CAS-91714-K2M3

Ombudsman's Determination

Applicant	Mr S
Scheme	The Jaguar Pension Plan **(the Plan)**
Respondent	Jaguar Land Rover Pension Trustees Limited (**the Trustee**)

Complaint Summary

1. Mr S complained that, in 2021, the Trustee failed to consider his ill health early retirement (**IHER**) application properly by refusing to award him a Serious IHER pension from the Plan.

2. He said that it was only after he had: (a) complained in December 2021 under Stage One of the Plan's Internal Dispute Resolution Procedure (**IDRP**), and (b) supplied additional medical evidence that the Trustee:

   2.1. in February 2022, decided to approve his IHER application; and

   2.2. granted him a Serious IHER pension from 9 December 2021, his date of leaving Jaguar Land Rover Limited (**JLR**).

3. Mr S also complained that:-

   3.1. The Trustee did not directly inform him of its original decision on his IHER application. It was relayed to him during a "Teams meeting" with JLR's Human Resources Team (**the HR Team**) in October 2021.

   3.2. Dr Grobler, JLR's Consultant Occupational Health (**OH**) Physician, and the Trustee's Medical Adviser (**MA**), Health Partners, acted unethically by failing to obtain further evidence from the medical experts treating his conditions, as requested by him. It transpired that this evidence included a significant report from his Haematology consultant which showed that his life expectancy was short.

   3.3. Dr Grobler refused to correct the errors in his OH Outcome report dated 11 May 2021 and pressured him into approving its release to JLR. This flawed report was subsequently used by the Trustee and JLR when rejecting his IHER application and terminating his employment respectively.

   3.4. The Trustee improperly delegated its original decision to Health Partners by "blindly" following its medical advice.

3.5. The Trustee incorrectly classified him as a deferred, rather than an active, member of the Plan. So he cannot transfer his pension rights from the Plan without losing the value of the "IHER enhancement". If he accepts the Serious IHER pension, there will be no death benefits available to his children under the Plan.

3.6. Mr N, JLR's UK Pensions Manager and Secretary to the Trustee (one individual performing both roles), did not give him permission to directly contact the Plan administrator, Mercer, for details of the benefit options available to him from the Plan on IHER.

3.7. JLR's capability review process which commenced in February 2021 took 32 weeks to complete. It should have taken no more than 12 weeks.

Summary of the Ombudsman's Determination and reasons

4. The complaint is not upheld against the Trustee. The evidence does not support a finding that Mr S has suffered actual financial loss as a consequence of the way in which the Trustee dealt with his IHER application.

Detailed Determination

Material facts

5. Mr S was employed by JLR as a "Fleet Issue Management and Defect Engineer".

6. Mr S went on long term sick leave in August 2019 and attended regular absence review meetings with the HR Team.

7. During a meeting in February 2021, the HR Team decided that Mr S should enter into JLR's capability review process to explore: (a) his capability to attend work; and (b) whether any reasonable adjustments could be made to assist a return to work.

8. On 17 February 2021, the "JLR Admin Team" at Duradiamond Healthcare (now known as Health Partners) (**the JLR Admin Team**), informed Mr S that, following his recent referral to the OH service, a telephone appointment had been made for him with Dr Grobler on 24 February 2021.

9. On 25 February 2021, the JLR Admin Team informed Mr S that it had been asked to contact his "GP/Specialist for a report".

10. Mr S completed the "GP/Specialist Consent Form" on 25 February 2021 and returned it to the JLR Admin Team. He provided contact details for: (a) his GP practice, Woodside Medical Centre (**Woodside**); and (b) a Haematology consultant at University Hospital Coventry and Warwickshire (**UHCW**), Dr Mushkbar.

11. By signing the declaration on the form, Mr S consented to the OH service obtaining a medical report from his GP and/or "Treating Specialist". Mr S requested sight of this report before it was sent to the OH service.

12. On 26 February 2021, the JLR Admin Team informed Mr S that his GP had been asked to provide a report. It also said that:

> "We would also like to offer you the opportunity to view the outcome report the OH Service have prepared for your employer when this is available. This report will contain relevant, summarised information from the report from your GP coupled with our own consultant advice based on our knowledge of your organisation."

13. Mr S requested sight of the OH outcome report before its release to JLR.

14. Woodside received Dr Grobler's request for medical information on 1 March 2021. In his letter, Dr Grobler asked Woodside to send him:

    14.1. copies of "outpatient correspondence and test results" which were "relevant to any condition(s) that were impacting on Mr S' capability for work"; and

    14.2. a short letter to accompany this information if there were any "issues of particular occupational significance".

15. Dr Grobler enclosed with his letter Mr S' signed consent form and an information sheet which showed that:

> "Under the Access to Medical Reports Act (**AMRA**) patients have the right to ask to see the information that you propose to send to us in the first instance. Please note from the consent form we enclose whether or not they wish to exercise this right in order that the surgery can make the appropriate arrangements."

16. Woodside has subsequently said that:-

    16.1. At the time, it "just wrote back and confirmed his medical conditions".

    16.2. Dr Grobler did not ask it about Mr S' long-term health and prognosis.

    16.3. Dr Grobler's request was not made in "the normal way". OH would normally specify its questions clearly and set a deadline for a response.

    16.4. Mr S did not review its letter before it was sent to the JLR Admin Team.

    16.5. Mr S suffered from visual problems and requested its release without reviewing it.

17. Mr S received a copy of Dr Grobler's OH outcome report dated 11 May 2021 and noticed that there were some errors. He notified the JLR Admin Team accordingly which replied that it would forward any additional information he wished to be considered to Dr Grobler so that he could amend his report, if appropriate.

18. On 16 May 2021, Mr S supplied this information to the JLR Admin Team. He also requested copies of any medical reports received from UHCW that he said should have been sent to him for approval prior to release to the JLR Admin Team.

19. On 17 May 2021, the JLR Admin Team informed Mr S that: (a) it had asked Dr Grobler to respond to his questions; and (b) if a revised OH outcome report was necessary, he would be allowed to review it before its release to JLR.

20. In his e-mail dated 20 May 2021 to the JLR Admin Team, Mr S explained that he was requesting sight of the UHCW medical reports because:

> "…during my last telephone conversation with the JLR doctor, it was said that my cancer "is in remission", as the report from my GP did not state anything to this effect and knowing that there is no cure for multiple myeloma, I assume this must have come from UHCW however, I have not seen or released any report from UHCW. I assume my Haematology consultant has been contacted in order to complete the outcome report and as the terminology used during the review with the company doctor would indicate."

21. On 22 May 2021, the JLR Admin Team notified Mr S that it had not contacted UHCW.

22. On 27 May 2021, the JLR Admin Team told Mr S that Dr Grobler wished to see any reports from the medical specialists treating him which he had kept at home so that he could review them and advise accordingly.

23. Dr Grobler replied to Mr S' questions in a letter as follows:

> "The only information I have on your response to treatment for myeloma is the report from your GP dated 26 March 2021.
>
> Dr Athey-Pollard wrote…"In terms of his myeloma, he is currently on maintenance chemotherapy which is keeping his bloods stable".
>
> There is no mention of remission in my capability report…I did say in the report Mr S is having maintenance treatment on a monthly basis to keep cancer from progressing…and it is possible he may have a recurrence in future but at this stage his GP is saying treatment is effective.
>
> I did ask the GP in the request letter to attach outpatient letters from UHCW, but your GP did not do so."

24. On 7 June 2021, the HR Team sent Mr S a partially completed IHER application form. It asked him to fully complete and return the form. It also said that it would send the completed form to JLR's Reward Team which would then "liaise" with the Trustee.

25. On the same day, Mr S asked the JLR Admin Team whether it would be useful if he obtained a copy of the outpatient letters from UHCW.

