**the Williams Case**). Mr Williams complained to TPO that he was not awarded a pension based on total Incapacity, as defined in the TRW Pension Scheme rules. The complaint was upheld against the Trustees because their decision was based on advice that applied the wrong test and took an irrelevant factor into account. Specifically, whether awarding a pension would be in Mr Williams' best interests. Tony King, the former Pensions Ombudsman (**the Former PO**) directed that the Trustees "re-visit their decision taking into account the extent to which, at the time the decision is taken, treatments available to Mr Williams would impact on the permanency of his incapacity".

74. Regarding the issue of Mr Williams' incapacity, the Former PO made the following observation at paragraph 36 of his Determination:

> "The decision that the Trustees had to make was whether Mr Williams' incapacity was sufficiently serious to permanently prevent him from undertaking any paid employment with any employer or self-employment. They had to reach a decision on the balance of probabilities – so whether it was more likely than not that Mr Williams incapacity met that test. As far as future treatment is concerned, the proper way of considering it would have been to decide whether Mr Williams' incapacity would be permanent without future treatment and, if the answer was affirmative, to consider whether future treatment was likely to alter that".

75. At paragraph 39 of the Determination, the Former PO made the following statement:

> "In his report of 10 April 2007, Dr Sheard said that it would be premature to make a decision as to the permanence of Mr Williams' incapacity since the outcome of the untried treatments was not known. That is to duck a question which had to be answered one way or the other as at the date Mr Williams left service. It could not be left in abeyance pending the outcome of future treatments".

76. I issued a Preliminary Decision on 8 November 2023 (**the First Preliminary Decision**), upholding the complaint on the basis that the IRMPs did not properly consider whether Mr Y was capable of undertaking gainful employment before his

NPA. It followed that the Council did not fully consider the requirements of the 2013 Regulations.

Summary of Mr Y's position

77. *Mr Y's submissions concerning his medical conditions:-*

77.1. Due to his diagnosis of HAVS at level 3, a permanent and irreversible medical condition, he is permanently unable to perform his substantive post. His substantive post involves daily use of vibrating tools and equipment and being subjected to a cold canal/river environment. These activities are a trigger for an HAVS attack. Even going from a warm to cooler environment triggered HAVS attacks and he was unable to perform his substantive post.

77.2. Any form of work exacerbated the pain in his hands, arms, and neck. He reported this to his management team, but it was ignored. He was forced to continue performing work related tasks even when he was in severe pain.

77.3. Dr Maimbolwa acknowledged that the pain in his arms was severe and could affect his ability to work, even in an office environment, or undertake any work involving his hands.

77.4. Since his dismissal, he has been unable to secure gainful employment and is receiving ongoing medical support for HAVS, pain management and for his mental health condition.

78. *Mr Y's submissions concerning the medical evidence:-*

78.1. He does not consider that the Council fully explored whether future treatments were possible. In any event, he was dismissed before those treatments were known.

78.2. He was discharged from the Pain Clinic by Dr Lin at his last appointment and advised there were no further treatment options available to him.

78.3. Several of the consultants treating him said he would not be able to find reasonable employment before his NPA. The Council did not even consider him for the other tiers of ill health pension under the LGPS.

78.4. Regarding further treatment, his Consultant was referring to a stronger opioid based pain medication which would make him drowsy and unable to function on a normal level. He would not have been able to perform at work or undertake his substantive role. It was ruled out as he did not wish to become addicted to it.

78.5. Dr Kumar informed the Council that he was unlikely to be capable of undertaking any gainful employment before reaching his NPA due to his chronic pain and the nature of his depression. However, the Council ignored this.

79. *Mr Y's submissions concerning the Council's procedures:-*

79.1. He has taken legal advice in connection with his case. When assessing permanent capacity, TPO has confirmed in past cases that it may require the medical adviser (**the MA**) to take into account the impact of any future medical treatment on the member's incapacity.

79.2. In his Determination of Mr Williams' complaint (See paragraph 73 above) the Former PO concluded that the way to consider the impact of future medical treatments is to decide whether the member's incapacity was permanent without future treatment? If so, whether on the balance of probabilities future treatment would likely alter this? His legal adviser did not consider that the Council adopted this approach. If it had, it would likely have made a different decision.

