CAS-37578-F3C8

Ombudsman's Determination

Applicant	Mr N
Scheme	Local Government Pension Scheme (**the Scheme**)
Respondent	Caerphilly County Borough Council (**the Council**)

Outcome

1. I do not uphold Mr N's complaint and no further action is required by the Council.

Complaint summary

2. Mr N's complaint concerns the Council's decision not to award him an ill health retirement pension (**IHRP**).

Background information, including submissions from the parties

3. The Council is the Administering Authority for The Greater Gwent (Torfaen) Pension Fund (**the Fund**) which is part of the Scheme. Regulations 35 and 36 of the Local Government Pension Scheme 2013 (SI 2013/2356) (as amended) (**the Regulations**), apply to ill health retirement from active status. Regulation 35 provides for three tiers of benefits for ill health retirement depending upon the member's level of incapacity for future employment. Briefly:-

    - Tier 1, the member is unlikely to be capable of undertaking gainful employment before normal pension age.

    - Tier 2, the member is unlikely to be capable of undertaking any gainful employment within three years of leaving employment but is likely to be capable of such employment before normal pension age.

    - Tier 3, the member is likely to be capable of undertaking gainful employment within three years of leaving employment (or before normal pension age if earlier).

    Extracts from the relevant regulations are provided in Appendix 1.

4. Mr N worked full-time for the Council as a Maintenance Technician. Mr N went on sickness absence from 5 January 2016 to 31 July 2016, due to developing Diabetes type 2 which caused problems with his legs. Following advice from Occupational Health (**OH**), Mr N returned to work from 1 August 2016 on amended duties. However, he awaited further investigations and treatments and requested an updated GP report. Relevant sections of Mr N's medical evidence are set out in Appendix 2.

5. On 15 September 2016, Mr N saw the OH doctor for another assessment, however he was still waiting for his GP to issue a report.

6. On 5 January 2017, Mr N attended another OH assessment. The OH doctor concluded, based on the printouts from the GP and information from Mr N, that Mr N was fit for work with amended duties.

7. On 17 January 2017, Mr N attended a meeting with his line manager and a HR officer to discuss the report from the OH. During the meeting, Mr N was advised that the amended duties were coming to an end, and they could not sustain the position long term. Other options were presented to Mr N such as redeployment or a career break.

8. Mr N told his manager that he did not want to explore the option of redeployment as he felt this would be limited due to his ill health. It was agreed that Mr N should seek further advice from his GP regarding treatments available to him. Another meeting would be arranged in the near future.

9. On 10 and 21 February 2017, meetings were held with Mr N, his manager and a HR officer to further discuss his options. At the latter meeting, Mr N provided an updated GP report dated 17 February 2017. However, the same options were proposed to Mr N such as redeployment or a career break. He was also reminded that the amended duties were only a temporary measure. Mr N requested to apply for an IHRP as he felt there were no other options for him.

10. Mr N went on sickness absence from 27 February 2017. He was subsequently referred by the Council to an independent registered medical practitioner (**IRMP**) for an IHRP assessment.

11. In her report of 25 April 2017, Dr Wolf, the IRMP, concluded that Mr N was not eligible for an IHRP as he was still undergoing treatments and his symptoms could improve sufficiently to return to more active work. Dr Wolf said that "he is restricted in walking distance to 20-30yds., though this is less when walking up inclines and stairs. This has meant that he is currently able to fulfil his role as building maintenance technician which involves frequent walking".

12. On 17 May 2017, Dr Griffiths, the OH Doctor, contacted Dr Woolf asking if she had made a mistake in her statement in that instead of "he is currently able" should this be "he is currently unable". On 15 August 2017, Dr Woolf updated her report to "he is currently unable."