26. The JLR Admin Team replied in its e-mail dated 9 June 2021 as follows:

> "…the clinician has come back and advised us of the below:

> Please inform the employee no consent notification will go to HR/manager if we do not hear from them in the next 2 days. Then action accordingly…if we have not received explicit consent in next 2 days.
>
> Bearing this in mind, can you please advise if you consent to release?"

27. On 10 June 2021, Mr S gave his consent for the OH outcome report to be released to JLR. He said, however, that he was concerned that no outpatient letters had been obtained from UHCW. He also submitted a recent report received from the Ophthalmology department for review by Dr Grobler.

28. On 11 June 2021, the JLR Admin Team notified Mr S that it had sent the OH outcome report to JLR and also asked Dr Grobler to review the new evidence.

29. On 16 June 2021, the JLR Admin Team informed Mr S that Dr Grobler looked forward to receiving any additional letters from UHCW which Mr S had kept that would explain his prognosis in more detail than his GP had proffered.

30. On 23 June 2021, Mr S sent the JLR Admin Team another recent report from the Ophthalmology department which showed that his vision was not as described in the OH outcome report. He said that Dr Grobler's report might need updating and enquired again whether UHCW had been asked to provide a report, as authorised by him on the "GP/Specialist Consent Form".

31. On 24 June 2021, the JLR Admin Team replied that it had forwarded his latest evidence to Dr Grobler for review. It also said that:

> "I can confirm that UHCW were not contacted to issue a report, we only contacted your GP surgery for a report upon Dr Grobler's request and did not ask them to provide any letters from UHCW."

32. Dr Bennett of Health Partners prepared a "Pension Scheme Medical Adviser Report" on 28 June 2021.The JLR Admin Team sent a copy of this report to Mr S for review.

33. On 5 July 2021, Mr S notified the JLR Admin Team that there were inaccuracies in this report and provided full details. He recommended that medical reports from the Haematology, Cardiology, Neurology and Ophthalmology departments of UHCW were obtained for "a full and complete report" of his conditions. He also said that:

> "I cannot understand how a Medical Adviser Report of this magnitude and importance can be completed without consulting the consultants in charge of my health."

34. Dr Bennett amended her report on 13 July 2021[1] to take into account the points made by Mr S. In her revised report, Dr Bennett wrote that:

[1] A copy of this amended report was sent to Mr S on 13 July 2021 by the JLR Admin Team so that he could review it and provide his comments.

"On this occasion I have reviewed:

- The OH Report from Dr Grobler, dated 11.05.2021
- Medical report from Dr Athey-Pollard, GP, dated 26.03.2021
- Medical report from Dr Lakshmi, Trust Grade in Ophthalmology, dated 09.03.2021
- Medical report from Dr Sachdev, STA Ophthalmology, dated 14.06.2021

The medical evidence documents that Mr S has a type of blood cancer…The type of cancer that he has is not curable…It is possible that he may have a recurrence in the future but at this stage his GP is saying treatment to date has been effective.

…Mr S is waiting for a surgical intervention for his cancer…The OH physician Dr Grobler reports that Mr S has been told that a backlog due to the pandemic is likely to delay his treatment. Mr S has since contacted the OH team to state that his surgical intervention was cancelled due to his heart condition and not the pandemic. The surgical treatment is aimed at improving his prognosis and may improve his work capability.

…Mr S is suffering from blurred vision. He has diagnoses of bilateral early cataracts and a condition called blepharitis…with dry eyes. He is waiting for right eye cataract extraction and intraocular lens implants….

Mr S has a heart condition and required surgical intervention in 2006 and again in 2020. He experiences breathlessness on physical exertion, and the underlying reason for this is not clear. He had a Covid infection in April 2020 and has asked his GP to consider a referral for long Covid syndrome.

…Mr S has lower back, hip, and neck pain and feels fatigued…

In June 2021…Dr Grobler was of the opinion that Mr S may be fit to return to his role with adjustments. Recommended adjustments included a phased return to work, a workplace assessment…to identify visual aids to support Mr S with desk-based work involving a computer, no physical exertion at work, limited walking, parking near his workplace and a workplace risk assessment on his vulnerability to Covid-19.

In my opinion, there is clear evidence that Mr S has several health conditions which are taking their toll on his overall physical health, however, he has not at this stage exhausted all treatment options…There is therefore not sufficient evidence on which to state that his health conditions are likely to permanently incapacitate him from following his normal occupation.

> It is my expectation that with additional evidenced-based treatments which are currently widely available for his specific illnesses his conditions could resolve and/or improve, bringing increased functional capability, which may allow a return to work.
>
> In line with my views, it is Dr Grobler's opinion that there is no evidence of a physical or mental impairment that will continue to prevent Mr S from following his normal occupation…He states that treatment options have not been exhausted and adjustments could be considered.
>
> A report dated March 2021 from Mr S' GP…has been reviewed. This confirms the above findings.
>
> …it is unlikely there is substantial new medical evidence to consider. Mr S has asked that additional medical reports are requested from his haematologist, cardiologist, neurologist, and ophthalmologist to obtain a full and complete report of his conditions before making ill health retirement recommendations. In my view these reports are unlikely to add value. They are likely to confirm his medical conditions but are unlikely to demonstrate his permanent incapacity for work. If, however, the Trustee would like for us to obtain these reports then we would be happy to approach the relevant specialists…
>
> It is therefore my opinion that there is no reasonable medical evidence that Mr S' health problems prevent him from following the duties of his current employment or suitable alternative employment, or that his level of incapacity will be continuing to Normal Pension Age (**NPA**) and so it is therefore unlikely that the criteria for ill health incapacity[2] are met.
>
> I am mindful that I provide advice only but if the Trustee support Mr S' application I would then recommend a review of his circumstances to confirm his ongoing health and treatments."

35. In his e-mail dated 4 October 2021 to the HR Team, Mr N said that:

> "I've now heard back from the Trustee and as expected I'm afraid they don't support the application for IHER. I presume you will now refer back to the employee?"

36. The HR Team subsequently notified Mr S during an absence review meeting that his IHER application had been unsuccessful.

37. On 14 October 2021, the HR Team offered Mr S a Settlement Agreement (**SA**) which involved the termination of his employment with JLR on 31 October 2021. Mr S says

[2] The definitions of "Incapacity" and "Serious Incapacity" in the Plan's Trust Deed and Rules (**the Plan Rules**) are set out in Appendix One below.

that he declined the SA because it would have prevented him from appealing the Trustee's decision on his IHER application.

38. On 22 October 2021, the HR Team provided Mr S with details of the "OH complaints process" and said that:

> "In reference to the IHER appeal…I have …been advised that the Trustee doesn't provide a formal response to members, that decisions are fed back to the JLR team to pass onto the individual – as in your case. As evidence that the Trustee has considered the application, please see the attached e-mail[3] from the UK Pensions Manager…"

39. On 1 December 2021, Mr S notified Mr N that he intended to appeal the Trustee's decision to reject his IHER application.

40. On 9 December 2021, Mr S attended a "Final Capability Review Meeting".

41. JLR terminated Mr S' employment with immediate effect on the grounds of capability because:-

    41.1. The advice from the OH outcome report was that he would not be able to return to work, with or without adjustments.

    41.2. Suitable searches for alternative work were prevented by his condition.

    41.3. JLR's sick pay and holiday pay had expired.

    41.4. His IHER application had been declined.

42. Mr S made a complaint under the IDRP on 30 December 2021. He submitted additional medical evidence which he had obtained from Woodside and UHCW in support of his appeal. This included a letter from Dr Mushkbar, Haematology consultant, which showed that his life expectancy was short.