79.3. At the time of his dismissal, the specialists treating him did not indicate whether his condition would likely be permanent, although they reached that conclusion more recently. They also did not indicate whether the treatments being proposed were likely to improve his condition; they merely recommended treatment.

79.4. He spoke to the OH doctors during his appointments concerning the possibility of early payment of retirement pension on ill health grounds. He was told on numerous occasions that he met the threshold. However, they were unable to put this in their reports because the Council did not ask them to comment on his eligibility to prevent him from receiving his pension.

79.5. The Council was biased; it limited itself to considering the reports provided by the IRMPs. The referrals did not include a copy of his substantive job description. The Council ignored his Consultant's opinion that the pain he was experiencing was related to HAVS due to nerve damage. He suspects that the Council did not send OH all the correspondence it received from his specialists. The information the Council sent to OH was often inaccurate. On one occasion, OH was asked whether he should be allowed to work outdoors when he has an allergy to bees; he does not have an allergy to bees.

79.6. He does not consider that he saw the appropriate OH consultants, based on the questions they asked him. They informed him that he should have been referred to a pension ill health specialist.

79.7. In his report, dated 20 November 2014, Dr Maimbolwa said that pain was not a symptom of HAVS; this contradicts the report from his Consultant. He questions whether Dr Maimbolwa was the appropriate specialist to consider his application. Even results of a basic internet search lists pain, numbness, pins and needles and difficulty moving, as symptoms of HAVS.

79.8. His GP is a Hand Arm Vibration specialist and was working for Health Management Ltd at the time. He said on several occasions that he could not

understand why the Council did not ask Health Management Ltd whether ill health retirement was an option in his case. As an ill health retirement advisor, his GP considered that he met the criteria for early payment of retirement pension on ill health grounds.

79.9. His GP, his mental health specialist, and his Consultant all said that his medical conditions would be longstanding. In his letter dated 6 August 2015, Dr Imam said he was unfit for work for the foreseeable future. Based on this information alone, he should have met the criteria for early payment of retirement pension on ill health grounds. All his specialists said that ill health retirement was the likely route. He believes this information was not passed to OH.

79.10. His employer refused to take his ill health seriously and did all that it could to fudge and obstruct the process. He saw several different OH doctors; they were not given accurate information about his case and were unable to refer to the duties set out in the job description for his substantive post. There is no record of the information that was shared with OH, or minutes of meetings, to substantiate that the Council followed a fair and proper process.

79.11. He was dismissed on the grounds of ill health because he reported incidences of serious misconduct by a former manager at the Council. Senior managers did not protect his identity and he was then ostracised and had to be redeployed into the post of Riverside Ranger, where the alleged intimidation and bullying continued from both colleagues and managers. When he became unwell, and unfit to perform his substantive duties, the Council initiated the process of dismissing him on ill health grounds. He was told that managers would do everything possible to stop the early release of his pension.

79.12. Management and human resources received letters from his doctors and Dr Imam stating that he was unfit for any form of work before NPA, but this evidence was not considered or forwarded to the IRMPs. When he attended the meetings, he shared the letters with the IRMPs. However, they advised that they could only answer the referral questions and could not take the evidence into consideration.

Summary of the Council's position

80. *The Council's submissions concerning the medical evidence:-*

80.1. The Council does not agree with Mr Y's assertion that all treatment for his pain has now been exhausted. It is not correct that Dr Lin confirmed that his medical condition was permanent and irreversible.

80.2. The Council also disagrees that when Dr Imam advised that Mr Y was unlikely to be able to return to work in the foreseeable future this should have been interpreted as not before his NPA. Dr Imam referred to the recommendation that Mr Y receive CBT and to the likelihood of an improvement in his

depression if his physical symptoms improve. He advised that an assessment would be necessary in the future to determine Mr Y's fitness to work.

