Ombudsman's Determination

Applicant	Mr N
Scheme	Local Government Pension Scheme (**LGPS**)
Respondents	Cumbria County Council (**CCC**)

Outcome

1. Mr N's complaint is upheld and to put matters right CCC should review its decision with regard to his award of Tier 2 benefits.

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

Complaint summary

3. Mr N has complained that CCC failed to consider his eligibility for Tier 1 ill health retirement benefits in a proper manner.

Background information, including submissions from the parties

Background

4. Mr N retired in June 2011. His eligibility for Tier 1 benefits was the subject of a previous determination by the then Deputy Ombudsman in January 2015[1]. Amongst other things, CCC was directed to make a fresh decision as to Mr N's eligibility, having sought an opinion from an Independent Registered Medical Practitioner (**IRMP**) who had not previously been involved in the case.

5. As at the date of Mr N's retirement, the relevant regulations were the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (SI2007/1166) (as amended). Regulation 20 provided for three tiers of ill health retirement benefits depending upon the level of capacity for "gainful employment" (as defined). Tier 1 benefits were payable if there was no reasonable prospect of Mr N being capable of undertaking any gainful employment before his normal retirement age. Gainful employment was defined as "paid employment for not less than 30 hours in each week for a period of not less than 12 months".

[1] *PO-3572*

6. Subsequent to the Deputy Ombudsman issuing a final determination, Mr N and CCC obtained a consent order (the **Consent Order**) setting out an agreed approach to carrying out her directions. Amongst other things, Dr Kerry was appointed as IRMP. The Consent Order also set out what information was to be provided for Dr Kerry. In addition, Mr N was provided with an opportunity to submit additional information.

7. CCC referred Mr N's case to Dr Kerry in July 2015. Its letter enclosed a copy of the Consent Order and the agreed medical reports; with the exception of Mr N's occupational health records. Dr Kerry was given the address of the Mr N's former employer's occupational health provider and told he could obtain these from them. CCC confirmed that Mr N had provided it with evidence that he had been assigned to the support group for Employment and Support Allowance (**ESA**) by the Department for Work and Pensions (**DWP**). Dr Kerry was asked to provide a comprehensive report to support his recommendation. Dr Kerry issued his report in August 2015.

8. Having seen a copy of Dr Kerry's report, Mr N also commissioned a report from Dr Kent, an occupational health specialist. Summaries of the reports provided by Drs Kerry and Kent are provided in an appendix to this document. Summaries of the other medical reports relating to Mr N's case were provided in the previous Deputy Ombudsman's determination and are not repeated here.

9. CCC issued a decision, on 20 October 2015, confirming the decision to award Mr N Tier 2 benefits. The decision maker gave the following reasons:-

    - In order for Mr N to be granted Tier 1 benefits, CCC must determine that there was no reasonable prospect of him being capable of undertaking gainful employment before his normal retirement age.

    - The Deputy Ombudsman had directed CCC to refer Mr N's case to an IRMP who had not previously been involved in his case. It had gone further than this by offering Mr N the opportunity to select his own IRMP. He had declined to do so and confirmed he wished to proceed with its suggested IRMP, Dr Kerry.

    - Mr N had been given the opportunity to provide Dr Kerry with additional information but did not do so. Dr Kerry had offered Mr N a consultation but he had declined this.

    - Dr Kerry had been provided with the agreed medical reports and no others.

    - Mr N had left employment in 2011 and Dr Kerry was required to review his case as at June 2011.

    - Dr Kerry was of the opinion that Mr N would be fit to return to employment.

    - She was not bound by Dr Kerry's opinion but it was a relevant factor to be taken into account in reaching her decision. She was entitled to rely on Dr Kerry's opinion unless there was a cogent reason why she should not. She did not consider there to be any omissions or errors of fact or misunderstanding in

Dr Kerry's report and he was provided with all of the relevant available evidence.

- Mr N had provided a copy of Dr Kent's report, together with a covering email explaining why she should consider it. She was not required, by the Deputy Ombudsman's determination or the LGPS regulations, to consider Dr Kent's report. The onus was on CCC to appoint the IRMP; not Mr N. She had, however, reviewed the report.

- Her primary concern with Dr Kent's report was that he referred, throughout, to Mr N's condition in 2015. Dr Kent had referred to Mr N suffering from an "enduring" illness and that his medication continued to cause him significant side effects. He had referred to Mr N "remaining unfit for work". This indicated that his assessment was in relation to Mr N's eligibility for Tier 1 benefits now. It was for this reason that she did not think Dr Kent's report could be relied upon in making her decision.

- Dr Kent had criticised Dr Kerry's report because he did not have a consultation with Mr N but this was Mr N's decision.