43. In his e-mail dated 2 February 2022, Dr Iley, JLR's Chief Medical Officer, responded to Mr S' OH complaint that was also made in December 2021.

44. Dr Iley said that:

> "I have reviewed the clinical notes…I have spoken with Dr Grobler and I have discussed your case with Dr Sheard, the Medical Director and Senior Pensions Doctor at Health Partners. I can find no evidence that Dr Grobler or any other doctor involved acted unethically or failed in their duty as Pension Trustee advisors. Dr Grobler made and offered his opinion based on the information available to him. He and the pension doctor did not at the time deem further information helpful when offering their opinions.

[3] An e-mail dated 4 October 2021 to the HR Team.

I have reviewed the communication chain and note that an incorrect e-mail was used and therefore there was a delay in the Trustee receiving the information from the OHP advisors. This was corrected at the time and has been corrected in the process to avoid a repeat. I can only apologise for this delay which does not appear to be anything other than an unforced error. We have taken steps avoid a recurrence…

Having reviewed the whole case, both Dr Sheard and I agree that there are learning lessons that all doctors involved in pension reviews should be aware of including how to make the process as smooth as possible, how to communicate to those involved in a timely manner and when further medical evidence may be helpful. We have organised a meeting to discuss these points and learn from them as well as share them with our HR colleagues. We have also changed the process with our HR colleagues so that employees are informed of their options for appeal at the time and do not need to write in or ask.

I am sorry that the process and support has not been as good as we would have liked, and I can reassure you that we have taken onboard the learning lessons. We have already made changes, and if during any ongoing work we find more improvements we will enact them."

45. In his Stage One IDRP decision letter dated 11 February 2022, Mr N said that:-

45.1. He had instructed Health Partners to reassess Mr S' application for IHER / Serious IHER, after taking into account the additional medical evidence provided.

45.2. The results of the review[4] were shared with the Trustee which now approved his application for a Serious IHER pension[5] from his leaving date, 9 December 2021.

45.3. The Trustee and Health Partners had adhered to the requirements of the Pensions Regulator's guidance concerning good governance. Specifically, the Trustee did not delegate its decision to Health Partners by "blindly following" its recommendation. It had a dedicated Discretionary Committee for the purposes of reviewing such applications and drew its own conclusions. The Trustee's directors were not medical experts and, quite rightly, took into consideration any advice received from Health Partners.

[4] Relevant paragraphs taken from Dr Sheard's Pension Scheme Medical Adviser Report dated 24 January 2022 are set out in Appendix Two below.

[5]Where a member leaves service due to Serious Incapacity, his/her pension is calculated based on retirement at NPA. Rule 6.4 of the Plan Rules requires the consent of the Trustee and JLR where a member leaves service before NPA due to Incapacity and chooses to receive an immediate pension. Rule 6.4 is set out in Appendix One below.

45.4. The Trustee did fail to notify Mr S directly of the original outcome of his IHER application for which he would like to sincerely apologise. He had updated the Trustee's procedures to ensure this step was taken for any future applications by other members of the Plan.

45.5. He had provided Health Partners with details of the points Mr S made about "specific guidance for OH practitioners and advisers". He had also asked it to review its processes in order to identify any improvements that could be made to prevent a recurrence of Mr S' situation.

46. On 3 March 2022, Mercer informed Mr S that it was seeking confirmation of his IHER with JLR and would send him an IHER quotation as soon as possible.

47. On 18 March 2022, Mercer notified Mr S that Mr N had requested all enquiries concerning IHER should be directed to him.

48. Mercer enclosed a "Pension Early Retirement Pack" (**the Pack**) with its covering letter dated 12 April 2022 to Mr S.

49. The Pack included an IHER quotation which showed that the estimated benefits[6] available to Mr S if he retired on 9 December 2021 were as follows:

49.1. a full pension of £23,082.11 per annum; or

49.2. a maximum tax-free cash sum of £82,751.77 plus a residual pension of £17,943.52 per annum.

A contingent spouse's pension of £11,541.06 per annum on death after retirement was available with both options.

50. Mr S received the Pack on 19 April 2022. Mr S replied on the same day that:-

50.1. He could not make an informed decision because no cash equivalent transfer value (**CETV**) details had been supplied by Mercer.

50.2. As his retirement was on the grounds of serious ill health, he should be entitled to a "serious ill health lump sum" from the Plan in accordance with HMRC rules.

50.3. As his sick pay ran out on 11 August 2021, this should, at the very least, be the commencement date of his IHER pension. Furthermore, the capability review process which began in February 2021 should not have taken more than three months to complete if it had been followed correctly.

51. On 19 April 2022, Mr N replied as follows:

[6] These figures were based on Mr S' prospective service to his Normal Retirement Date (**NRD**), 9 December 2030, and his final pensionable salary of £45,771.80 per annum

> "The payment of a one-off lump sum due to serious ill health (as defined by HMRC) is dependent on a member having a life expectancy of less than 1 year. The report from Health Partners did not support this and so this is not available to you. It should be noted that serious ill health as defined in the Plan Rules is different to that used by HMRC. Under the Plan Rules it means your pension is enhanced to reflect the pensionable service you would have completed up to NPA had you not retired but your benefits are still paid in pension form. HMRC's definition of serious ill health is that used for determining whether you qualify for a one-off lump as mentioned above.
>
> Your exit date of 9 December 2021 on the grounds of serious ill health is what has been notified to me by the Company and is what the quotation has been based on. If you dispute this you will need to raise this with your case worker or line manager from JLR. As UK Pensions Manager I have no input into an individual's exit date or insight into the circumstances of their pay."

52. On 27 April 2022, Mr N sent Mr S details of the CETV available to him from the Plan. He said that the CETV of £414,634.33 had been calculated as at 26 April 2022 and was: (a) based on his "standard" deferred pension as at 9 December 2021 of £17,551.35 per annum; and (b) guaranteed for three months.

53. On 10 May 2022, Mercer told Mr S that it could not supply him with additional IHER figures without authorisation from JLR and suggested that he contact Mr N.

54. Mr S declined the offer of a Serious IHER pension from the Plan because, in his view, it did not put him back in the position he would have been in if the "failings of JLR, Health Partners, the Trustee, Dr Grobler, Dr Bennett, Dr Iley and [Mr N] had not occurred".

55. In its Stage Two IDRP decision letter of 23 June 2022 to Mr S, the Trustee said that:-

    55.1. It had upheld his complaint at Stage One IDRP and approved his application for a Serious IHER pension from 9 December 2021. This offer was still available to him.

    55.2. There were, however, elements of his complaint made at Stage Two IDRP which it did not uphold and some that fell outside of its remit.

    55.3. It was not satisfied that Mr S had suffered any financial loss for which he should be compensated.

    55.4. An active member of the Plan did not have a right to a guaranteed CETV. So this option would not have been available to Mr S whilst he was an active member. He had a deferred pension from the Plan which continued to be revalued during the period of deferment in accordance with the Plan Rules.

    55.5. Members who had been granted IHER were not entitled to an enhanced CETV to take into account ill health as an alternative to receiving an IHER pension.

55.6. There was also a distinction between a CETV and a serious ill health lump sum. In accordance with the Plan Rules[7] and the Finance Act 2004, in order for a serious ill health lump sum to be paid, it must have received evidence from a registered medical practitioner that the member was expected to live for less than one year. No such evidence had been received for Mr S.

55.7. CETVs were calculated in accordance with actuarial factors determined by it from time to time with the advice of the Plan actuary. No member had the right, at any particular time, for a CETV calculated based on any particular factors or actuarial assumptions.

55.8. It had the power to increase benefits where: (a) this was directed by JLR; and (b) JLR paid any additional contributions that it deemed necessary, for which purpose it would consider advice from the Plan actuary[8].