81. *The Council's submissions concerning the decision making process:-*

81.1. The Council made the decision not to grant Mr Y early payment of retirement pension on ill health grounds because the Council had received advice from two IRMPs that Mr Y did not meet the first condition. Specifically, there were treatment options available that would likely improve his health conditions such that he could return to work.

81.2. The primary purpose in determining Mr Y's appeal was to review the decision rather than to award him early payment of retirement pension on ill health grounds. There is no evidence to suggest that the Council made any attempt to influence the decision of its OH provider.

81.3. The Williams Case is authority when considering potential treatment options in ill health retirement cases. The rationale for the Former PO's Determination is that the IRMP must provide an opinion as to whether, on the balance of probabilities, potential treatment options would be effective as at the point at which the relevant employment ended. The only question that arises from the application of the Williams Case, is whether the correct test was applied by the IRMPs when considering the treatment options that were available to Mr Y.

81.4. The Council obtained two separate opinions from two different IRMPs as to whether Mr Y satisfied the first condition under regulation 35 of the 2013 Regulations. The Council and the IRMPs involved in Mr Y's case complied with their obligations under the 2013 Regulations and the Guidance. The IRMPs applied the correct test, as set out in the Williams Case.

81.5. The IRMPs took into account that Mr Y was still receiving treatment, as they were obliged to consider treatment options. The fact that he was not in a steady state of health did not form part of their reasoning that the first condition was not satisfied.

81.6. Both IRMPs considered all of the relevant medical evidence and provided a narrative report setting out their reasoning. The IRMPs also expressed their views on the effectiveness of any treatment options.

81.7. The OH reports contain a reasoned analysis of the evidence available together with objective decision making in respect of the issues to be determined. The IRMPs had not previously advised, given an opinion, or been involved in Mr Y's case.

81.8. In reaching their opinion, the IRMPs clearly demonstrated that they understood and correctly applied the criteria for ill health retirement under the LGPS and in doing so considered the potential treatment options. It was only after the Council received their opinions that the Council made its decision.

81.9. It is clear from the evidence that Dr Haseldine understood the criteria under the LGPS on which he was to advise. It is also clear from the medical report provided by Dr Haseldine, dated 18 May 2015, that he identified the pertinent issue in Mr Y's case; the potential for available treatment options. Dr Haseldine's opinion was that the requirement of permanent incapacity is on the balance of probabilities, unlikely to be met.

81.10. However, it could be argued that Dr Haseldine's further comments that treatments may allow sufficient improvement to allow Mr Y to return to his duties "and that it is therefore not possible to say that his conditions cause him, on the balance of probabilities to be permanently incapable, does not fully apply the correct test as set out in the Williams [Case]". While the Council accepts that Dr Haseldine should also have considered this point in the context of the Guidance, specifically paragraph 23 of Part V, Dr Hunt's opinion applies the correct test.

81.11. Dr Hunt mentioned Mr Y's age when referring to the prospect of him returning to work in the future. In cases such as these, the proximity of retirement age is a relevant determining factor. The Council disagrees that this amounted to direct age discrimination.

81.12. The Council accepts that it is good practice for an IRMP to provide an explanation for their advice. There is no obligation on an IRMP under the 2013 Regulations, the Guidance or following the Williams Case, to provide a certain level of explanation regarding their advice on the criteria for ill health retirement under the LGPS. Similarly, there is no requirement on the Council to seek clarification from the IRMP. The Guidance merely recommends that the IRMP provides a narrative report to assist the Scheme employer to understand their reasoning. Notwithstanding, this would place too high a burden on a Scheme employer; a burden which was clearly not envisaged or intended by the legislature.

82. *The Council's submissions concerning any alleged non-financial injustice Mr Y has sustained:-*

82.1. The Council dealt with Mr Y's case in a timely manner. It does not consider that it would be just and equitable in the circumstances for the PO to make an award for distress and inconvenience.

83. *The Council's further submissions concerning the interpretation of the Guidance and 2013 Regulations:-*

    83.1. The Council is of the view that there is no requirement in the Guidance in respect of the level of detail required of an IRMP in any report that they may provide. Further, it is a recommendation, rather than mandated, that a IRMP provides a narrative report.