13. Following the IRMP's report, the Council considered Mr N's eligibility for an IHRP. The Council decided that it was not in a position to make a determination regarding this matter. The reason for this was that the Council had only received a printout of Mr N's records from his GP and not a report as requested in the letter from the OH. Furthermore, the reports from the Consultant Vascular Surgeon and the Core Trainee were not up to date to allow the Council to consider Mr N's health situation at the time. The decision was made that Mr N should provide more up to date evidence, following which the Council would reconsider its determination.

14. In October 2017, Mr N provided more recent evidence in support of his new IHRP application. The Council subsequently referred him to another IRMP for an assessment.

15. On 31 October 2017, Dr Mansouri, the IRMP, issued his report, in which he said that as Mr N had not exhausted all treatments available, he was unable to conclude that his incapacity would be permanent. Consequently, in his view, Mr N was not eligible for an IHRP. Dr Mansouri also noted that in August 2017, Mr N had returned to alternative work which involved painting.

16. On 7 November 2017, the Council wrote to Mr N with a decision to decline his IHRP application. It said, based on the IRMP's report and all available medical evidence, it concluded that Mr N did not meet the criteria for IHRP. It advised him of his right to appeal under the Scheme's two-stage internal dispute resolution procedure (**IDRP**).

17. On 17 November 2017, Mr N appealed under stage one of the IDRP. In his submissions, Mr N said, in summary:-

    - He was unable to work and carry out his job with the Council.
    - He referred to the opinion of Dr Jayasinghe who said that an operation on his arteries was a major risk and it could result in a double amputation.
    - He was 55 years old with a dependent family to support. He could not put his wife or family through such risks that could leave him with life changing results.
    - It was unfair to put him through the operation where the results were uncertain.
    - He could not walk for more than 30 yards as he was in constant pain and a lot of stress and anxiety.
    - In August 2016, he was told to return to work. He did so even though he struggled.

18. On 23 November 2017, a meeting was held with Mr N, his manager, HR and the Trade Union Representative. The Council told Mr N that a decision had been made to terminate his employment with effect of 23 November 2017, because he was unable to carry out the duties of his job. He was provided with a right to appeal against this decision.

19. On 9 February 2018, Mr N provided reports dated 31 January 2018, from his Consultant Vascular Surgeon, Dr Ambler, in support of his stage one IDRP appeal.

20. On 8 May 2018, the stage one decision maker for the Council, in its role as the Administering Authority for the Fund, sent Mr N his decision. He concluded that it was important to seek a medical opinion from Dr Mansouri to ensure he was fully aware of the contents of the recently received reports. Dr Mansouri confirmed that the contents of the reports from Dr Ambler did not alter his opinion. (Dr Mansouri's comments are set out in Appendix 2).

21. In June 2018, Mr N appealed the Council's decision under stage two of the IDRP. In his submissions, Mr N said:

- He felt that the stage one decision was unfair as he was extremely unwell and could not walk for more than 20 to 30 yards.
- His health would not improve and it was being medically managed as best it could. There were no surgical procedures that would improve his condition. So, he believed he would be eligible for at least Tier 2 IHRP.
- He was struggling financially and had concerns that he might fail to meet his mortgage payments.
- He was a loyal employee of the Council for over 30 years, and he was very disappointed to find himself in this situation.
- He understood there were three tiers of IHRP under the Scheme Rules. He did not believe he would ever be able to find gainful employment prior to his normal pension age of 65 and certainly not within the next three years as required by the criteria for Tier 2.
- It was now six months after his employment ceased and he had not been able to find a "single day's work." Even if this fact could be disputed, Tier 3 was still available to him.

22. On 24 August 2018, the stage two decision maker on behalf of the Council, sent Mr N her decision. She said, in summary:-

- The criteria under the Regulations must be met in order to be eligible for an IHRP. Before making its decision, the Council must obtain a certificate from an IRMP.
- Based on Dr Woolf's report of April 2017, the Council was unable to make a decision whether or not Mr N met the criteria for an IHR. This is because it was still waiting for Mr N's GP's report and specialists' reports.
- In October 2017, Mr N was assessed afresh by Dr Mansouri who had sight of Mr N's most recent medical evidence.