55.9. Whilst in theory this power could be used to enhance Mr S' CETV, JLR's consent would be required. It had discussed this with JLR, but agreement was not provided.

55.10. It was under a duty to act in the best interests of all beneficiaries of the Plan. So it would be inappropriate to augment the benefits of one member to the detriment of the other members.

55.11. It could only pay the benefits as stipulated in the Plan Rules. To do so otherwise, would be a breach of trust. Furthermore, paying benefits in excess of that to which members were entitled could render the payment unauthorised under the Finance Act 2004 and subject to penal tax charges.

55.12. It would like to sincerely apologise to Mr S that it did not notify him directly of the initial outcome of his IHER application.

55.13. It had a "conflicts of interest" policy in place which applied to both the Trustee's Directors and members of the Secretariat employed by JLR that currently comprised of: (a) the UK Pensions Manager and Secretary to the Trustee; (b) the Assistant Secretary to the Trustee; and (c) any additional support as required from time to time from within the HR Team.

55.14. The Secretariat worked closely with the Trustee, the Trustee's advisers and JLR's senior management. There was a process in place for ensuring that any actual or potential conflicts were identified and managed effectively.

55.15. It was not unusual for a pensions manager to be involved in making decisions that relate to complaints under Stage One IDRP where the scheme operated a two-stage process as this fell within his/her remit. It did not consider that Mr S' complaint, or the facts to which it related, were affected by a conflict of interest

[7] This is in accordance with Rule 21.1 of the Plan Rules.

[8] This is in accordance with Rule 21.3 of the Plan Rules as set out in Appendix One below

on the part of Mr N. A two-stage process ensured impartiality when considering his complaint under IDRP.

Summary of Mr S' position

56. Mr S said that:

> "JLR appointed [Mr N] as their UK Pensions Manager and as the Secretary to the Trustee, making him the designated decision maker for all applications to the Plan, in order to control all pension applications in JLR's favour…
>
> During a meeting with JLR, ACAS and Mr S on 20 April 2022, [Mr N] announced that JLR have placed a hold on pension enhancements which require a cash injection from the company:
>
> "…and in current financial circumstances, there's a general stop on any enhancements to pensions that require a cash injection from the company".
>
> This 2-line statement from [Mr N], affects all active members of the company pension schemes, who make an application to their pension scheme, which would require a cash injection from JLR to make up the members deficit to normal retirement age. i.e. ALL applications for IHER are affected by his statement."

57. During times of financial constraints, JLR employees are allowed to conduct themselves outside of "JLR's Policies, Codes of Conduct, Ethics and UK Law" and JLR allowed this to continue. He raised his concerns with JLR's Chief Executive Officer, in order to save JLR "the scrutiny of external investigation".

58. He also contends that:

> "In order to deliver their commitments to JLR, [Mr N] and the OHP (Dr Grobler) needed to work together to ensure [Mr N] was provided with an advisory report he could not accept as an application for IHER…Mr S does not believe his application ever got through to a meeting of the trustees for their consideration, Mr S believes [Mr N] prevented this from happening, knowing in his role as Secretary to the Trustee, he was able to correct his initial error at Stage 1 IDRP (as he did in Mr S' case). One final act for their plan to work, ensure not to provide any documentation to the employee, leaving the employee in a position of not knowing what to do…and then, delay, delay, delay the process to the point where the employee's employment is terminated, then treating the employee as a deferred member of the pension scheme following acceptance for IHER at stage 1 IDRP, hence relieving JLR's obligation to enhance individual pension award..."

59. JLR had its own employees in control of all applications to the Plan requiring cash enhancements by it. However, this meant both Mr N and Dr Grobler had dual obligations, the first being to the employee and the second to JLR. The Pensions

Regulator (**TPR**) and the General Medical Council (**GMC)** both publish clarification regarding where their duties lay.

60. TPR states:

"A conflict of interest may arise when a fiduciary (which includes a trustee) is required to take a decision where:

1. the fiduciary is obliged to act in the best interests of his beneficiary; and
2. at the same time he has or may have either:

a) a separate personal interest; or

b) another fiduciary duty owed to a different beneficiary in relation to that decision, giving rise to a possible conflict with his first fiduciary duty, which needs to be properly addressed."

61. The GMC states:

"Good medical practice describes what it means to be a good doctor.

It says that as a good doctor you will:

- make the care of your patient your first concern
- be competent and keep your professional knowledge and skills up to date
- take prompt action if you think patient safety is being compromised
- establish and maintain good partnerships with your patients and colleagues
- maintain trust in you and the profession by being open, honest and acting with integrity…

<u>Conflicts of interest</u>

Trust between you and your patients is essential to maintaining effective professional relationships, and your conduct must justify your patients' trust in you and the public's trust in the profession. Trust may be damaged if your interests affect, or are seen to affect, your professional judgement. Conflicts of interest may arise in a range of situations. They are not confined to financial interests and may also include other personal interests.

Conflicts of interest are not always avoidable, and whether a particular conflict creates a serious concern will depend on the circumstances and what steps have been taken to mitigate the risks, for example, by following established procedures for declaring and managing a conflict.

You should:

a) use your professional judgement to identify when conflicts of interest arise

b) avoid conflicts of interest wherever possible

c) declare any conflict to anyone affected, formally and as early as possible, in line with the policies of your employer or the organisation contracting your services

d) get advice about the implications of any potential conflict of interest make sure that the conflict does not affect your decisions about patient care.

If you are in doubt about whether there is a conflict of interest, act as though there is."

62. Dr Grobler's request for medical information sent in February 2021 to Woodside was so vague that his GP "did not know what was being asked".

63. He told Dr Grobler that he had suffered from visual impairment in both eyes since September 2020, "a vulnerability Dr Grobler and JLR exploited".

64. Dr Grobler asked him to supply medical reports from UHCW that he should have requested. Dr Grobler also claimed that he was preventing the release of the OH outcome report despite failing to address his concerns or correct the errors in it first.

65. The JLR Admin Team informed him on 9 June 2021 that Dr Grobler had said that if he did not give his consent for the release of the OH outcome report within the next two days, he would tell JLR that "no consent notification" was received. In response to this pressure from Dr Grobler, he authorised its release because he believed that: (a) refusing to do so "would go against him"; and (b) his concerns would be subsequently dealt with by the Trustee and Health Partners.

66. Dr Bennett acknowledged in her "Pension Scheme Medical Adviser Report" dated 13 July 2021 that he had asked for reports from the specialists treating his medical conditions. Mr N, however, decided to disregard his request when considering his IHER application.

67. The capability review process was flawed because Dr Grobler: (a) did not request any supporting medical evidence from his GP practice; and (b) pressured him into releasing the OH outcome report to JLR.

68. The Trustee has supported a business model used by Mr N to avoid "the triggering of events which would have required JLR to pay an enhancement to member's pension".

69. Under the section entitled "Anti-avoidance powers" of TPR's website, it states:

"Our anti-avoidance powers enable us to take action to protect savers' benefits and the Pension Protection Fund. We use them against employers (or

those associated with them) who have put those benefits at risk, or where it is reasonable to require them to provide financial support to the scheme. The main circumstances in which would use these powers are:

- one of the main purposes of their actions was to stop the triggering or recovery of all or part of a debt due to the scheme under section 75 of the Pensions Act 1995, A s75 debt reflects the amount of extra cash that a scheme would need, on top of existing assets, to buy annuities to secure members' benefits in full.

70. He has made a separate complaint to TPR to see if it can hold JLR accountable for its actions.

71. His employment tribunal hearing with Midlands West Employment Tribunal (**MWET**) on 17 November 2022 was postponed until 10 November 2023. He has sought a further six months stay of proceedings so that The Pensions Ombudsman (**TPO**) can complete its investigation of his complaint.