    83.2. It follows that there is no requirement in the 2013 Regulations nor the Guidance for a scheme employer to question or seek clarification regarding any report that might have been provided by an IRMP.

The Council's submission concerning the First Preliminary Decision

84. The Council submitted that the basis on which the Deputy Ombudsman (**DPO**) initially intended to uphold the complaint was flawed. The Council's view was that the IRMPs were not required to consider the issue of whether Mr Y was capable of undertaking gainful employment before his NPA. This is because the IRMPs had concluded that he was not permanently incapable of undertaking the duties of his former role with the Council.

85. The First Preliminary Decision relied on the Guidance for its findings. However, the Council submitted that references to aspects of the Guidance in the First Preliminary Decision were inaccurate and look to import wording into the Guidance which goes far beyond its correct interpretation.

86. The Adjudicator assigned to this case obtained additional information from the Council following its further submissions in response to the First Preliminary Decision. On 9 April 2024, I issued a Second Preliminary Decision on the complaint.

Conclusion

87. Mr Y's main complaint is that the Council refused his application for early payment of retirement pension on ill health grounds despite the fact that his employment was terminated because of his ill health. He contends that his GP and treating specialists said he would be unable to work again before his NPA.

Ill health cases generally

88. When someone complains that they have not been awarded the ill health or incapacity benefits for which they believe they are eligible, I will look at the way the decision has been reached. I will not look at the medical evidence and make my own decision based on it, nor will I ask for more medical reports to be obtained.

89. I will consider whether the decision-maker has: (i) gone about making the decision in the right way; and (ii) made a decision that makes sense based on the evidence. I do not have to agree with the decision and will not interfere just because I think the decision-maker could have reached a different decision.

90. If I find that the decision-making process was flawed, I can direct the decision-maker to look at the case again. However, my role is not to decide whether the member is eligible for an ill health retirement pension or to overrule the opinion of the medical experts. It is for the decision-maker to weigh the available medical evidence provided by the medical advisers and other medical practitioners.

91. I can also look at whether there was any maladministration. For example, undue delay during the decision-making process. If I find maladministration, I may also make an award for any non-financial injustice which the member has suffered.

The relevance of the Williams Case

92. As a matter of law, I am not bound by my own Determinations or past Determinations. I recognise that Mr Y's complaint shares similarities with the Williams Case to the extent that there was some uncertainty concerning the likely course of Mr Y's medical conditions.

93. The Former PO emphasised that the role of the Trustee's appointed medical adviser was to give his expert opinion on whether Mr Williams' incapacity fulfilled the relevant definition at a particular point in time. It was not material to a decision made at a particular point in time whether work is good for physical and mental wellbeing. The medical adviser had applied the wrong test and took an irrelevant factor into account. The Former PO directed the Trustees to make a new decision, applying the correct tests in relation to the permanence of incapacity. The Williams Case is considered further in paragraph 98 below.

94. Where treatment is ongoing or yet to be tried, I would expect the appointed medical adviser to comment on the likelihood of the treatment improving the member's health to a sufficient extent to enable them to be capable of discharging efficiently the duties of their employment.

Section 61 of the Equality Act 2010

95. Mr Y has alleged discrimination and unfair treatment in relation to the Fund. Under Section 61 of the Equality Act 2010, a person responsible for an occupational pension scheme must not discriminate against, harass, or victimise another person when carrying out its functions in relation to a scheme.

96. The Council accepted that Mr Y was unable to undertake the adjusted duties of his role as a Riverside Ranger.

97. The issue the Council was required to consider was whether his incapacity was likely to be permanent. In other words, whether Mr Y was likely to recover sufficiently before his NPA to be capable of discharging efficiently the duties of his role. This assessment had to be made based on the medical evidence available at the time.

98. In the Williams Case, the Former PO concluded that:

> "age is relevant, but only to the extent that the shorter the time to retirement age the less likely it is that a serious condition will change. In that sense incapacity is more likely to be permanent (that is, to last at least until retirement age) for an older person than for a younger one".

