The Pensions Ombudsman

Ombudsman's Determination

Applicant	Miss L
Scheme	John Lewis Partnership Trust For Pensions (**the Scheme**)
Respondent	John Lewis Partnership Pensions Trust (**the Trustee**)

Outcome

1. I do not uphold Miss L's complaint and no further action is required by the Trustee.

Complaint summary

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

Background information, including submissions from the parties

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

4. Miss L held the position of supermarket assistant in customer services with the John Lewis Group (the **Employer**). In July 2010 she was diagnosed with complex regional pain syndrome (**CRPS**), a condition that causes chronic pain.

5. After 2010, Miss L worked solely on the retail checkouts, mainly on the tills. In November 2016, at the age of 37, her contract was terminated on the grounds of medical incapacity.

6. On 3 January 2017, Miss L was notified of the Pension Office's decision that she did not fully meet the Scheme's criteria for an incapacity pension. She was informed that the medical evidence indicated she could do paid work in a retail environment that did not require lifting or moving heavy items.

7. Miss L appealed the decision on 31 January 2017. She maintained that she had pursued all the treatment options available to her.

8. In considering Miss L's appeal, the Trustee obtained an addendum report from the Scheme's medical adviser, Dr Eraneva, dated 17 June 2017 (the **Report**). In her Report, Dr Eraneva listed a number of pain relief options that remained to be considered.

9. Miss L's appeal was rejected by the Trustee and in 2018 she brought a complaint (the **Original Complaint** [PO-19380]) about that decision to The Pensions Ombudsman (**TPO**).

10. Miss L's original complaint was considered by a TPO Adjudicator. The Adjudicator's conclusions were as follows:-

    - In cases such as this, the Ombudsman would look to see whether a decision could safely be made without the decision-maker seeking further clarification. The Adjudicator considered that Miss L's case was finely balanced on this point.

    - The Adjudicator said that the Ombudsman would likely uphold Miss L's complaint and direct that the Trustee reconsider the matter. She recommended that the Trustee look at Miss L's case again, unless it was able to provide evidence that it had sought clarification from Dr Eraneva on the treatment options she had in mind.

    - Where these were options Miss L had already tried, the Trustee should ask Dr Eraneva why these were considered likely to result in sufficient improvement in Miss L's condition in the future before it made its decision again. The Adjudicator said that Miss L would then have the satisfaction of knowing that, whatever the outcome, her application for early payment of her pension had been properly considered taking into account all relevant factors.

    - The Adjudicator considered that the Trustee's failure to assess Miss L's application in a proper manner would have caused her significant distress and inconvenience. She said that it would be appropriate in the circumstances for the Trustee to make an award of £500 to Miss L to put right the significant non-financial injustice it had caused her.

11. In September 2018, the Trustee agreed to review its decision to refuse Miss L's application for an incapacity pension.

12. On 26 September 2018, the Trustee wrote to Miss L. It referred to the Report and asked Miss L to clarify the following:-

    - Which of the treatment options had she tried and what impact had they had on her health?
    - Were there any treatments listed that she had not tried? If so, would she consider them?
    - If there were treatment options she had not tried and would not consider, could she explain why she would not try them?
    - Was there anything else that she thought was relevant to her application for an incapacity pension that she would like the Trustee to consider?

13. Miss L responded to the Trustee on 5 October 2018. In her letter, she quoted from the Royal College of Physicians guidance (the **Guidance**).

14. The Guidance explained that CRPS "is a debilitating, painful condition in a limb, associated with sensory, motor, autonomic, skin and bone abnormalities" for which there was no proven cure.

15. She said that she had noticed that Dr Eraneva had simply 'cut and pasted' the entire section on CRPS from the Guidance into her Report. Dr Eraneva had not amended or deleted straightforward treatments such as sleep hygiene, relaxation techniques and coping skills which had already been considered. She added that while some orthodox treatment options had been included in the Report, many were not and did not work in isolation, for example patient education and support.

16. Miss L provided the Trustee with a detailed summation of her symptoms and some of the more conventional treatments she had tried, including a TENS machine and desensitisation. She said she had also tried mirror visual feedback, which showed how rare her condition was as the physiotherapist had to order the equipment and learn how to use it.

17. Miss L said that the combination of holistic and conventional treatments had only properly begun after she was referred to the Pain Management clinic (the **Pain Clinic**) and started receiving care more appropriate to her condition. Many of the treatment options were ongoing, with the support of Birmingham Healthy Minds (**Healthy Minds**).

18. Miss L confirmed that she had not been referred to a specialist treatment centre. Her treatment had been provided by her GP, various hospitals, the Pain Clinic and Healthy Minds. She had tried to obtain a referral to the Royal National Hospital for Rheumatic Diseases (the **RNHRD**) in Bath. She explained that the RNHRD had a specialist unit for the management of CRPS in adults. However, her GP and her Pain Management Consultant considered that she had been offered all the available treatment options.