- Dr Kent had referred to Mr N having applied for jobs with lower levels of stress, as suggested by Dr Kerry, and said he had been unable to pursue these because of his medical condition. However, Mr N had not provided Dr Kerry with any evidence of this despite having been given the opportunity to submit further information to Dr Kerry before he made his assessment.

- She had reviewed all of the medical evidence. This showed that there were contrasting opinions as to whether or not Mr N was eligible for Tier 1 benefits. She was not a medical adviser and had to rely on the medical evidence when making a decision.

- She felt it was appropriate to place greater weight on Dr Kerry's report because:-

  - CCC and Mr N had agreed Dr Kerry should be appointed as IRMP.

  - Mr N had been given the opportunity to choose his own IRMP and had declined to do so.

  - Mr N had been given the opportunity to provide Dr Kerry with additional information and had declined to do so.

  - Mr N had been given the opportunity to attend a consultation with Dr Kerry and had declined to do so.

  - Dr Kerry had been provided with all of the medical evidence, together with a copy of the Deputy Ombudsman's determination.

- There were potential errors/misunderstanding in Dr Kent's report regarding the date of the assessment.
- It was unreasonable for Mr N now to choose Dr Kent's report as the overriding opinion simply because it was favourable to him.
- There were no omissions or errors of fact or misunderstanding in Dr Kerry's report.

10. On 12 November 2015, Mr N's solicitors wrote to CCC's solicitors saying he wished to challenge the decision and referring to judicial review. CCC's solicitors responded by saying, amongst other things, that the appropriate route for such a challenge would be the internal dispute resolution (**IDR**) procedure; rather than a judicial review.

11. Mr N submitted an IDR appeal on 1 February 2016. CCC acknowledged Mr N's appeal on 22 March 2016. It sent Mr N a further letter, on 16 May 2016, saying it was considering his case and apologising for the length of time taken. CCC also wrote to Dr Kerry asking for clarification. It asked Dr Kerry to confirm whether or not he had considered the relevant statutory criteria for ill health retirement and the guidance issued by the Department for Communities and Local Government (**DCLG**). It also asked him to provide copies of any notes he had made in the course of his assessment; particularly, any evidence of his consideration of the statutory requirements and/or the DCLG guidance.

12. Dr Kerry wrote to CCC on two further occasions: 21 June 2016 and 22 March 2017. He said he had offered Mr N a face-to-face assessment but this had been declined. He said he had made his decision based upon Mr N's GP records, a report from a consultant psychiatrist, the Consent Order and the Deputy Ombudsman's determination. He said he had taken note of Mr N's past medical history and the medication he was receiving. Dr Kerry said Mr N's GP, in February 2012, had confirmed Mr N was suffering from a severe mental health problem and he was of the opinion this was because of the stress of his job. He expressed the view that Mr N was not fit to return to his former role but, "at the time of his dismissal and at the time of [Dr Kerry's] assessment", he was capable of other types of administrative and clerical work. Dr Kerry confirmed he had considered the statutory criteria for ill health retirement and the DCLG guidance. He said he had been provided with copies of Mr N's GP's report, a report from a consultant psychiatrist, "the council notes" and the Deputy Ombudsman's determination. Dr Kerry provided CCC with a pro forma certificate in June 2016.

13. Having not received a decision from CCC under the IDR procedure, Mr N applied to the Pensions Ombudsman in May 2016. He was asked to pursue the IDR route. However, having received confirmation from Mr N that he still had not received an IDR decision, his complaint was accepted for investigation in October 2016. CCC has since said that the delay in dealing with Mr N's IDR application was a result of it seeking additional information from Dr Kerry. It has said that it regrets this delay.

Mr N's position

14. Mr N submits:-

- CCC failed to adhere to the timetable set out in the Deputy Ombudsman's determination. As a result he was forced to employ a solicitor and barrister to initiate legal action to enforce the Deputy Ombudsman's decision.
- He took legal advice on CCC's decision and was advised that it was substantially flawed. He was advised to challenge the decision through the Courts. As part of the pre-action discussions, he agreed to refer the matter back to the Ombudsman.
- He was advised to pursue the IDR route in the first instance and submitted an appeal on 1 February 2016. He received an acknowledgement six weeks later. His appeal was not determined within the prescribed three month period.
- He feels he would be prejudiced by any decision taken by any senior officer at CCC. If the Ombudsman were to uphold his complaint, he does not want his case referred back to CCC. It has shown itself to be unable and unwilling to deal with the matter in a proper manner.
- He would like the Ombudsman to order CCC to pay him a Tier 1 pension or compensation calculated to enable him to purchase an equivalent pension.
- He has incurred legal costs amounting to £600 and he would like to be reimbursed for these.
- He would also like an apology from CCC for the way in which it has dealt with his case.