- As there was no evidence Mr N was permanently incapable of undertaking his substantive role, the Council decided not to award him an IHRP.
- Her opinion was that the Council's decision was based on the advice of the IRMP and was undertaken based on timely and available information. The decision was reasonable in the context of the evidence considered and was in accordance with the Regulations.
- She could see no reason to overturn the Council's original decision not to award Mr N an IHRP.

23. Following the complaint being referred to The Pensions Ombudsman, Mr N and the Council made further submissions that have been summarised below.

Mr N's position

24. Mr N submitted:-

- His condition had not improved and he was still being monitored by his doctor.
- He was still unable to walk very far without resting and rarely leaves the house anymore.
- He and his wife were struggling financially as he had not been able to work.
- He felt let down by the Council and the system after working all his life and not having been able to claim his IHRP. As a result, he had to claim his pension lump sum in order to survive.
- He believed he met the criteria for an IHRP because his doctors warned him of the risk of undertaking an operation, which would be an amputation of his limb.

The Council's position

25. The Council submitted:-

- It reiterated its points from the stage two IDRP decision and referred to the criteria under the Regulations.
- It had followed the process correctly when making a decision regarding Mr N's eligibility for an IHRP.
- Its advisers took account of all timely and available information. It sought advice from two different IRMPs and based on the advice, it made a reasonable decision not to award Mr N an IHRP.
- However, if Mr N's condition changed or he had new medical information, he might wish to submit a request for consideration of entitlement to an IHRP as a deferred member of the Scheme.

Adjudicator's Opinion

26. Mr N's complaint was considered by one of our Adjudicators who concluded that no further action was required by the Council. The Adjudicator's findings are summarised in paragraphs 27 to 46 below.

27. Members' entitlement to benefits when taking early retirement due to ill-health is determined by the Scheme Regulations. The Scheme Regulations set out the circumstances in which members are eligible for ill-health benefits, the conditions they must satisfy and the way in which decisions about ill-health benefits must be taken.

28. In Mr N's case, the relevant regulations were Regulation 35 and 36 of the Scheme (see Appendix 1). Regulation 36 stated that: "A decision as to whether a member is entitled under Regulation 35…to early payment of a retirement pension…shall be made by the Scheme employer… after that authority has obtained a certificate from an IRMP." In this case, the Council, as Mr N's employer, was the decision-maker.

29. The Council, after obtaining a certificate from an IRMP, needed to consider Mr N's IHRP application in accordance with the Regulations and properly explain why his application could, or could not, be approved. It must ask the right questions and consider only relevant information before reaching a reasonable decision.

30. Regulation 35(3) and (4) of the Regulations stated that:

> "(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."

31. If Mr N met the two conditions, the Council could then consider which tier of benefits he should receive. The tier of benefits awarded depended upon the likelihood that Mr N would be capable of undertaking gainful employment at some time before his normal pension age.

32. The first IRMP, Dr Woolf, in her report of 25 April 2017, concluded that although Mr N was currently not fit for his role, there were still treatments available to him and, in her opinion, he was not eligible for an IHRP. Following this report, the Council confirmed that it could not reach a decision about Mr N's IHRP eligibility because it was still waiting for an up to date GP report and specialists' reports.

33. The second IRMP, Dr Mansouri, in his report of 31 October 2017, concluded that Mr N had not exhausted all the treatment options available to him and as such he was unable to conclude that his incapacity was permanent. He then said that although Mr N was unfit for his current role, he was fit for an alternative work with less walking.