19. Miss L pointed out that she had been provided with employment related support by her Employer, through “reasonable adjustments”, and had continued to work for five years on reduced hours prior to her dismissal on the grounds of ill health. If a company the size of the Employer could not accommodate her, she questioned whether any other employer would do so.

20. She said that she would be willing to try any treatment offered to her, that she had not already received, provided the benefit outweighed the risk.

21. On 31 January 2019, the Trustee wrote to Miss L to set out the reports and other medical evidence it had received from her GP, most of which predated her Original Complaint. It said that the most recent available report from the Pain Clinic was dated 19 October 2016 and there was also a response from the RNHRD dated 12 October 2017, following a referral.

22. The Trustee asked whether there were any further medical reports available from the period October 2016 to July 2017 from specialists such as the Pain Clinic, the joint psychology/physiotherapy clinic (the **Joint Clinic**), or any other support service she had attended. It said that she had mentioned that she had attended these clinics in her letter of 5 October 2018, but her GP had not provided any medical records or reports relating to this. The Trustee invited her to provide copies of any other reports that she would like the Trustee’s Appeals Committee to refer to when reconsidering its decision.

23. Miss L replied to the Trustee on 16 February 2019. She said that she had received one-to-one care from the Joint Clinic and listed a number of dates from her own records. She also enclosed a copy of a letter, dated 6 February 2019, confirming her attendance at the Healthy Minds group. She said that she wanted a copy of a letter sent by her GP, on 3 March 2011, to Dr Hickson, the Waitrose Occupational Physician to be considered. She wanted to ensure that the Appeals Committee had a copy of all the correspondence relating to her case.

24. On 6 March 2019, Dr Eraneva submitted her report to the Trustee for discussion (Extracts can be found in the Appendix). The report showed that she had considered the following:

- additional information from the specialist at the Pain Clinic, Dr Tewani, dated 19 October 2016;
- the letter from the GP to Dr Hickson dated 3 March 2011;
- the Optometrist’s report dated 2 February 2016;
- Ophthalmology reports dated 6 October 2016, and 12 September 2016;
- the letter dated 6 February 2019, confirming Miss L’s attendance at the Healthy Minds group in April, June, August and September 2016; and

- information from Miss L regarding her one-to-one session at the Joint Clinic on 25 October 2016.

25. Dr Eraneva's conclusion was that the medical information available at the time of Miss L's appeal did not support a finding of substantial duration of incapacity or permanent incapacity. She explained that this was because medical intervention was ongoing. Furthermore, Miss L had not been reviewed by a specialist.

26. Miss L's case was considered by the Appeals Committee on 1 April 2019. It noted that the medical evidence would be a significant factor in deciding whether Miss L met the eligibility criteria for an incapacity pension from the Scheme.

27. The Appeals Committee decided the medical evidence did not indicate that, on the balance of probabilities, Miss L would remain unable to work for a substantial period of time. As Miss L was 40 years old, and her Normal Pension Age (**NRA**) was 65, her earning capacity would not be seriously impaired for a substantial period of time. Consequently, she did not meet the qualifying criteria to be considered for an incapacity pension from the Scheme. It agreed to uphold the Trustee's original decision.

28. In April 2019, Miss L complained to TPO about the new decision. She said that she fulfilled the criteria for an incapacity pension. Consequently, she could not understand why she was not entitled to receive it.

29. **The Trustee's position**

- The Trustee followed an appropriate and proper decision-making process. It obtained further information from Miss L and medical evidence from her doctors, which it provided to Dr Eraneva.

- It had reviewed the medical evidence with Dr Eraneva and identified further potential medical evidence that Miss L could provide to the Trustee.

- It then obtained an updated report from Dr Eraneva before the Appeals Committee reconsidered Miss L's application.

- Having considered the additional information, the Appeals Committee upheld the original decision not to award Miss L an incapacity pension on the basis that the definition of incapacity had not been met.

30. **Miss L's position**

- She has not been able to work since her dismissal and her medical condition has not improved. The Employer is a large organisation and if she had been able to work in any capacity, after 11 years of service, it would have chosen to redeploy her. In her view, her earning capacity has been seriously impaired.

- If she was approaching her NRA and had the same medical condition it seems the Trustee may have provided her with an incapacity pension. She feels she has been discriminated against because of her age.

- The Appeals Committee suggested she should continue to explore treatment options. Her original diagnosis was in 2010, so every option available has already been considered.

- Since she was dismissed on the grounds of ill health, she should be given the option to access her pension to improve her financial situation and end the ongoing distress this matter is causing her.