72. He has raised separate complaints with: (a) University Hospital of Leicester (**UHL**); (b) Patient Information and Liaison Service (**PILS**); (c) UHCW; (d) the Parliamentary and Health Services Ombudsman (**PHSO**); and (e) the General Medical Council (**GMC**). He is considering making complaints to: (a) the Health and Safety Executive (**HSE**); (b) Action Fraud UK; and (c) Professional Standards Authority (**PSA**).

73. He said that:

> "…this is not about money to me anymore. It is about exposing the action of JLR and the Trustee in the actions and process they have followed and continue to follow just to deliver a $, regardless of the law…
>
> JLR's GP was certainly not competent enough to request a report from my consultant in support of my IHER, despite numerous requests by myself…
>
> They were, however, very knowledgeable that by not requesting the report, it would prevent triggering JLR's obligation to IHER enhancements while the employee was an active member of the scheme. [Mr N's] business model in a nutshell, supported by Mr Adrian Mardell, Dr Grobler and Dr Iley all knew they were breaking the law but, they had been getting away with it for years, why would this occasion be any different?"

74. Mr S also said that:

> "Your [TPO's] actions are in breach of The Human Rights Act – Article 6: 'Right to a fair trial', by preventing release of a key document, in support of an ongoing Employment Tribunal...
>
> I am currently not able to leave the house, the only transport I have, I cannot afford to put it through its MOT so it is now off the road…I am not able to walk

> too far and I am in constant pain, we are prisoners in our own home, this is a breach of The Human Rights Act – Article 5: "Rights to liberty and security".
>
> [Mr N] has had access to my post since January 2023, he has all our financial information, this is a breach of The Human Rights Act - Article 8: "Respect for Your Private and Family Life".
>
> [Mr N] has convinced my cancer consultant to support his activities, resulting in a loss of trust between myself and my cancer consultant, this is a breach of article 2 of The Human Rights Act "Right to Life".
>
> Progressed into convincing my GP into issuing a report which will stop an income protection policy from paying out, this is in breach of The Human Rights Act - Article 3: 'Freedom From torture and inhuman or degrading treatment".
>
> All this has developed from another breach in The Human Rights Act – Article 14: "Protection from Discrimination" which was breached on 22 October 2021, circa 2 months before JLR dismissed me in order to avoid paying a section 75 pension debt.
>
> There is a clear conflict of interest with [Mr N's] obligations to deliver cost savings for the company and his duties to the pension scheme, he did this by fraudulent means by not complying with TPR's legal requirements..."

75. Mr S requested an oral hearing. However, due to personal and health reasons, he said he would not be able to attend in person. He asked to attend by "other means".

76. He believed that a "tracker" attached to an e-mail from TPO sent to him in December 2023 was intended to "infect his PC". He also asserts that the name of the individual at TPO by whom the e-mail was sent matches the name of an employee at JLR, and asserts that the probability of this being coincidental is low.

Summary of the Trustee's position

77. Mr S has not been "penalised" in any way and can take a Serious IHER pension from the Plan backdated to his date of leaving JLR, 9 December 2021.

78. The capability review process was the responsibility of JLR. The length of time taken to complete it was outside of its control. In any event, there was no timescale set out in legislation for completing the process. It is unaware of an agreed timescale or a specific timetable having been communicated to Mr S. Furthermore, Mr S has not provided any evidence of a clear agreement with JLR concerning the timescales for this process.

79. It must keep accurate records of members in the Plan to meet its legal obligations. It would not be proper to record and treat Mr S as an active member when he had ceased both: (a) employment with JLR; and (b) accrual of pension benefits in the Plan. Its records correctly reflect that Mr S currently is a deferred member of the Plan.

80. Mr S says that he "would like to be treated as an active member to transfer [his] pension pot…out of the Jaguar Plan". Active members of the Plan, however, have no statutory right to a CETV. Under Section 93(4)(a) of the Pension Schemes Act 1993, it is a condition that the member is no longer accruing rights to benefits in order to be entitled to a statutory CETV.

81. The option to transfer his benefits from the Plan is only available during Mr S' lifetime.

82. It is unaware of any "refusal" by Dr Grobler to "correct errors" in the OH outcome report or any pressure applied by him on Mr S into agreeing the release of it to JLR.

83. It is unaware that access to Mercer by Mr S for information about the Plan was "blocked" by Mr N. Mr S may contact Mercer at any time and he has not presented any clear evidence to substantiate his allegation. The fact that the process in place required authorisation from Mr N before the provision of IHER figures to Mr S does not indicate any restriction to access to Mercer.

84. Based on Mr S' current status, under rule 8.5 of the Plan Rules, where a member dies before NPA with a deferred pension that has not yet started, a death benefit is payable if there is no spouse/civil partner pension or children's pension payable. This benefit will be equal to the total contributions paid by the member with accumulated interest at 3% per annum (or such rate as it may decide).

85. Rule 9.1 of the Plan Rules stipulates that where a member dies leaving a surviving spouse or civil partner, the spouse or civil partner will receive a pension for life. If the member dies before NPA with a deferred pension that has not yet commenced, the pension will be equal to one half of the member's preserved pension.

86. Mr N does not have a "business model" for IHER applications. He has also not broken the law. All his actions have been taken in accordance with the Plan Rules.

87. The Plan is not a multi-employer scheme. In any event, a section 75 debt has not been triggered in the Plan, as Mr S seems to believe.

Request for an oral hearing

88. Mr S submitted a request for me to hold an oral hearing. The purpose of an oral hearing is to assist me in reaching my determination. Circumstances in which a hearing may be appropriate include: (a) where there are differing accounts of a particular material event and the credibility of witnesses needs to be tested; (b) where the honesty and integrity of a party has been questioned and the party concerned has requested a hearing; or (c) where there are disputed material and primary facts which cannot be properly determined from the papers.

89. Mr S also indicated that an additional reason in support of an oral hearing is that he has had IT and network issues between December 2023 and January 2024. He asserts that these were caused by the 'tracker' he claims to have identified, attached to an e-mail from TPO with the intention to infect his PC, which has prevented him from progressing his complaint. He appears to allege that the true sender of the e-

mail was an employee of JLR. These are extraordinary allegations, for which Mr S has provided no substantive evidence. I refer to them only as they are relevant to the background behind his request for an oral hearing, but they are, for the avoidance of doubt, refuted.

90. Mr S was formally notified that I had refused his request on 5 February 2024. I do not consider that any of the circumstances in paragraph 88 apply here, and there are no other compelling factors in favour of holding an oral hearing in this case.

91. Notwithstanding the reason for the IT and network issues Mr S states he has experienced, he has been able to submit comments and documentation via e-mail to my office when requested, and has done so. He was also granted an extension of time in which to make submissions. So, I cannot see that he has been prevented from making the submissions he has wished to in writing. If he had been prevented from corresponding via e-mail, he was also able to make submissions in writing by post.

92. Accordingly, I consider that I can properly determine the case on the basis of the detailed written representations and the documentation which has already been submitted by, and shared with, the parties.

Conclusions

93. The Trustee is under a legal obligation to administer the Plan in accordance with the Plan Rules.

94. In accordance with rule 6.4 of the Plan Rules, if a member leaves the service of JLR before NPA because of Incapacity or Serious Incapacity, he/she may choose an immediate pension from the Plan if the Trustee and JLR consent. If a member leaves service because of Incapacity, the pension will normally be calculated as if the member retired early but disregarding the usual minimum age limit for payment. If a member leaves service because of Serious Incapacity, the pension will normally be calculated on the basis of the pensionable service the member would have completed had he/she remained a member until his/her NPA.