34. During the IDRP appeals, Mr N provided more medical reports from Dr Ambler which were considered by Dr Mansouri in his report dated 31 October 2017. Dr Ambler said, "best treatment strategy is best medical therapy and continue[d] exercise as the literature suggests that intervention at this stage is associated with a significant risk of earlier amputation." Dr Mansouri confirmed that the additional medical report did not change his opinion and stated that surgical interventions may be considered if Mr N's symptoms deteriorate. He also said that "given possible effects of the medical interventions available, I have no evidence to indicate that he will be permanently incapable of undertaking his substantive role."

35. In the Adjudicator's view, she did not see how Dr Mansouri's conclusion could have been reached from the content of Dr Ambler's report. In the Adjudicator's opinion, an ordinary reading would suggest that surgical intervention carried a significant risk of earlier amputation.

36. It was also unclear what the further "medical interventions" to which Dr Mansouri referred were available. Given that Dr Ambler stated that Mr N was already engaging with the best medical treatment options and was still significantly limited with surgery carrying a significant risk of amputation, in the Adjudicator's view this conclusion by Dr Mansouri was not supported by the medical evidence presented to him.

37. Furthermore, Dr Mansouri referred to the "possible" effects of the purported medical interventions available. It was the Adjudicator's opinion that this applied the incorrect level of probability set out in the Regulations. When considering permanence, Regulation 2 defines "permanently incapable" for the purposes of Regulation 35(3) as follows:

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

38. Applying a "possible" test set a lower bar of probability than "more likely than not", even if medical interventions had been recommended by Dr Ambler. Dr Mansouri's opinion was that Mr N was, at the time of assessment, unfit for his substantive role. The fact that it was "possible" that a further future intervention would improve his condition is not the correct test under the Regulations. In the Adjudicator's view, the question Dr Mansouri ought to have addressed, under the Regulations, was "given Mr N's current incapability of performing his substantive role, and the fact that he was already receiving, in Dr Ambler's opinion, best medical treatment, is it more likely than not that a further medical intervention would result in Mr N being capable of performing his role (not a lighter alternative role with more sitting down) before he reached normal pension age?"

39. On that basis, the Adjudicator's view was that Dr Mansouri did not apply the proper test set out in Regulation 35(3) to establish whether Mr N was permanently incapable of discharging efficiently the duties of the employment in which he was engaged.

40. The Adjudicator would have expected the Council to have actively reviewed Dr Mansouri's report. Whilst it could only do so from a layman's perspective, had it done

so, in the Adjudicator's view, it would have realised that Dr Mansouri had applied the wrong standard of probability under Regulation 35(3). In the Adjudicator's opinion the Council's failure to do so amounted to an error of law.

41. However, despite this error of law, both conditions in Regulation 35(3) and 35(4) needed to be satisfied, in the opinion of the IRMP, for a member to be entitled to an ill health pension. As set out above, the condition in Regulation 35(4) was that the member is not immediately (upon termination) capable of carrying out any gainful employment. Gainful employment was defined widely as "paid employment for not less than 30 hours in each week for a period of not less than 12 months." Crucially, this was not restricted to employment with the employer.

42. Despite the brevity of Dr Mansouri's conclusions regarding Regulation 35(4), in the Adjudicator's view, there was no discernible error in how he reached the conclusion that Mr N was capable of carrying out alternative work, which was also consistent with the longer opinion of Dr Woolf.

43. In the adjudicator's view, the Council, looking at the decision-making process as a whole, reached an overall decision that was consistent with its duties under Regulations 35 and 36 of the Regulations. A decision-maker could choose to prefer one expert's medical evidence over other medical evidence provided that doing so was not perverse. Based on the overall medical evidence presented by the IRMPs, the Adjudicator's view was that the Council did not reach a decision that no decision-making body, acting reasonably, could have reached.

44. The Adjudicator's opinion was that, while the error of law identified above amounted to maladministration, this did not affect the overall decision. Consequently, there was no reason to remit the matter back to the Council to reconsider.