Adjudicator's Opinion

31. Miss L's complaint was considered by one of our Adjudicators who concluded that no further action was required by the Trustee. The Adjudicator's findings are summarised below:-

    31.1. As stated in paragraph 10 above, the Original Complaint was investigated by TPO in 2018. The Adjudicator did not include the arguments put forward as part of that complaint. This new complaint concerns the actions that were subsequently taken by the Trustee.

    31.2. Miss L has alleged discrimination and unfair treatment on the part of the Trustee. She has not provided corroborating evidence that she has been unfairly treated because of her age. For Miss L to have a valid age discrimination case, she must demonstrate that she was treated less favourably than a member in an identical position to her.

    31.3. The fact that the decision was remitted back to the Trustee should not be taken as an indication that I would have disagreed with the decision. It simply means that the Adjudicator at the time concluded that the Trustee had not gone about it in the correct way.

    31.4. A member's entitlement to early retirement pension due to ill health is determined by the applicable scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members are eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

    31.5. The relevant rules in this case are The Rules of the John Lewis Partnership Trust for Pensions, adopted on 22 November 2005 (the **Rules**).

    31.6. The Rules define 'incapacitated' as:

    "… suffering from such physical or mental deterioration which in the opinion of the [Trustee] prevents the Member from following his normal employment and which seriously impairs his earning capacity and in the opinion of the [Trustee]

is likely to do so for a substantial period. In forming its opinion the [Trustee] must obtain and consider the advice of a registered medical practitioner."

31.7. In relation to the incapacity pension, Rule D3 (b) of the Rules says:

"… the Trustee may decide to pay an incapacity pension to: -

(i) a Pensionable Member … before attaining the later of age 65 and Normal Pension Date because of ill health and who is Incapacitated; …

The amount of incapacity pension shall be decided by the Trustee…"

31.8. The Scheme's provisions allow the Trustee to vary, suspend or reinstate the incapacity pension at any time before the member reaches age 65. The Rules state that the Trustee shall administer the ill-health provisions in line with the provisions set out in paragraph 1 of Schedule 28 to the Finance Act 2004 (the **Finance Act**).

31.9. Under Schedule 28 of the Finance Act, for a pension to be paid to a member before age 55, the following criteria must have been satisfied immediately before he/she becomes entitled to it:

"… (a) the scheme administrator has received evidence from a registered medical practitioner that the member is (and will continue to be) incapable of carrying on the member's occupation because of physical or mental impairment, and

(b) the member has in fact ceased to carry on the member's occupation." (the **Ill-health Condition**).

31.10. The decision regarding Miss L's entitlement to an incapacity pension under Rule D3 (b) was for the Trustee to make. However, before making the decision, the Trustee was required, under Schedule 28 of the Finance Act, to obtain advice from a registered medical practitioner (**RMP**). In this case, the RMP was Dr Eraneva.

31.11. The Trustee asked Dr Eraneva to clarify the specific treatment options she had in mind that would be potentially beneficial to Miss L. And, where these were options Miss L had already tried, why she considered that they would likely result in sufficient improvement in Miss L's condition in the future.

31.12. Before obtaining Dr Eraneva's answers to those questions, the Trustee invited Miss L to clarify which of the treatment options, that Dr Eraneva had listed in her Report, she had already tried. Also, what impact they had on her health. The Trustee asked if there were any treatment options she was not prepared to try and whether there was anything else she would like the Appeals Committee to consider.

31.13. In her response, Miss L said that many of the treatment options were ongoing, largely with the support of Healthy Minds. She also said that she had not been

to a specialist treatment centre and that she would be willing to try any treatment offered to her.

31.14. In her report dated 6 March 2019, Dr Eraneva detailed the additional evidence that had been obtained as part of the review process. In the Adjudicator's view, the additional information Miss L provided, together with the additional reports from her GP, were considered by Dr Eraneva at the time.

31.15. Dr Eraneva commented that there was some diagnostic uncertainty raised by Dr Kapur, in a report dated 18 April 2016, and that other medical conditions that might be relevant were fibromyalgia and chronic pain as well as mood disorder and sleep disturbance. She suggested that a clinical review by a pain specialist, such as Dr Kapur or Dr Tewani, would be appropriate. This would enable them to assess the progression of Miss L's condition and to consider whether there was any merit in adjusting the interventions. Or, whether her symptoms had changed or were caused by a different medical condition. She noted that at the last appointment at the Pain Clinic, Dr Tewani had adjusted Miss L's medication and was planning a review.