99. I find no basis on which to conclude that Mr Y was discriminated against, harassed or victimised by the Council in relation to the Fund. The evidence Mr Y has presented does not support inconsistency in the Council's treatment of employees who apply for early payment of retirement pension on ill health grounds.

100. For Mr Y to have a valid claim for age discrimination, he must demonstrate that he was treated less favourably than a member in an otherwise identical position to him, but of a different age. I am not persuaded from the evidence Mr Y has put forward that he has been unfairly treated because of his age. I am satisfied that his age was considered solely in the context of the potential years available for further treatment. When forming a view on whether further treatment would likely improve a member's health sufficiently to enable the member to return to work, the number of years remaining to NPA is a relevant consideration.

The interpretation of the LGPS ill health retirement provisions

101. The 2013 Regulations set out the circumstances in which a member is eligible for ill health retirement benefits, the conditions they must satisfy, and the way decisions must be taken.

102. The eligibility criteria for PIP are set out in the Social Security (Personal Independence Payment) Regulations 2013 and are not as stringent as the criteria for ill health retirement from active status under the 2013 Regulations. The fact that Mr Y was awarded PIP, does not mean that he is automatically eligible for an award under Regulation 35 of the 2013 Regulations.

103. To be eligible for early payment of retirement pension on ill health grounds under Regulation 35, the member must satisfy both the first condition and the second condition. It is for the decision-maker to decide, on the balance of probabilities, whether the first condition and second condition have been met. It is a finding of fact rather than an exercise of discretion. The decision-maker is expected to make its decision based on the information available at the time the relevant employment ended, or on information that has been received at a later date commenting on the member's medical condition at that point in time.

104. It is for the Council, as the decision-maker in this case, to decide whether Mr Y satisfies the first condition and the second condition after obtaining the certified opinion of an IRMP.

105. The first condition is that Mr Y must be deemed permanently incapable of discharging efficiently the duties of the employment he was engaged in with the

Council. The second condition is that Mr Y is not immediately capable of undertaking any gainful employment.

106. The 2013 Regulations do not specify the type of employment; the expressions 'Whose employment is terminated' and 'who is in an employment' are used and are not defined in the 2013 Regulations.

107. Mr Y maintains that the Council amended his post of Riverside Ranger without consulting him. He considers that his application should have been assessed on his full job description.

108. The evidence indicates that the Council adjusted Mr Y's role due to the limitations caused by his medical conditions. It maintains that it implemented all reasonable adjustments to enable Mr Y to return to work. It is unclear whether those adjustments were implemented on the basis that he could revert to his old role if his health improved.

109. The terms set out in Mr Y's employment contract, and any legally binding change(s), were a relevant consideration for the decision-maker. If Mr Y accepted a change in his working conditions for a reasonable period of time, without any objection, which the evidence suggests, there may have been an implied change in his contract terms. If his role was substantially and legally changed, the decision-maker would not have been prevented from applying the 2013 Regulations to his adjusted post.

The decision making process

110. On 8 September 2015, the Council informed Mr Y of its decision to terminate his employment on the grounds of ill health and in its confirmation letter of the same date the Council confirmed the termination of his employment. The letter did not refer to the payment of a pension on ill health grounds or make an express decision in respect of Mr Y's application for a review of the decision on his ill health retirement. Rather than confirm its own decision, in respect of whether Mr Y was permanently incapable, the Council set out that it was the opinion and decision of Dr Hunt that Mr Y was not permanently incapable of the duties of his current post.

111. The Council had obtained two reports from IRMPs who did not consider that Mr Y satisfied the first condition under Regulation 35(3) of the 2013 Regulations for early payment of retirement pension on ill health grounds. The Council's position is that the decision to refuse Mr Y's application was correctly made because it was based on the advice it received from the two IRMPs.

112. Both IRMPs decided, based on the evidence available to them, that Mr Y may not be permanently incapable until his NPA. They concluded that, on the balance of probabilities, existing treatments could at a future date enable Mr Y to return to work. By implication, Mr Y was not sufficiently ill as to rule this out.

113. Neither of the IRMPs refer to the Guidance in their reports; they do refer to the 2013 Regulations and the question of whether Mr Y is permanently incapable, as required by the 2013 Regulations.