45. Mr N referred to his current condition having deteriorated. However, the Council's decision could only be assessed by reference to the medical evidence which was or could have been available at the time the decision was taken. Mr N had to satisfy the criteria set out in the Regulations at the time his employment ceased.

46. It was, however, open to Mr N to contact the Council to submit a new application for an IHRP from deferred status, which could take into account more recent medical evidence about his condition deteriorating. If Mr N chose to do this, the Adjudicator would expect the Council to engage with him promptly and thoroughly consider his application under the Regulations. Consequently, it was the Adjudicator's opinion that this complaint should not be upheld.

47. Mr N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr N did not provide further comments, and having reviewed the complaint, I agree with the Adjudicator's Opinion.

Ombudsman's decision

48. Mr N is unhappy that the Council refused his application for an IHRP.

49. It is not my role to review the medical evidence and come to a decision of my own as to Mr N's eligibility for payment of benefits under the Regulations. I am primarily concerned with the decision making process. Medical (and other) evidence is reviewed in order to determine whether it supported the decision made. The issues considered include: whether the relevant regulations have been correctly applied; whether appropriate evidence has been obtained and considered; whether the correct questions have been asked; and whether the decision is supported by the available relevant evidence.

50. The weight which is attached to any of the evidence is for the Council to decide (including giving some of it little or no weight). It is open to the Council to prefer evidence from its own advisers; unless there is a cogent reason why it should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the IRMP. If the decision making process is found to be flawed, the appropriate course of action is for the decision to be remitted for the Council to reconsider. However, it must ensure that any medical advice upon which it places weight has addressed the right questions under the Regulations.

51. I appreciate that the Council is not a medical professional itself and can only review the medical advice from a lay person's perspective. The same applies for me and my staff. The questions the Council might be expected to ask of its IRMPs are only those which a reasonably informed lay person might ask. In order to arrive at a reasonable decision about an IHRP, the Council is required to satisfy itself whether or not, on the balance of probabilities Mr N was likely to be able to return to work before normal pensionable age and must be able to provide reasons for that conclusion.

52. From the information provided by all parties to the complaint, I agree with the Adjudicator that, although there was an error of law in the IRMP's assessment, the Council made its decision concerning Mr N's IHRP application in the correct way, for broadly the same reasons as set out in paragraphs 29 to 44 above.

53. I find that the Regulations have been correctly applied and that the relevant medical evidence was considered. I find no grounds to remit the decision back to the Council for reconsideration.

54. Mr N may wish to contact the Council regarding an option to submit a new IHRP application from a deferred status.

55. I do not uphold Mr N's complaint.

Anthony Arter CBE

Deputy Pensions Ombudsman
16 May 2024

Appendix 1

The Local Government Pension Scheme 2013 (SI 2013/2356) (as amended)

1. Regulations 35, 'Early payment of retirement pension on ill-health grounds: active members', provides:

   "(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."

2. Regulation 36, 'Role of the IRMP', provides:

“(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).”

Appendix 2

Medical evidence

1. In his report of 6 April 2016, Consultant Vascular Surgeon, Mr Shandall said:

   "I understand he has recently been diagnosed as diabetic and was put on Gliclazide and he also stopped smoking in January and started on Statin. He has no other relevant history.

   On examination he is rather obese so it was difficult to feel his femorals but I could feel his left femoral. I could not feel pulses below that. He may well have femoral popliteal disease accounting for his symptoms. I have given him advice regarding continuing to stop smoking, controlling his diabetes and taking his Statin. I have also given him advice regarding exercise."

2. In her report of 7 April 2016, the OH Doctor, Dr Griffiths said:

   "[Mr N] tells me that he was struggling in work as this often involves going up and down flights of stairs a number of times at each job.

   In December [Mr N] consulted his GP regarding these symptoms and blood tests that were performed showed that he has Type 2 Diabetes. This is now controlled on medication and is unlikely to be the cause of his leg pains. His GP suggested to him that the pain may be due to problems with his circulation and he has been referred to a vascular surgeon and for a scan. He is still awaiting these appointments although he tells me he has booked privately to see the surgeon on the 8th of April to try and speed up the process.