31.16. Dr Eraneva also noted that, after the original diagnosis of CRPS in 2010, subsequent medical reports had referred to improvement in the condition in response to appropriate pain clinic interventions that included medication, nerve blocks, physiotherapy and psychological treatments and other interventions. However, there was "diagnostic complexity" in that the medical reports and records referred to features of chronic pain and fibromyalgia as well as anxiety and low mood. It was for this reason that she had recommended a specialist review of the diagnosis in her original report to the Trustee dated 1 November 2016.

31.17. Dr Eraneva said that the last available specialist reports, which detailed clinical findings, and made recommendations for interventions, were from the rheumatologist dated 15 May 2014. Also, from the specialist at the Pain Clinic, Dr Tewani dated 19 October 2016, in which a review in December 2016 was advised. There had been no specialist assessment since then.

31.18. Dr Eraneva noted that the one-to-one sessions at the Joint Clinic, and Miss L's attendance at the "monthly Long-Term conditions group", were ongoing as at 13 June 2017. Previous reports indicated Miss L's positive response to these interventions. Furthermore, pain management support could be repeated over time.

31.19. Dr Eraneva said that in the case of an individual with ongoing symptoms, a review at the pain clinic, as was planned in Miss L's case, would be recommended so that intervention options could be tailored to the current clinical picture. However, in the absence of up to date specialist information it was difficult to comment on further available intervention options other than in general terms.

31.20. Consequently, taking into account all the additional information that had been obtained, Dr Eraneva's opinion was that the available medical information did not support a finding of substantial duration of incapacity or permanent incapacity. Intervention was ongoing and a review by a specialist was outstanding.

31.21. The Trustee is not bound by the opinion expressed by the RMP and should come to a properly considered decision of its own. That said, the weight which is attached to any of the evidence is for the Trustee to decide, including giving some of it little or no weight[1]. It is open to the Trustee to accept the advice it receives from an RMP, unless there is a good reason why it should not do so or should first seek clarification. For example, where there are errors or omissions of fact or a misunderstanding of the relevant rules. The reason would have to be obvious to a lay person. The Trustee would not be expected to challenge a medical opinion.

31.22. The minutes of the Appeals Committee meeting on 1 April 2019, show that Miss L's appeal was duly considered. The minutes note that the medical evidence should be a significant factor when deciding whether Miss L met the eligibility criteria for an incapacity pension from the Scheme. The Appeals Committee noted that the medical evidence did not indicate that, on the balance of probabilities, she would remain unable to work for a substantial period of time. It concluded that Miss L's earning capacity had not been seriously impaired for a substantial period of time. Consequently, she did not meet the qualifying criteria for an incapacity pension from the Scheme. It agreed to uphold the original decision not to award her an incapacity pension.

31.23. In the Adjudicator's opinion, on the basis of the medical evidence that was made available to the Appeals Committee the decision made sense. It was reasonable in the circumstances for the Appeals Committee to have decided that her condition did not preclude her from being capable of following her occupation or seriously impair her earning capacity for a substantial period.

31.24. He appreciated that Miss L does not agree with the views expressed by Dr Eraneva, or the decision reached by the Trustee, and he acknowledged that she is still experiencing issues with her health. However, he did not consider that there are grounds for concluding that the Trustee should not have accepted the medical advice it received in reaching its decision.

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

33. Miss L has made the following points set out in Paragraphs 34 to 44 below.

---

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

34. She says that the incapacity pension that should be available to her, is not a great amount as she only ever worked part-time. She was aware that should she be dismissed, she would be unable to find further employment due to memory issues and the like, related to brain fog, not to mention the actual physical aspect of her work. It was for this reason she appealed against the decision to be dismissed and fought to keep her job.

35. She did in fact cease her occupation, even though Dr Eraneva thought she was quite capable. She believes it is a flaw that she can be dismissed by the Employer, which considers her unfit to work, but that the Trustee says that she can work. If the Trustee finds her fit for work, then it should reinstate her. The Employer is a large enough organisation with enough variety of jobs that if it felt she can be employed it should redeploy her. This is fundamentally wrong, either an incapacity pension should be awarded or she should be redeployed.

36. Regardless, she feels the Employer at the time of her dismissal wanted her out. She did not share the details of her health with anyone other than those who needed to know and for many years her managers were happy to continue with the adjustments that had been implemented for her to work. The fact the Employer wanted her out became evident sometime later in an internal note which suggested she should be investigated for potential serious misconduct for dishonesty and claiming sick pay when she was not actually sick. She was also filmed shopping in another branch while on sick leave. This filming without her permission was considered potential serious misconduct, and she was not found guilty of any wrongdoing, and yet she was ultimately dismissed.

37. She had mainly worked on checkouts, handling money, cash a lot of the time. She was a ‘stand in supervisor’ and used to train new and existing staff on how to use tills, especially when the systems changed. She used to help cover overtime at her branch and assisted at another when that was due to open, and after opening. She considers that she was exemplary at her job and yet in a heartbeat it all changed.