95. The definitions of Incapacity and Serious Incapacity in the Plan Rules stipulate that:-

    95.1. It is the Trustee, acting on medical advice from its MA, who decides whether a member is suffering from Incapacity or Serious Incapacity.

    95.2. If the Trustee forms the opinion that the member's health problems would prevent him/her from permanently following his/her normal occupation, then he/she would meet the conditions for Incapacity.

    95.3. If the Trustee considers that the member was also incapable of carrying out any duties that his/her employer might reasonably assign to him/her having regard to the duties carried out by him/her immediately before becoming ill, he/she would then satisfy the criteria for Serious Incapacity.

96. The Trustee was consequently the decision maker required to assess whether Mr S met the definition of “Incapacity” or “Serious Incapacity” in the Plan Rules, after seeking medical evidence from Health Partners.

97. I am not a medical expert and it is not my role to review the medical evidence and come to a decision of my own as to Mr S’ eligibility for IHER benefits from the Plan.

98. I am primarily concerned with the decision-making process. Medical (and other) evidence is reviewed to determine whether it supported the decision made. The issues considered include: (a) whether the applicable scheme rules or regulations have been correctly interpreted; (b) whether appropriate evidence has been obtained and considered; and (c) whether the decision is supported by the available relevant evidence.

99. If I find that the decision-making process is flawed, or that the decision reached by the Trustee is not supported by the evidence, the case is normally remitted to the Trustee to reconsider. I cannot overturn the decision just because I might have acted differently when presented with the same evidence.

100. It is for the Trustee to decide the weight to attach to any of the evidence, including whether to give some of it little or no weight. It is open to the Trustee to prefer evidence from its MA provided there is no good reason why it should not do so. The kind of things I have in mind are errors or omissions of fact or a misunderstanding of the relevant rules; but the Trustee is not expected to challenge medical opinion unless the evidence on which the medical opinion is based is obviously flawed or insufficient.

101. I am satisfied that the original decision to decline Mr S’ IHER application was made by the Trustee after it had considered the medical evidence and taken advice from Dr Bennett. I note Mr S has alleged that it was Mr N and not the Trustee who made this decision but I have seen no clear evidence which corroborates his allegation.

102. In her report dated 13 July 2021, Dr Bennett listed the medical evidence provided with the application which included Dr Grobler’s OH outcome report dated 11 May 2021.

103. The role of OH physicians such as Dr Bennett and Dr Grobler is different from that of a treating doctor in several aspects. Their focus is on the functional consequences of Mr S’ medical conditions and how that change in function impacted on his capacity for work in the context of the Plan Rules. They must carry out a forensic analysis of the available relevant medical evidence and consider that against the requirements of the Plan Rules. It is not their remit to add to the weight of any medical evidence but to objectively assess the evidence presented in support of any application or subsequent dispute. It was open, however, to them to request further medical evidence should the need arise.

104. It was consequently for Dr Bennett and Dr Grobler to exercise their professional judgement in deciding whether or not they required further information from the

specialists treating Mr S before forming their medical opinions. They both decided that they already had sufficient evidence to do so and obtaining further information would not significantly add to their understanding of Mr S' conditions.

105. Mr S provided contact details for Woodside and Dr Mushkbar on the "GP/Specialist Consent Form". By signing the declaration on the form, Mr S consented to the OH service obtaining a medical report from his GP and/or "Treating Specialist".

106. Dr Grobler chose to only contact Woodside for a medical report, and this decision was communicated to Mr S on 26 February 2021. With the benefit of hindsight, it would have been better if Dr Grobler had also asked Dr Mushkbar for a medical report at the time. By doing so, he would most probably have learnt much earlier that Mr S' prognosis for his multiple myeloma was poor and his life expectancy was short.

107. However, Dr Grobler did ask Woodside in February 2021 for copies of the outpatient correspondence and test results of Mr S' conditions which were impacting on his capability for work, which would likely have included correspondence from Dr Mushkbar. Regrettably, Woodside did not enclose the requested evidence with its medical report.

108. I note that Mr S asked to see a copy of his GP's medical report before it was sent to Dr Grobler. It is regrettable that Mr S subsequently had to instruct his GP to issue this report without him checking it first because of his eyesight problems. I consider that if Mr S had reviewed the report, he could have requested his GP to (a) amend the report if he had any concerns about it; and (b) comply with Dr Grobler's request for copies of the outpatient correspondence and test results to be sent to him.

109. When Mr S received a copy of Dr Grobler's OH outcome report, he noticed that there were some errors. The JLR Admin Team gave Mr S an opportunity to supply any additional evidence he wished Dr Grobler to consider before deciding whether or not it was necessary to amend his report.

110. Dr Grobler subsequently responded to Mr S' questions about his report by letter. He also asked Mr S to provide any medical reports from the specialists treating him which he had at home so that he could examine them.

111. Mr S sent Dr Grobler two recent reports from the Ophthalmology department and enquired whether it would be useful if he obtained a copy of the outpatients correspondence from UHCW.

112. It would have been better if Dr Grobler had deferred sending the OH outcome report to JLR until he had studied the evidence which Mr S was willing to get for him, especially when he had unsuccessfully tried to obtain it from Mr S' GP.

113. Dr Grobler specified a deadline of 11 June 2021 for Mr S to give his consent for the release of the OH outcome report to JLR instead. It is clear to me that Dr Grobler did consequently put Mr S under some pressure into making his decision. Mr S did not have to agree to this deadline but he decided not to challenge it at the time.

114. I note, however, that after the OH outcome report was sent to JLR, Dr Grobler was still willing to consider any medical evidence which Mr S had in his possession that would provide a more detailed explanation of his prognosis. Furthermore, he supplied Dr Bennett with a copy of the report from the Ophthalmology department showing that Mr S' vision was not as described in his OH outcome report. I am consequently satisfied that Dr Grobler satisfactorily drew to Dr Bennett's attention the inconsistencies in his report with the available medical evidence, despite choosing not to amend it.

115. Dr Bennett prepared her medical report on 28 June 2021. She amended it on 13 July 2021 in order to take into account the discrepancies which Mr S had found. In particular, she specified in her report that she had been made aware Mr S' surgical treatment for cancer was delayed not because of the Covid-19 pandemic, as reported by Dr Grobler, but because of his heart condition.

116. Dr Bennett also explained why she considered that it was unnecessary for her to obtain medical reports from all the consultants treating Mr S at UHCW before forming her medical opinion. With the benefit of hindsight, it would have been helpful if Dr Bennett had reviewed these reports before providing her advice to the Trustee.

117. Dr Bennett informed the Trustee that if it wished to see these reports, she could obtain them. It is unfortunate that the Trustee declined her offer because if it had considered them before making its decision, it would most likely have discovered that the prognosis for Mr S' multiple myeloma was pessimistic much earlier than it did.

118. However, I cannot disregard that the medical report from Mr S' GP said that his "bloods" were being kept stable through "maintenance chemotherapy" and the treatment for his multiple myeloma was currently effective. So I consider it was not obvious that there was insufficient information to make a decision at the time and there was no reason why the Trustee could not rely on the advice it received from Dr Bennett in reaching its original decision.

119. Dr Bennett's opinion was given on the balance of probabilities, which I consider is the correct standard under the Plan Rules, and there would always be an element of uncertainty in any prognosis.

120. However, the decision was not communicated to Mr S by the Trustee, but via a Teams conversation with HR. I find that the Trustee should have directly informed Mr S of its original decision to reject his IHER application and its failure to do so was maladministration. I note that the Trustee has sincerely apologised to Mr S for its mistake and updated its procedures to ensure this step will be taken for any future applications by other members of the Plan. I consider that apology to be sufficient in these circumstances.