15. The following points are taken from Mr N's IDR submission:-

- CCC's decision is defective because it is based on a report by the IRMP instructed by it which fails to engage with the relevant statutory criteria; particularly that relating to gainful employment. This is addressed correctly in Dr Kent's report.
- Dr Kerry's report makes no detailed assessment of the contemporaneous medical evidence and does not give any reasons for his recommendation, as required under the relevant guidance to IRMPs.
- Dr Kerry did not issue a certificate, as required by regulation 20. It was not sustainable for CCC to argue that this was not required because it had been directed to make a fresh decision.
- The factors taken into account by the decision maker are flawed. They all relate to him declining an invitation to an examination by Dr Kerry or an incorrect interpretation of Dr Kent's opinion being based on his current state of

health. He had declined the invitation to an examination because it would have been irrelevant to determining the state of his health at retirement. Dr Kent had made it clear, in his report, that his opinion was based on the medical evidence available at his retirement.

- The decision maker had referred to him not providing evidence of attempts to obtain employment, but criticised Dr Kent for taking this into account.

16. Having seen an opinion from one of our Adjudicators, Mr N submitted further comments. The key points are summarised briefly below:-

    - He understood the Ombudsman was unable to substitute a decision of his own for that reached by CCC.

    - He did not think seeking clarification from Dr Kerry would address the failings identified in the decision making process.

CCC's position

17. CCC submits:-

    - Dr Kerry engaged with the statutory criteria for ill health retirement. This was not explicit in his initial report but there was no suggestion that the statutory criteria had not been followed. Dr Kerry subsequently confirmed that he had engaged with the statutory criteria.

    - The previous Deputy Ombudsman's determination did not require it to obtain a further certificate from the IRMP.

    - Two additional medical reports were obtained and both have been taken into account.

    - It regrets the delay in dealing with Mr N's second stage IDR application and that he was not updated more often. This was the result of trying to obtain further information from Dr Kerry which it was not able to control.

    - The decision issued in October 2015 went into detail as to why Dr Kerry's conclusions were preferred to those of Dr Kent (see paragraph 9).

    - Further detail was provided in its response to Mr N's solicitors of 3 December 2015.

    - With regard to Dr Kent's report, it makes the following points:-

        - The first two pages contain little in the way of opinion. They consist of a summary of the steps taken to reach a diagnosis and a medical history.

        - The fact that this information was not contained in Dr Kerry's report is not relevant because he confirmed that he had the relevant reports, read them and taken them into account.

- Dr Kerry agreed with Dr Kent that Bipolar Disorder was diagnosed in 2011. The difference is that Dr Kerry put this down to the stress associated with Mr N's previous employment and, therefore, considered that there was a distinct possibility of his being able to perform alternative work.

- Dr Kent refers to Mr N's health at the time of his consultation with him and after leaving employment. This is irrelevant because it is an assessment of Mr N's health in 2011 which is required. This is repeated in Dr Kent's opinion.

- Dr Kent refers to Mr N's award of and continued receipt of ESA. This is not material to determining which tier of benefit Mr N was eligible for. The fact that he still receives ESA should not be taken into account and the fact that he received it in 2011 is not indicative of whether he was likely to be capable of gainful employment prior to age 65.

- Mr N's condition had increased in intensity between 2009 and 2011, and medical treatment was problematical due to side-effects. Dr Kent concluded that it would not be reasonable to anticipate ongoing improvement in Mr N's condition up to 2024. This assumption is stark and not grounded on the available medical evidence. He does not refer to the absence of stress, which is understood to have been the trigger to the increase in intensity in Mr N's condition.

- It is not contested that Mr N was not capable of undertaking gainful employment (as defined) in the two years preceding his retirement. The likelihood that he would be able to undertake gainful employment in the following 14 years, without the stress associated with his former role, is contested.

- It is not clear that the psychology report, indicating cognitive and functional impairment in the period 2009 to 2011, was relevant to Mr N's employability in all fields. There is a cross over between the assessment and Mr N's former role, but there was no specific analysis of capability in some other role with a different employer. There was no reference to the removal of stress.

- Mr N's unsuccessful attempts to return to work in the period 2009 to 2011 indicate not only that he was unfit for work but, with the suicide attempt, also that it was a risk to his mental health. It is accepted that it was unlikely that Mr N could have effectively returned to his former role. However, this does not deal with the question of his ability to undertake gainful employment in the following 14 years.

- Dr Kent's opinion was no more detailed or comprehensive than Dr Kerry's.

- The IRMP appointed with Mr N's agreement considers that, in 2011, there was a distinct possibility that he would have been able to perform gainful employment before 2024. The doctor appointed by Mr N disagrees.

- It is down to CCC to consider the two opinions and determine what weight to give either. There is no evidence that the decision it reached was based on irrelevant matters and all relevant matters were taken into account. The conclusions reached would seem to be reasonable.