38. She believes there was a vendetta against her because the Employer did not understand what was wrong with her or how it impacted her. She feels she was bullied and harassed after the Employer had drawn its own unfounded conclusions. She had worked with all of those who participated in the harassment for years without any issues until she became unwell.

39. Dr Eraneva’s report says a “specialist review of the diagnosis was recommended in the original summary dated 01.11.16”, and “the GP records for the period November 2016-June 2017 do not contain any consultations related to upper limb pain or musculoskeletal symptoms”. When her contract was terminated, her condition was then as it had been, and on the whole is still. There are episodes of pain flare ups and extreme fatigue, but she will only go to the GP if she cannot manage or feels that the issue is unrelated to the CRPS or fibromyalgia. As her employment has been terminated, she does not need a sick note, and therefore does not need to visit her GP.

40. The Adjudicator refers to the fact that she had not attended a specialist treatment centre or assessment, but this is beyond her control. The Trustee is asking her for the impossible. It is fully aware that a GP needs to refer a patient and the patient has no say over when or where a referral is made. She was under the care of a pain management specialist while her pain medication was adjusted and reviewed. Once the specialist was confident her condition had stabilised, she was in effect discharged and placed back into the care of her GP. She cannot return to Pain Management, or any other specialist, without a GP referral and appointment, and finds the expectation of the Trustee for her to have recent and up to date ‘specialist reports’ to be highly unreasonable.

41. The Adjudicator also says that after her original diagnosis of CRPS subsequent medical reports referred to “improvement in the condition in response to appropriate pain clinic interventions that included medication, nerve blocks, physiotherapy and psychological treatments”. She says this is not entirely correct. Some interventions, like the medication, worked while others such as the nerve block did not.

42. In her view, she has been offered all the appropriate therapies by the GP and specialists she has seen. However, if the Trustee has something available to her, as she has said before she is prepared to try it if the benefit outweighs the risk.

43. The Trustee relied on medical evidence that indicated she did not have a long term medical condition. Considering she was diagnosed in July 2010, and in December 2022 she is still taking the prescribed medication for her condition, she feels it is fair that with the passing of time she has invalidated the medical evidence.

44. Overall, she believes the Employer would never have accepted her back for the reasons she has given. However, it should never have got to that stage. The doctors the Trustee uses to identify incapacity pensions should be the same ones that validate if someone should be dismissed due to ill health. The Employer should not use two different processes to measure ill health, for their own individual purposes.

Ombudsman’s decision

45. It may help if I explain that it is not my role to make a decision on Miss L’s eligibility for a pension under Rule D3 (b). My role is to consider the decision-making process undertaken by the Trustee.

46. Much of the response from Miss L relates to her treatment as an employee and, as such, is outside my jurisdiction. I can only comment on these to the extent they affect her entitlement to an incapacity pension.

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

48. Rule D3 (b) states that “the Trustee **may** (my emphasis) decide to pay an incapacity pension”. So there is no obligation on the Trustee to do so and the payment of such a

pension is entirely at its discretion. Furthermore, the amount of incapacity pension is also for the Trustee to decide as is the continued payment of an incapacity pension.

49. Because Miss L was applying for an incapacity pension as an active member, under Rule D3 (b), she had to meet the criteria for payment at the time her employment ceased in November 2016. The Rules define incapacity as suffering from such physical or mental deterioration which in the opinion of the Trustee prevents the Member from following his normal employment and which seriously impairs his earning capacity and in the opinion of the Trustee is likely to do so for a substantial period. In forming its opinion the Trustee must obtain and consider the advice of a registered medical practitioner.

50. The Trustee has to review the medical and other evidence in order to determine whether it supports the provision of an incapacity pension. However, the weight which is attached to any of the evidence is for the Trustee to decide (including giving some of it little or no weight). It is open to the Trustee to prefer evidence from its own advisers; unless there is a cogent reason why it should not or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the RMP. If the decision-making process is found to be flawed, the appropriate course of action is for the decision to be remitted for the Trustee to reconsider.

51. Miss L argues that the Trustee should use the same RMP as the Employer in determining her fitness for work. This is a matter for the Trustee to decide and, in my experience, many trustees and decision makers obtain an independent opinion to ensure that it is not swayed by any influence from, or allegiance to, the employer. In this respect I find the Trustee’s actions entirely reasonable.

52. As agreed after Miss L’s original complaint to TPO, the Trustee offered Miss L a further opportunity to provide details of the treatments she had received and their effectiveness. It then asked Dr Eraneva to review this, obtain any further information she felt necessary and provide an updated report on Miss L’s condition. Dr Eraneva’s conclusion was that Miss L did not meet the requirements for an incapacity pension as intervention was ongoing, and specialist review remained outstanding.