121. In any event, despite the procedural points identified above, I consider that the Trustee took appropriate action to put matters right for Mr S at Stage One IDRP after obtaining a further medical opinion from its MA. In its IDRP response, the Trustee revised its previous decision and decided that Mr S was entitled to receive a Serious

IHER pension from the Plan. So I am satisfied that the Trustee: (a) gave proper consideration to Mr S' application at Stage One IDRP by assessing all the relevant medical evidence available; and (b) acted in accordance with the Plan Rules and the principles outlined in paragraph 98 above.

122. Under the Plan Rules, "service" is defined as "employment with [JLR]" and "pensionable service" is defined as "service after joining the Plan." Mr S was dismissed on 9 December 2021 on capability grounds for reasons connected with ill health. At this point, he ceased to be an active member and became a deferred member of the Plan.

123. However, the Trustee has offered to Mr S a Serious IHER pension backdated to 9 December 2021. This puts Mr S into the same position he would have been in had he taken ill health retirement from active status.

124. Mr S has complained that, if he were an active member, he would be able to take a CETV from the Plan. However, under Section 93(4)(a) of the Pension Schemes Act 1993 (**the 1993 Act**), an active member does not have a statutory right to transfer his/her benefits out of the Plan. So, Mr S has not lost the opportunity to take a CETV. Indeed, it is only once he became a deferred member that he acquired the statutory right to do so.

125. Under section 94(1) of the 1993 Act, a deferred member has the right to take the cash equivalent of their "transferrable rights." In Mr S' case, his transferrable rights are to the accrued benefits he is entitled to under the Plan Rules. The Plan Rules do not stipulate that members who have been offered a Serious IHER pension are entitled to an enhanced CETV as an alternative to taking an IHER pension from the Plan. So, Mr S has no statutory right to an enhanced CETV.

126. If Mr S declines the Trustee's offer of a Serious IHER pension, his entitlement under the Plan Rules would be to a deferred pension from the Plan at NPA, or to take the CETV of his accrued benefits under the Plan Rules to another registered pension scheme.

127. Rule 21.3 of the Plan Rules provides that the Trustee is able to pay enhanced benefits to any member, including an enhanced CETV, if directed to do so by JLR. The Trustee says there was no written correspondence between the Trustee and JLR in relation to a potential enhanced CETV. During a verbal discussion between Mr N and JLR, JLR stated its position that no pension enhancements would be approved that would give rise to an immediate cash payment from JLR. Mr N provided this explanation to Mr S verbally.

128. The explanation given by the Trustee and by Mr N to Mr S are consistent and I have no reason to doubt that this is JLR's position. However, clearly it would have been better practice for these communications to be in writing.

129. Under section 166(1) of the Finance Act 2004 (**the 2004 Act**), a registered pension scheme may pay a lump sum to a member in cases of serious ill health. The

conditions for this payment are set out in paragraph 4 of Schedule 29 to the 2004 Act and requires a medical opinion that a member is expected to live for less than one year. Despite the severity of Mr S' ongoing health conditions, I have seen no indication that such prognosis has been made. I find that the Trustee was not able to pay Mr S a serious ill health commutation lump sum.

130. I agree with the Trustee that there is no clear evidence to substantiate Mr S' contention that Mr N deliberately "blocked" his access to Mercer for information about the Plan. I consider his request that any enquiries concerning IHER benefits should be made through him to be reasonable given Mr S' situation.

131. Mr S' complaint that JLR's capability review process was flawed and took too long to complete is a matter of employment law. This is also the case for many of the serious allegations which he has made against Mr N and Dr Grobler as shown in the summary of his position on the complaint above. It is not in my jurisdiction to investigate these complaints.

132. I will briefly address Mr S' allegations that TPO and the respondent have breached various articles of the European Convention for the Protection of Human Rights and Fundamental Freedoms as described in paragraph 74 above. Under section 6(1) of The Human Rights Act 1998, it is unlawful for a public authority to act in a way which is incompatible with a Convention right.

133. Mr S asserts that TPO has breached article 6 of the Convention (Right to a fair trial) by refusing to disclose the Trustee's formal response to the Midlands West Employment Tribunal.

134. TPO confirmed to Mr S on 7 November 2023 that it was unable, under section 149(5) of the 1993 Act to disclose information to a third party unless the third party is listed in section 149(6), and TPO considers that the disclosure would enable or assist that person to discharge any of its functions. The employment tribunal is not listed in section 149(6).

135. In any event, despite being instructed to keep investigation materials confidential, Mr S proceeded to disclose the formal response to the MWET on 9 December 2023, so the prejudice Mr S claims to have suffered by TPO's non-disclosure of the Trustee's formal response is unclear.

136. Regarding Mr S' remaining allegations of breaches of his Convention rights, these are levelled principally against JLR and Mr N. Even to the extent that Mr N and JLR might be considered to include the Trustee (the sole respondent to Mr S complaint), none of these persons are public authorities, and are therefore outside the scope of section 6(1) of The Human Rights Act 1998.

137. For completeness, I will also briefly address Mr S' comments about section 75 of the Pensions Act 1995. In certain circumstances, the liabilities of a scheme may crystallise, resulting in a debt due from the employer to the scheme under section 75

of the Pensions Act 1995. Such a debt is typically known as a “debt on an employer” or a “section 75 debt”.

138. Section 75 debts can be triggered on the insolvency of an employer and in a multi-employer scheme, the occurrence of an employment cessation event.

139. I have seen no evidence that a “relevant event” such as an insolvency event or the passing of a resolution for a voluntary winding up has triggered a section 75 debt in the Plan on JLR. Mr S’ assertion that Mr N’s fraudulent actions on behalf of JLR were to stop the triggering or recovery of all or part of a debt due to the Plan under section 75 of the Pensions Act 1995 is consequently unjustified.

140. Furthermore, for essentially the reasons given by the Trustee in its Stage Two IDRP decision letter to Mr S dated 23 June 2022 as shown in subparagraphs 55.13 to 55.15 above, I am satisfied that there has been no conflict of interest between Mr N’s obligations to deliver cost savings for JLR and his duties to the Plan as Mr S believes.

141. In conclusion, Mr S has not suffered any actual financial loss because the Trustee has offered a Serious IHER pension backdated to 9 December 2021, which treats him in the same manner as if he had taken serious ill health retirement from active membership of the Plan. I do consider that Mr S has experienced some distress and inconvenience dealing with this matter, and the Trustee’s failure to directly inform him about its original decision was maladministration. However, the Trustee has apologised to Mr S and has stated that it will review its procedures for future cases. In the context of it addressing Mr S’ substantive complaint at Stage One IDRP, I consider this action to be a sufficient remedy.

142. Had Dr Grobler approached Dr Mushkbar and had Dr Bennett obtained the further reports, it is possible that the Trustee might have concluded earlier that Mr S suffered from Serious Incapacity. However, any distress and inconvenience suffered by Mr S from this delay was primarily the result of the actions of Health Partners and Woodside, not the Trustee.

143. Regarding the length of time it took JLR to complete its capability assessment, whilst this may have caused Mr S further distress and inconvenience, this is a matter of employment law and not within my jurisdiction.

144. While I sympathise with Mr S’ circumstances, I do not uphold his complaint.

Dominic Harris

Pensions Ombudsman

20 February 2024

Appendix One

The definition of “Incapacity” in the Plan Rules dated 6 April 2017 is:

> “…physical or mental impairment that in the opinion of the Trustees prevents (and will continue to prevent) the Member from following his or her normal occupation. Before deciding whether a Member is suffering from Incapacity, the Trustees must obtain evidence from a registered medical practitioner that the Member is (and will continue to be) incapable of carrying on his or her occupation. The Trustees' decision as to whether a Member is suffering from Incapacity will then be final."