   His GP has certified him as unfit for work and his current certificate runs up until 15/5/16.

   Fitness for work

   Based upon the information available to me and the nature of his employment I believe that [Mr N] is unfit for his current role.

   An amendment to his hours/phased return would not be of benefit as his symptoms are not related to the duration of his shifts.

   If he were able to perform a sedentary role he could be considered fit for work.

   Additional Advice

   Answers to your specific questions.

   The condition has not been caused by work but the nature of his job makes the symptoms worse.

   As described above a change in work pattern would not be of benefit but a change in the nature of his role to something sedentary might enable him to

return to work. If there was a possibility of this I would suggest it would need to be temporary for a period of 3 to 6 months as there is a potential with treatment for him to be able to return to his current role."

3. In his report of 13 June 2016, Core Trainee, Dr Shinkwin said:

   "I saw this 53 year old gentleman with Mr Lewis in clinic today. Over the past 9-10 months he has noticed increasingly worsening cramp like pain in both calves on exertion. He notes the pain eases off after 10 minutes or so and he is able to walk again. At present the problem is stopping him from working. On questioning he denies any pain in the feet or legs at night.

   [Mr N] has recently been diagnosed with diabetes and until January was smoking cigarettes. He appears to have accrued a 40-60 year pack history. He is now occasionally using an e-cigarette and again trying to cut down on this too. I note he has previously been started on a statin but at present doesn't take any antiplatelet medication.

   On examination in clinic today his femoral pulses were fairly difficult to feel and he had no pulses in either feet (sic). I have done toe pressures in clinic today with the right toe having a pressure of 30 mm/Hg and the left toe having a pressure of 32 mm/Hg. This gives an index of 0.23 and 0.24 respectively.

   After discussion with Mr Lewis, he and the patient have decided that he should be started on Aspirin and for the time being be discharged back to your care. Should his symptoms get worse please re-refer back to us for further investigations and management."

4. In her report of 21 July 2016, the OH Doctor, Dr Griffiths said:

   "[Mr N] tells me that following his last assessment he has now seen a vascular surgeon privately and also a different surgeon on the NHS. He tells me that following his NHS appointment it was suggested that he take aspirin to see if it improved his symptoms. He has been doing this for more than a month now and states that his pain is exactly the same as it was previously. He has also had a discussion with his GP whether the tablet he takes for diabetes might be contributing to his leg pain and for the last 10 days he has been off these tablets. Again this does not seem to have made a significant difference to his symptoms. [Mr N] again stated that he is pain-free at rest but after walking about 30 yards or upstairs he gets severe pain in his calf which is only relieved after resting for a prolonged period.

   The condition he is describing is typical of claudication which is a pain which is caused when not enough blood gets through to the muscles when an individual is active. This condition is more likely to in those who smoke and those who have diabetes. [Mr N] tells me he has now given up smoking and his diabetes is well controlled.

Fitness for work

Based upon the information available to me and the nature of his employment I believe that [Mr N] remains unfit for his substantive post. At present without further information I am unable to give advice on how long this situation is likely to last.

Additional Advice

If temporary redeployment to a sedentary role were to be available it is my opinion that [Mr N] would be able to return to work whilst he awaits further investigations/treatment. Driving would be a suitable work activity. If he were to be found a sedentary role he would need still to have access to the appropriate facilities e.g. toilets.

The Prognosis

I would need further information in order to be able to comment upon the prognosis of this case.

If a medical report is needed?

If deemed acceptable to your service area, I will write to his GP to request a report so that I may give further advice regarding his fitness for work, adjustments and the long-term prognosis.

Follow up

I have arranged a review with [Mr N] in six weeks to re-assess his case with the benefit of the additional information from his GP.