53. I am satisfied that the Trustee has fulfilled its responsibility and carried out the actions identified in the conclusions to Miss L’s original complaint. I will therefore now consider the decision that it has reached.

54. While Miss L’s attitude to not bothering her GP with what she sees as an incurable problem is perhaps admirable, it is her responsibility to mitigate her position by doing all she can to ensure that she is fit for work. As she says, for further specialist treatment to be made available to her requires referral by her GP, but if she does not attend her GP further treatment is never going to be considered. So to some extent that rests with her.

55. The decision reached by the Trustee has to be assessed in light of the medical information that was, or could have been, available at the time her employment

ended, or later comments on her condition at that time. Any subsequent development in Miss L's condition is not relevant to this assessment unless it could reasonably have been foreseen at the time of the decision.

56. To consider Miss L's eligibility for an incapacity pension, the Trustee had to be certain that she was suffering from such physical or mental deterioration which not only prevented her from following her normal employment but which also seriously impaired her earning capacity and in its opinion was likely to do so for a substantial period.

57. Miss L's submissions show that she is still experiencing issues with her health and for that she has my genuine sympathy. However, as the Adjudicator said in his Opinion, the view of Dr Kapur was that there was some uncertainty as to the diagnosis of her condition and it is clear from the contemporaneous medical evidence that the precise cause of her symptoms was not clear and that various treatments were being tried and further future treatments considered.

58. Clearly, Miss L does not agree with the conclusions reached by the RMP and the Trustee. But, as I have said, it is not my role to make a decision on Miss L's eligibility for a pension under Rule D3 (b).

59. My review of the RMP's report is to determine whether or not there was any reason why the Trustee should not have relied on it in reaching a decision. This would include errors or omissions of fact, irrelevant matters taken into account or a misinterpretation of the relevant regulations.

60. The RMP's suggestions concerning treatment or its views on the likely outcome of treatment would not normally be something I would expect the Trustee to query. But if, for example, there was an obvious disparity between the RMP's view and those of Miss L's treating doctors, I would expect this to be explained to the Trustee and to Miss L. However, I have seen no such obvious disparity in Miss L's case.

61. In summary, I find that there was no reason why the Trustee should not have relied on the advice it received from the RMP in reaching its decision. Its decision is supported by that advice and is compliant with the Rules. The fact that Miss L's condition since then has not progressed as might have been hoped for in 2016, does not undermine the Trustee's decision.

62. I do not uphold Miss L's complaint.

Anthony Arter

Pensions Ombudsman
21 December 2022

Appendix

Medical Evidence

Extract from Dr Eraneva's report dated 6 March 2019

"This summary has been prepared in response to direction by the Pensions Ombudsman Adjudicator to re-consider this application taking into account what medical evidence was available at the IDRP appeal stages, in March 2017 and in June 2017.

Additional information was requested from [Miss L] and from her GP. Whilst part of this information extends beyond June 2017, I have been asked to limit the references to medical evidence to the timeframe in question, namely between November 2016 and June 2017…

1. **First summary report dated 01.11.16**

Relevant points from [the first summary dated 01.11.16] include:

- [Miss L] had worked for several years with her condition until the start of long-term absence in February 2016, which she attributed to cessation of adjustments at work (letter from [Miss L] dated 05.10.18)
- The Fitness to Work Checklist assessment documented work capacity with adjustments.
- Documented positive responses to intervention (pain clinic report dated 11.02.16).
- Clinical doubt about the ongoing diagnosis of complex regional pain syndrome (CRPS) as outlined in the detailed report by Dr Kapur at pain management services at the Queen Elizabeth Hospital dated 18.04.16. This report also documented an improvement in symptoms in the right hand, which was consistent with previous pain clinic reports. In subsequent correspondence [Miss L] focused on the CRPS diagnosis and thus the responses in later summaries were tailored towards that.

As part of the appeal process, further medical evidence was obtained from [Miss L] and her GP…

The report from Dr Tewani dated 19.10.16 documents that [Miss L] had recently experienced a flare of pain, that she had stopped one medication and restarted another at a low dose and had tried complementary treatment with no effect. As she expressed suicidal ideation, she was also seen by a psychologist at the clinic, who confirmed that [Miss L] was due to receive psychological input in due course. The GP was advised to restart the medication that had been stopped (duloxetine) and to cease the low dose new medication (citalopram). Dr Tewani suggested a follow-up at her clinic in December 2016.

In her letter dated 16th February 2019 [Miss L] lists a joint clinic appointment on the 25th October 2016.

Relevant GP records entries for 2016 are:

05.05.16: "has meeting at work next week re return to work; doing well"

25.05.16: “seen in pain clinic; pain control improved”.
01.09.16: “has been given notice at work; irritable, low mood, anxious”
29.09.16: “coping better, less anxious, irritability improved”
11.10.16: “joint pain and stiffness all joints, especially hands and back and feet.”