114. In his report, Dr Haseldine, the first IRMP, briefly refers to the Tier 1 benefits under the LGPS and whether Mr Y is capable of gainful employment before NPA. He acknowledges that Mr Y is undergoing treatment and comments that they may allow a sufficient improvement in his health. He also acknowledges that Mr Y is taking Venlafaxine for his depression and is awaiting CBT.

115. Concerning the question of whether Mr Y is permanently incapable, Dr Haseldine makes the following statement in his report under the heading "Reasoning":

> "For both conditions Mr [Y] is still under active treatment that may allow sufficient improvement for his health to allow him to return to his previous, adjusted, duties. It is therefore not possible to say that his conditions cause him, on the balance of probabilities, to be permanently incapable of discharging his Local Government employment as a result of ill health or infirmity of mind or body."

116. My reading of this is that Dr Haseldine is unable to say that Mr Y will be permanently incapable as there is ongoing and future treatment that may help resolve his medical conditions.

117. Dr Hunt, the second IRMP, decided based on the evidence available to her that Mr Y may not be permanently incapable until NPA. In her report, under the heading of "Rationale", Dr Hunt refers to the medical opinion expressed by Dr Lin when making the following observation:

> "…there are outstanding treatment options that could be tried if the most recent treatment [Mr Y] has had is unsuccessful".

118. Dr Hunt also refers to the treatment that Mr Y had received for depression and the fact that he had responded to treatment previously and had been able to work in remission. The implication is that the treatment is both available and would be suitable for Mr Y. Dr Hunt acknowledges that any treatment may take several years; she explains that Dr Lin did not indicate that Mr Y's condition is permanent. This conclusion supported Dr Hunt's opinion that Mr Y did not have a medical condition that would render him permanently incapable of discharging efficiently the duties of the employment in which he was engaged.

119. Dr Hunt focuses on the difficulty that is reflected throughout Mr Y's medical assessments. Namely, that it is difficult to presume that a medical condition will not resolve or improve until evidence-based treatments, which are currently and widely available for that condition, have been completed. Dr Hunt explains that the reason for this difficulty is that the logical expectation, in most circumstances, is that the remaining treatment options will improve symptoms and functional capabilities to enable a return to work.

120. Dr Hunt continues that, where applications are considered before all evidence-based treatments have taken place, account is taken of the following:-

    120.1. The likely effect of treatment options on the incapacitating effects of the individual's medical condition.

    120.2. The likely outcome of treatment or the prospect of treatment taking place before NPA; and whether that treatment will result in improved functional capabilities to enable a return to work.

121. The IRMPs adopted a reasonable approach to the extent that they focused on current treatments that may prove successful before considering what other treatments might be possible. However, they were required to go further. Paragraph 23 of Part V of the Guidance states:

    "…consideration must, therefore, be given not to the immediate or foreseeable future, but to the date when the member attains their normal pension age. The independent registered medical practitioner should also consider whether the member would be capable following further treatment. Consideration should include whether that treatment is readily available and appropriate for the member and whether, with treatment, the member is likely to become capable before normal pension age..."

122. Paragraph 36(4) of the 2013 Regulations, states that the Scheme employer and IRMP must have regard to guidance given by the Secretary of State when carrying out their functions under Regulations 36(4). Part III of the Guidance explains that the Scheme employer will need to understand the reasoning of the IRMP when making its decision and recommends that the IRMP provides a narrative report to accompany the certificate.

123. The Council has challenged the necessity of the IRMPs to provide a narrative report and has questioned the level of detail that is required. I accept there is no mandatory requirement for the Council to request or for the IRMP to provide a narrative report. However, as referred to in paragraphs 117 to 120 above, Dr Hunt did provide the Council with a detailed evidence-based report that showed she understood the legislative requirements. Taking this into consideration, I do not consider it unreasonable to expect an IRMP to comment on issues that are set out in the Guidance.