If there are any specific questions or concerns regarding the recommendations made or you would like to discuss this case further, please do not hesitate to contact the Occupational Health department."

5. In her report of 15 September 2016, Dr Griffiths said:

"Update

[Mr N] tells me that since I last saw him his symptoms remained virtually unchanged…

With regard to amended duties [Mr N] tells me initially he was doing office-based work but he is now working in the stores. He tells me that this involves walking regularly throughout the day but only short distances and he finds this suitable and is not experiencing any symptoms at present.

I had arranged this appointment to review [Mr N's] condition with further information from his GP but have not received the GP report. We have chased this up today and I have also asked [Mr N] to go to the surgery and asked for it to be returned to us as soon as possible.

Fitness for Work

Based upon the information available to me and the nature of his amended duties I believe that [Mr N] is fit for work.

Without the information I have requested from his GP I am unable at present to give any further advice on his prognosis and long-term fitness for work or further adjustments."

6. In her report of 5 January 2017, Dr Griffiths said:

"Fitness for work

Based upon the information available to me and the nature of his employment I believe that [Mr N] is fit for work on amended duties as previously detailed.

Suitable activities include driving and walking for short distances.

It is my opinion that this adjustment to the nature of his role would need to be in place indefinitely or until such time as he received further intervention for his claudication symptoms.

…

The prognosis

[Mr N] is now on medication and has stopped smoking so it is unlikely that his symptoms will get worse however the blockage in his arteries is unlikely to improve without a specific intervention. As yet no treatment of this kind has been planned it is therefore likely that his clinical condition will remain unchanged for the foreseeable future.

Follow up

I have not arranged any follow up, but would be happy to review [Mr N] again at your request if you have any further concerns regarding his fitness for his current employment."

7. In her updated report of 25 April 2017, the IRMP, Dr Woolf said:

"It is often difficult to conclude that an illness will not resolve or improve until all evidence-based treatments currently widely available have been completed. The reason for this difficulty is the realistic expectation in most circumstances that remaining treatment options will improve symptoms and functional capabilities.

Having considered the available information including the occupational health records, I do not think that at this point [Mr N] qualifies for retirement on the grounds of ill health. He has peripheral vascular disease causing pains in his legs when he walks and he is restricted in walking distance to 20-30yds., though this is less when walking up inclines and stairs. This has meant that he

is currently unable to fulfil his role as a building maintenance technician which involves frequent walking of distances that aggravate his symptoms. He also has diabetes which is a risk factor for vascular disease. [Mr N] is managed conservatively at present, and it seems that both his GP and his consultant are not keen for him to undergo surgery, except as a "last resort". However, this means that all reasonable treatment options have not been completed and it is quite possible that in the next 12 years leading up to retirement age, [Mr N] may need to, or opt to, undergo surgery. This could improve his symptoms sufficiently to return to more active work. In view of this, I cannot at this point recommend retirement on the grounds of ill health, though I do recognise that his medical condition does significantly restrict his employment at present."

8. In his report of 6 October 2017, GP, Dr Jayasinghe said:

"[Mr N] was diagnosed with Type 2 diabetes in December 2015. Around the same time, he had complained to GP about having intermittent claudication symptoms in his legs. He was referred to the vascular clinic in December 2015 via NHS but decided to see Mr A Shandall, a Consultant Vascular Surgeon privately in April 2016…

He was later seen in the outpatients clinic of vascular surgery in the Royal Gwent Hospital on 13.06.2016…Both his Diabetes and Peripheral Vascular disease are being managed with drug therapy at the moment.

He is continuing to report of bilateral leg pains and that because of the pain he is unable to return to normal work.

His recent most HbA1C (Diabetic monitoring) is 93 mmol which indicates his diabetes is poorly controlled.

[Mr N] has clearly mentioned to me on 03.07.2017 that he is not able to get back to work with his leg pain."