I confirm that the above information, had it been available, would not have altered the advice that the medical evidence did not support substantial duration or permanence of incapacity. This is because reasonable intervention at the joint clinic had just started and there had been a recent change in medication. Neither intervention had been in lace long enough to have a chance to show benefit.

2. Summary dated 3rd March 2017 in response to IDRP stage 1 appeal

No new medical information was provided as part of the original appeal. In her appeal letter dated 31.01.17, [Miss L] stated: “In January 2017 I am relieved to say that the medication along with the joint clinic and the long-term health conditions workshops, have alleviated many of the visible symptoms, though there are some remaining issues still to be resolved.”

…

No further pain clinic reports have been provided.

The GP records do not contain any consultations relevant to limb pain for this timeframe.

The ophthalmology appointments were to investigate the reported blurring of vision and at this stage all investigations, including an MRI of the brain, were reported as normal.

The hand x-ray was reported as normal.

- **What specific treatment options have been explored?**

The information provided by [Miss L] and the letter from Healthy Minds states that she attended four group sessions with the long-term conditions team, and three one-to-one sessions at the joint clinic attached to the pain clinic between November 2016 and March 2017.

Medication

- **What specific treatment options remain untried?**

When considering this, it is important to bear in mind the diagnostic uncertainty raised by Dr Kapur in the report dated 18.04.16. From the available information, the other medical conditions that may be relevant are fibromyalgia and chronic pain as well as mood disorder and sleep disturbance.

There is some overlap in the treatment approaches for chronic pain, fibromyalgia and complex regional pain syndrome, and there are specific additional interventions for complex regional pain syndrome that are not relevant to the other conditions.

The interventions common to all these conditions include medication together with psychological and physiotherapy inputs that aim to improve the experience of pain and thus increase function, without necessarily expecting full resolution of symptoms.

From the information provided by [Miss L] she was having this combined psychological and physiotherapy intervention via the joint clinic, and she had had 4 sessions by this time. 4 sessions would represent the early stages of such intervention.

Evidence-based guidance also highlights the importance of engagement with intervention and adequately addressing potential co-existing problems, for example, poor sleep and low mood.

Clinical review by a pain specialist such as Dr Tewani or Dr Kapur would be appropriate to assess progress and to consider whether there is merit in adjusting interventions either in relation to a clinical response or if symptoms have changed or are thought to have a different cause. At the last available pain clinic appointment (report dated 19.10.16), the specialist Dr Tewani had adjusted the medication and was planning review.

- **Are these untried treatment options available to the Partner?**

[Miss L] was already under the care of the pain clinic at that time and follow-up had been suggested for December 2016.

- **Would it, in your opinion, be reasonable for the Partner to undertake those treatment options, taking into account for example the risk to the member in undertaking the treatment, the probability of its success, and how invasive the treatment is?**

The above interventions are non-invasive, low risk and evidence based. Active engagement by the individual and active management of co-existing conditions will give a good outlook for symptom improvement.

[Miss L] is reported as having had a good response to the combined psychology and physiotherapy approach in 2014…Such interventions merit repeating in individuals who report persistent symptoms…

In view of the above, I confirm that the additional medical information, had it been available at the time of the IDRP stage 1 appeal, would not have altered the opinion offered, namely that the medical evidence did not support the criteria of substantial duration or permanence of incapacity.

3. **Summary dated 13th June 2017 in response to IDRP Stage 2 appeal.**

No new medical information was provided as part of this appeal. Information that has since become available is as follows:…

The GP records for March – June 2017 refer to repeat prescriptions and receipt of reports from the ophthalmology clinic. There are no entries related to limb pain.

The ophthalmology report dated 04.05.17 states “can read computer screen and read OK but looking at keyboard is difficult whilst working”.

- **What specific treatment options have been explored?**

The information provided by [Miss L] and the letter from Healthy Minds state that she attended three further group sessions with the long-term conditions team, and three one-to-one sessions at the joint clinic attached to the pain clinic.

This suggests that the total number of monthly Long-Term Health Conditions group sessions was 10 to 11 (since starting in April 2016) at the time of the stage 2 appeal, with seven one-to-one sessions at the joint clinic.

Medication

- **What specific treatment options remain untried?**

As at March 2017, it remained appropriate to have clinical review by a pain specialist to assess progress and to consider whether there was merit in adjusting interventions.

- **Are these untried treatment options available to the Partner?**

[Miss L] was under the care of the pain clinic, under whose auspices she was attending the joint clinic.