The definition of “Serious Incapacity” in the Plan Rules is:

> “…Incapacity that the Trustees, after taking such medical advice as they think appropriate, consider will stop the Member (otherwise than temporarily) from carrying out any duties that the Employer may reasonably assign to him or her having regard to the duties carried out by him or her immediately before becoming incapacitated.”

Rule 6.4 entitled “Incapacity Retirement” in the Plan Rules states:

> “A Member who leaves Service before NPA because of Incapacity may, if the Trustees and the Company consent, choose an immediate pension…
>
> The pension will normally be calculated as described in Rule 6.3 (early retirement) but disregarding the usual minimum age limit for payment.
>
> If the Member is leaving Service because of Serious Incapacity, the pension will normally be calculated as described in Rule 6.1 (retirement at NPA)…

Rule 21.3 entitled “Discretionary Benefits” in the Plan Rules states:

> “If the Company so directs and the Employers pay any additional contributions that the Trustees consider necessary (for which purpose the Trustees will consider advice from the Actuary), the Trustees will provide:
>
> 21.3.1 Increased or additional benefits for, or in respect of, any Member;
>
> 21.3.2 Benefits for, or in respect of, a Member or Members different, or on different terms (including as to time of payment) from those set out elsewhere in the Rules…

The Trustees may also provide benefits under this Rule if the Company consents.

Any benefits provided under this Rule must be consistent with the Contracting-out, Preservation, Revaluation and Transfer Value Laws and authorised for the purposes of Part 4 of the Finance Act 2004.

Appendix Two

Relevant excerpts taken from Dr Sheard's "Pension Scheme Medical Adviser Report" dated 24 January 2022

Mr S' application/appeal for ill health retirement has been passed to me for consideration…

I understand that the original evidence consisted of…

I have considered the evidence above and new evidence submitted by Mr S as part of his appeal…

- Report from Dr T James, GP dated 1/12/2021
- Fit note/sick note indicating that Mr S is unfit for work as a result of multiple myeloma from 19/11/2021 until 31/12/2021
- Mr S' letter of 30/12/2021
- Report from Dr U Chaka Consultant in Anaesthetics and Pain Clinic dated 12/10/2021
- Report from V Thakrar Senior Optometrist dated 8/11/2021
- Report from Dr M Mushkbar consultant Haematologist dated 26/11/2021
- Report from Dr H Abdelsalam cardiology clinical fellow dated 9/3/2021
- Report from D Wright physiotherapist dated 17/10/2018
- MRI report dated 16/12/2015

In my opinion, the original medical evidence was clear in stating that Mr S was unfit for work and I note that, at the time, he had been unfit for work for nearly 2 years and so, statistically, the likelihood of a return to work was becoming statistically very small.

However the JLR consultant occupational physician indicated he may be able to return to work with some aids and adjustment and the GP's report did not identify any new or significant deterioration in Mr S' health so significant as to likely to make this opinion unsafe.

The reports from the eye specialists did not identify any medical condition that could not be resolved sufficiently in time to allow Mr S to return to desk-based computer screen work.

There was no evidence that his cardiac condition was actively progressive or preventing him from working.

His musculoskeletal problems were significant but had been considered by the JLR consultant occupational physician in formulating his opinion.

In the circumstances it is perhaps unsurprising that the MA to the Trustee felt that there was not yet sufficient evidence that, despite his multiple health problems, Mr S was unable to improve in functional capacity sufficient to allow him to return to sedentary work.

I further note that the MA to the Trustee thought it unlikely that there would be substantial other information that could be considered given the information Mr S had provided and the GP report. However, it is noted that Mr S had requested additional medical reports

from his haematologist, cardiologist, neurologist and ophthalmologist and that if the Trustee wanted these reports, could be requested.

In my experience it would not be usual to request this number of specialist reports as, pragmatically, in most instances information from the specialists serves only to corroborate information provided by the employee to the OH service.

In the circumstances and having reviewed the original medical evidence it is my opinion that the advice given them was not unreasonable but that, perhaps, information from Mr S' blood cancer specialist might have been important (as turns out to be the case).

Considering the new evidence the MRI and physiotherapist reports could not be deemed contemporaneous and, pragmatically, while providing useful corroboration of Mr S' musculoskeletal issues could not be used as a measure of functional capacity in any ill health retirement determination at this time.

The report from the clinical fellow in cardiology indicates that although Mr S has a significant history of ischaemic heart disease, at that time of assessment he had no significant evidence of progressive cardiac disease requiring any further new active medical intervention and that he would be discharged from follow-up unless any further serious health issues were identified. In the circumstances there is no evidence here of any cardiac condition that would prevent him from returning to desk-based work.

The report from the eye specialist indicates he has had uncomplicated cataract surgery to his right eye and that he will have a similar treatment to his left eye in due course. Again, this is not evidence of permanent incapacity for desk-based work.

The consultant in anaesthesia/pain management identifies he may benefit from some further treatments. It is unclear whether these have been provided as yet but it is likely would potentially have a substantial impact upon his head pain and so the report would not yet identify permanent incapacity for desk-based work as further treatment options remain.

The GP writes in support of Mr S' appeal noting he has significant medical issues that when taken together have a substantial impact upon his activities of daily living. He notes that Mr S' multiple myeloma has had a sub-optimal response to treatment and that his prognosis is therefore guarded. He notes that he has reduced mobility as a result of his musculoskeletal problems, breathlessness and fatigue.

The GP also notes Mr S has reduced mental well-being and so overall requests that the Trustee reconsider his application for IHER.

However, the most significant new information comes from the consultant Haematologist who notes that Mr S has been absent from work since August 2019 and that as he progresses through further lines of treatment his ability to continue to work will be significantly affected. She therefore supports her appeal.

It is this report that the GP, writing in December 2021, relies upon for detail of Mr S' prognosis for his multiple myeloma as the consultant Haematologist records that at the time of diagnosis, he was initiated on treatment but that, unfortunately, he had a sub-

optimal response to the same. Further treatment has then resulted in partial remission only and it is noted that this has been complicated by side effects of his treatment including pain and significant fatigue.

The consultant Haematologist advises that Mr S is not a good candidate for bone marrow transplantation and so remains in partial remission only.

It is noted that multiple myeloma is not a curable condition the level of response to any treatment is extremely important. The consultant Haematologist notes that at the time of diagnosis Mr S had a likelihood of progressive disease over some 5 ½ years and having failed first-line chemotherapy and only achieving a partial response from second-line chemotherapy and not being a strong candidate for transplant significantly increases the likelihood of progressive disease over shorter periods of time. It is also noted that further lines of treatment will be limited due to previous toxicity from chemotherapy and his associated heart disease. The Haematologist therefore feels he has a poor prognosis.

In light of the new evidence (in particular the new evidence of the consultant Haematologist), given that a further six or more months have passed without any substantial improvement in Mr S' functional capacity (as he describes it) and with still no likely return to work (and therefore an ever decreasing statistical likelihood of any return to work) my view is that the strength of his application is now substantially different than it was in June 2021.

In my opinion, on the balance of probabilities, Mr S now has both physical and mental impairment that will continue to prevent him from following his normal occupation and similarly has incapacity that will stop him (otherwise than temporarily) from carrying out the duties that the Employer may reasonably assigned to him having regard to the duties carried out by him immediately before becoming incapacitated.

It is therefore my opinion that there is now reasonable medical evidence Mr S' health problems prevent him from following his occupation and that this is a permanent situation and that it is likely that the scheme definition as outline above is met for Serious Incapacity.

If the Trustee supports Mr S' application, I would not recommend a review of his circumstances to confirm his ongoing health problems and treatments as cure cannot be anticipated but I recognise the requirement for review is entirely at the discretion of the Trustee.

In my opinion this recommendation is a reasonable interpretation of the medical evidence base held at the time and is compatible with all the objective medical evidence presented."