124. On reviewing the evidence, I am not entirely persuaded that the IRMPs fully considered Mr Y's capacity at his NPA. However, I recognise that the IRMP's decision is made on the balance of probabilities taking into consideration all of the available evidence. Ultimately, it is for the Council to make a decision on whether a pension can be paid early on the grounds of ill health.

125. I am satisfied that there is sufficient reasoning in the narrative reports to enable the Council to understand, from a lay person's perspective, why the IRMPs do not consider that Mr Y is permanently incapable. However, there is insufficient evidence

to show how the Council reached its own decision to reject Mr Y's application for early release of pension based on ill health. While I appreciate that it is now many years since the Council made its decision, there is no evidence of who made the decision in respect of Mr Y's application and how it was made prior to the meeting on the 8 September 2015, on receipt of Dr Hunt's report. As detailed in paragraph 65 above, the meeting on 8 September 2015, focused on the termination of Mr Y's employment after he was presented with the decision Dr Hunt had reached in her latest report.

126. I find, on balance, that the Council's decision-making process was flawed as it placed too much focus on the termination of Mr Y's employment and failed to confirm its own decision that Mr Y was not permanently incapable of discharging efficiently his duties of employment. The Council shall make a new decision as to whether Mr Y fulfils the first condition and the second condition, taking into consideration the IRMP reports that were available to the Council prior to 8 September 2015.

Non-financial injustice

127. I have power to make reasonable awards for non-financial injustice (distress and inconvenience) arising as a consequence of maladministration.

128. Mr Y has likely sustained significant non-financial injustice as a consequence of the Council's failure to fully consider the requirements of the 2013 Regulations and the Guidance. He is entitled to an award of £500, in recognition of the distress and inconvenience the Council has caused him.

129. The complaint is upheld.

Directions

130. Within 28 days of the date of this Determination, the Council shall:

I. pay Mr Y a distress and inconvenience award of £500;

II. review Mr Y's case, based on the IRMP reports available as at 8 September 2015, and make a new decision under Regulation 35 of the 2013 Regulations;

III. notify Mr Y of that decision in writing, setting out how the decision was reached with specific reference to his eligibility under the first condition and the second condition and;

IV. if on review the Council decides that Mr Y is entitled to early payment of retirement pension on ill health grounds, arrange to pay him the pension backdated to 8 September 2015, the date of the original decision, plus interest.

131. The interest referred to above shall be calculated in accordance with Regulation 51 of The Local Government Pension Scheme (Administration) Regulations 2008.

Anthony Arter CBE

Deputy Pensions Ombudsman

29 April 2024

Appendix A

A list of the documents considered by Dr Hunt

1. GP report, from Dr Davenport, dated 20 November 2014.

2. Reports from Dr Lin, Consultant in Pain Management, dated 9 April 2015 and 30 July 2015.

3. Letter from Dr Imam, Consultant Psychiatrist, dated 6 August 2015.

4. Occupational health physician reports from: Dr Ephraim dated 15 January 2013; Dr Yew dated 17 January 2013; Dr Phillips dated 10 April 2013; Dr Ephraim dated 23 September 2013; Dr Maimbolwa dated 5 November 2014. Dr Maimbolwa dated 15 January 2015; Dr Macheridis dated 31 March 2015; Dr Maimbolwa dated 22 April 2015; Dr Farmah dated 13 May 2015. Dr Haseldine dated 18 May 2015; and Dr Crofts dated 2 July 2015.

Appendix B

A list of the documents reviewed by the decision-maker as part of the appeal process