9. In his report of 31 October 2017, the IRMP, Dr Mansouri said:

"I understand that the previous application for ill-health retirement in April 2017 was rejected.

…

I understand that [Mr N] has been diagnosed with long-standing diabetes for which he takes regular medication. [Mr N] has also been experiencing painful symptoms in his calves, which is aggravated by walking. This has been gradually deteriorating over the years. [Mr N] tells me that he is unable to comfortably walk longer than approximately 20-30yards, at present. This has affected his daily activities and ability to perform his work duties, for example [Mr N] is unable to go to a supermarket with his wife because he needs regular rest.

[Mr N] has been diagnosed with a circulatory condition in his legs which is probably secondary to his diabetes. This leads to insufficient blood supply to his calf muscles restricting his mobility. [Mr N] has been prescribed with Aspirin but this has had little effect on his walking difficulty. His diabetes medication has been revised and [Mr N] has been provided with lifestyle advice to help his circulatory problem. His specialist has discussed the possible option of a surgical treatment, if his symptoms deteriorate.

Opinion

[Mr N] has not exhausted all the treatment options available and as such I am unable to conclude that his incapacity will be permanent.

On the basis on my assessment on 31st October 2017 I advise that [Mr N] is currently unfit to undertake his usual duties, or any role which requires walking long distances or ascending/descending stairs. In my opinion, he is fit for an alternative work. [Mr N] tells me that he returned to a temporary work in August 2017. My understanding is that this work involved painting and allowed [Mr N] to regularly sit down."

10. In his report of 31 January 2018, Clinical Fellow in Vascular Surgery, Mr Ambler said:

"The above gentleman is known to us with symptomatic short distance claudication as a result of peripheral arterial disease. He is being treated according to International Guidelines which suggest that his optimal treatment strategy is with best medical therapy and supervised exercise. There are no operations which are recommended for treatment of his stage of peripheral arterial disease so his condition has already been optimised as best as possible. He will be significantly impaired by this condition if he has a job which requires walking."

11. In his supplementary report of 31 January 2018, Mr Ambler said:

"I have talked to [Mr N] about the situation and have recommended that he double the dose of statin tablets as there is evidence that people with peripheral arterial disease benefit from high dose statin therapy. In addition I have referred him to the supervised exercise programme as we do know that continued exercise can make things somewhat better. We had a conversation today about the benefits and risks of intervention and the fact that the evidence suggests that [Mr N's] best treatment strategy is best medical therapy and continue exercise at this point as the literature suggests that intervention at this stage is associated with a significant risk of earlier amputation.

[Mr N] has been told by his employer that he is not able to have ill health retirement despite his critical short distance claudication. I am somewhat surprised by this as he is engaging with the recommended best treatment options and despite this is significantly limited. I have told [Mr N] that I will copy this letter to him so that we have clarified things from a medical point of view.

I have not made a routine appointment to see him once again as he very wisely is not keen to pursue the options of intervention given the significant long-term risks associated with this. We would, however, be delighted to offer further advice or see him once more should things deteriorate or further advise be required."

12. In his further report of 28 March 2018, the IRMP, Dr Mansouri said:

"The medical report from Mr Ambler…dated 30th January 2018 states that [Mr N] has been diagnosed with a circulatory problem and he is able to walk up to 20-30 yards before he has to stop due to severe painful symptoms in his calves. Whilst the specialist has not considered a surgical intervention at present, he has indicated that this may be considered if [Mr N's] symptoms deteriorate in the future.

Having considered the specialist report, I am still unable to conclude that [Mr N] is currently incapable of undertaking an alternative role, for example a sedentary role or painting duties that he undertook before August 2017. I advise that [Mr N] is currently incapable of discharging the duties of his substantive post as a Maintenance Technician. On the other hand, given possible effects of the medical interventions available, I have no evidence to indicate that he will be permanently incapable of undertaking his substantive role."