- **Would it, in your opinion, be reasonable for the Partner to undertake those treatment options, taking into account for example the risk to the member in undertaking the treatment, the probability of its success, and how invasive the treatment is?**

Review of diagnosis and interventions is important to ensure that the interventions offered are appropriate.

In considering the general interventions of talking treatment and physiotherapy that are common for chronic pain and fibromyalgia, these will by their nature be non-invasive and low risk in that they focus on pain management techniques.

[Miss L] had responded positively to talking treatments in the past, after she had 12 sessions of cognitive behavioural therapy with Healthy Minds in 2016…and, as mentioned in section 2, many individuals benefit from revisiting these techniques.

As the above options are non-invasive, with evidence of a good response to the combined psychology/physiotherapy approach, I consider them to be reasonable.

I confirm that the additional information, had it been available at the time of the appeal, would not have altered the advice offered in the summary.

4. [Miss L]'s appeal letter dated 05.10.18

[Miss L] lists the following interventions in addition to those already listed in previous summaries:

4.1

- Use of TENS machine and desensitisation in 2010.
- Mirror visual feedback
- Vocational support or employment support: [Miss L] states that this was provided by Partnership (occupational) Health Services. The role of occupational health is to provide advice on fitness for work and relevant adjustments where appropriate. The FTWC dated 28.04.16 stated that [Miss L] was fit for part-time retail work with adjustments.
- Hydrotherapy with poor results.
- Hand therapy including knitting as part of the pain clinic.
- Postural control with physiotherapy.
- Patient education and support.
- Referral to the CRPS specialist treatment centre in Bath; the pain clinic report dated 10.05.11 states; "she came today enquiring of her referral to the Bath team for neuro-reprogramming therapy and I have explained to her that the best approach would be for the referral to come from primary care (i.e. the GP) as the PCT would need to resolve issues around funding. I am however happy to support this referral if you do make it."

The above interventions are part of those listed in the summary dated 13.06.17 as recommended for complex regional pain syndrome. From the information [Miss L] has provided, the above had been tried by the time of the completed application and appeal process, with the exception of the referral to the specialist unit at Bath.

4.2

- General exercise and strengthening.
- Splinting'
- Sleep hygiene and relaxation training through Birmingham Healthy Minds.
- Pacing, prioritising and planning activities, goal setting and self-management of symptoms.

[Miss L] reports that these activities are ongoing.

4.3

- Referral to joint therapy – this was recommended in August 2016.

The pain clinic report dated 19.10.16 states that [Miss L] was due to be seen at joint therapy. Therefore this intervention was not in place at the time of the original pension

assessment. Sessions had been attended by the time of the two appeals as detailed above.

5. Opinion

In summary [Miss L] reports right hand pain since 2010 when she was diagnosed with complex regional pain syndrome. Subsequent reports refer to improvement in that condition in response to appropriate pain clinic interventions that included medication, nerve blocks, physiotherapy and psychological treatments as well as the other interventions referred to in section 4.1 above…

[Miss L] worked with this condition from 2010 until 2016 with adjustments and reduced her working hours. The occupational health assessment (FTWC) dated 24.04.16 stated that she was fit for work with adjustments. In her letter dated 05.10.18, [Miss L] refers to difficulties in maintaining the adjustments that had been in place. The ophthalmology report dated 04.05.17 refers to keyboard use.

There is diagnostic complexity in that the medical reports and records refer to features of chronic pain and fibromyalgia as well as anxiety and low mood. For this reason, specialist review of the diagnosis was recommended in the original summary dated 01.11.16.

The last available specialist reports that detail clinical findings and make recommendations for interventions are from the rheumatologist, dated 15.05.14 and the pain clinic specialist, Dr Tewani, dated 19.10.16. There has been no specialist assessment since the last pain clinic appointment with Dr Tewani, at which review in December 2016 was advised.

The GP records for the period November 2016-June 2017 do not contain any consultations related to upper limb pain or musculoskeletal symptoms.

The available medical information confirms that [Miss L] attended the joint clinic for one-to-one sessions and a monthly Long-Term conditions group as detailed above. At the time of the last summary dated 13.06.17, these interventions were ongoing and the joint therapy sessions would have been expected to continue.

Previous reports detail [Miss L]'s positive response to these interventions. In addition, pain management support can be repeated over time rather than being seen as a "one-stop" intervention option.

In an individual with ongoing symptoms, one would recommend review at the pain clinic, as was planned, so that intervention options can be tailored to the current clinical picture.

In the absence of any more up to date specialist information it is difficult to comment on further available intervention options other than in the general terms described above.

Taking into account all the additional information that has been obtained, it is my opinion that, at the time of the stage 2 IDRP, the available medical information did not support substantial duration of incapacity or permanence of incapacity. This is because intervention was ongoing, and because specialist review remained outstanding.