1. Occupational Health Report provided by Dr Maimbolwa, dated 5 November 2014 (amended 7 November 2014).

2. Occupational Health Report provided by Dr Maimbolwa, dated 20 November 2014.

3. Occupational Health Report provided by Dr Maimbolwa, dated 15 January 2015 (amended 20, 27 and 28 January 2015).

4. Occupational Health Report provided by Dr Macheridis, dated 31 March 2015.

5. Occupational Health Report provided by Dr Maimbolwa, dated 22 April 2015.

6. Occupational Health Report provided by Dr Haseldine, dated 18 May 2015 (amended 28 May and 1 June 2015).

7. Letter to Council from Dr Crofts, dated 3 July 2015.

8. Letter to Council from Dr Hunt, dated 17 July 2015.

9. Letter to Dr Hunt from Dr Lin, dated 30th July 2015.

10. Letter to Dr Crofts from Dr Imam, dated 6th August 2015.

11. Occupational Health report provided by Dr Hunt, dated 17 August 2015.

12. Letter to Mr Y from Council, dated 8th September 2015.

13. DWP decision letter dated 4th December 2015, notifying him that he had been awarded PIP.

14. Mr Y's letter of appeal dated 14 February 2016.

Appendix C

Local Government Pension Scheme Regulations 2013 (SI2013/2356) (as amended)

132. As at the date Mr Y's employment ceased, Regulation 35 provided:

"(1) An active member who has qualifying service for a period of two years and whose employment is terminated by a Scheme employer on the grounds of ill health or infirmity of mind or body before that member reaches normal pension age, is entitled to, and must take, early payment of a retirement pension if that member satisfies the conditions in paragraphs (3) and (4) of this regulation.

(2) The amount of the retirement pension that a member who satisfies the conditions mentioned in paragraph (1) receives, is determined by which of the benefit tiers specified in paragraphs (5) to (7) that member qualifies for, calculated in accordance with regulation 39 (calculation of ill health pension amounts).

(3) The first condition is that the member is, as a result of ill health or infirmity of mind or body, permanently incapable of discharging efficiently the duties of the employment the member was engaged in.

(4) The second condition is that the member, as a result of ill health or infirmity of mind or body, is not immediately capable of undertaking any gainful employment.

(5) A member is entitled to Tier 1 benefits if that member is unlikely to be capable of undertaking gainful employment before normal pension age.

(6) A member is entitled to Tier 2 benefits if that member—

(a) is not entitled to Tier 1 benefits; and

(b) is unlikely to be capable of undertaking any gainful employment within three years of leaving the employment; but

(c) is likely to be able to undertake gainful employment before reaching normal pension age.

(7) Subject to regulation 37 (special provision in respect of members receiving Tier 3 benefits), if the member is likely to be capable of undertaking gainful employment within three years of leaving the employment, or before normal pension age if earlier, that member is entitled to Tier 3 benefits for so long as the member is not in gainful employment, up to a maximum of three years from the date the member left the employment".

133. Regulation 36 provided:

"(1) A decision as to whether a member is entitled under regulation 35 (early payment of retirement pension on ill health grounds: active

members) to early payment of retirement pension on grounds of ill health or infirmity of mind or body, and if so which tier of benefits the member qualifies for, shall be made by the member's Scheme employer after that authority has obtained a certificate from an IRMP as to -

(a) whether the member satisfies the conditions in regulation 35(3) and (4); and if so,

(b) how long the member is unlikely to be capable of undertaking gainful employment; and

(c) where a member has been working reduced contractual hours and had reduced pay as a consequence of the reduction in contractual hours, whether that member was in part time service wholly or partly as a result of the condition that caused or contributed to the member's ill health retirement.

(2) An IRMP from whom a certificate is obtained under paragraph (1) must not have previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested.

(2A) For the purposes of paragraph (2) an IRMP is not to be treated as having advised, given an opinion on or otherwise been involved in a particular case merely because another practitioner from the same occupational health provider has advised, given an opinion on or otherwise been involved in that case.

(3) If the Scheme employer is not the member's appropriate administering authority, it must first obtain that authority's approval to its choice of IRMP.

(4) The Scheme employer and IRMP must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation and regulations 37 (special provision in respect of members receiving Tier 3 benefits) and 38 (early payment of retirement pension on ill health grounds: deferred and deferred pensioner members).”

134. Schedule 1 states:

“permanently incapable” means “that the member will, more likely than not, be incapable until at the earliest, the member's [NPA]”.

“gainful employment” means “paid employment for not less than 30 hours in each week for a period of not less than 12 months”.

“IRMP” means an independent registered medical practitioner who is registered with the General Medical Council and holds one of the qualifications specified in that

Schedule. Alternatively, an “Associate, a Member, or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA state”.