- Considerable time and resource has been spent in considering Mr N's case. It has, for the most part, done all it can to accommodate his interests.

18. Having seen an opinion by one of our Adjudicators, CCC sought further comment from Dr Kerry (see appendix). It provided a copy of Dr Kerry's further comments and said it did not accept the Adjudicator's opinion.

Adjudicator's Opinion

19. Mr N's complaint was considered by one of our Adjudicators who concluded that further action was required by CCC. The Adjudicator's findings are summarised briefly below:-

- It was not the role of the Ombudsman to review the medical evidence and come to a decision of his own as to Mr N's eligibility for payment of Tier 1 benefits under regulation 20. The Ombudsman is primarily concerned with the decision making process. The Adjudicator had reviewed the medical (and other) evidence in order to determine whether it supported the decision made.

- The issues considered by the Adjudicator included: whether the relevant regulation had been correctly applied; whether appropriate evidence had been obtained and considered; and whether the decision was supported by the available relevant evidence.

- However, the weight which was attached to any of the evidence was for CCC to decide (including giving some of it little or no weight)[2]. It was open to CCC to prefer evidence from its own advisers; unless there was 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 regulation by the medical adviser.

- CCC was required to determine whether the decision to award Mr N Tier 2 benefits was appropriate or should have been replaced. This required CCC to take a view as to what should have been decided in June 2011, when Mr N retired. In order to do so, CCC required advice from an IRMP as to what

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

his/her opinion would have been in 2011, on the basis of the evidence available at that time.

- Mr N's preference was for the Ombudsman to make a decision as to his eligibility for Tier 1 benefits. However, if the decision making process was found to be flawed, the appropriate course of action was for the decision to be remitted for CCC to reconsider.

- For Mr N to be eligible for Tier 1 benefits under regulation 20, there had to be no reasonable prospect of him being capable of undertaking any gainful employment before his normal retirement age. Gainful employment was defined as "paid employment for not less than 30 hours in each week for a period of not less than 12 months". The definition of gainful employment clearly meant employment of any type and not just of a comparable nature to that which Mr N had undertaken previously. This was a very stringent eligibility test.

- CCC's decision and the reasoning behind it was set out in its letter of 20 October 2015. The decision maker had made the point that she was a layperson and reliant upon the medical evidence in making a decision. It was a fair point to make. The decision maker could not be expected to do any more than could be expected of a layperson in the circumstances; that is, to review the various reports in a critical manner. She could be expected to challenge errors or omissions of fact and to check that the medical adviser had applied the correct eligibility test. Matters of medical expertise, such as diagnosis, treatment and prognosis, were generally outside the scope of such a review.

- CCC's decision maker had said she had decided to give greater weight to Dr Kerry's opinion and gave her reasons for doing so. Although the decision maker had said she had reviewed all of the medical evidence, her reasons for giving greater weight to Dr Kerry's opinion were largely reasons for preferring it over that of Dr Kent. In particular, the decision maker had not referred to the view expressed by Dr Basu.

- The Adjudicator acknowledged that Dr Basu was not an IRMP or even an occupational health specialist, but noted he had expressed a view as to Mr N's future capacity for work. His reports were also contemporaneous with Mr N's retirement and, therefore, a useful contribution to the evidence. It would have been appropriate to consider his opinion even if the decision maker then determined to give it little or no weight. However, with no reference to Dr Basu's view and, therefore, no reason given for the weight attached to it, it was difficult to discern whether or not it had been given due consideration.

- Dr Kerry had referred to the two reports provided by Dr Basu. He had noted that Dr Basu was of the opinion it would be extremely difficult for Mr N to find a new job because of his cognitive ability. Dr Basu had expressed the view (in a report dated 6 May 2011) that Mr N would not be able to manage gainful employment in the foreseeable future. It should be recognised that Dr Basu

may not have been aware of the very specific definition of "gainful employment" used in the LGPS regulations when expressing this view. He had given the following reasons for anticipating a poor prognosis: Mr N had shown most of the risk factors associated with relapse; he had displayed severe residual symptoms; he had suffered from significant side-effects from his medication; and he had shown an abnormal EEG. In a report dated 28 March 2012, Dr Basu had noted there had been a decline in Mr N's cognitive functioning over the preceding two years.

- Dr Kerry had said he was of the opinion that Mr N would not be fit to return to his former role "due to the stress of the job". He went on to say Mr N would be fit to undertake other types of duties with lower levels of stress. Dr Kerry had not specifically commented on the factors identified by Dr Basu as likely to mean Mr N was not going to be capable of gainful employment. It would have been helpful if Dr Kerry had explained how he thought Mr N's capacity for gainful employment would be affected by these factors; particularly, how the decline in Mr N's cognitive functioning was likely to affect his capacity for gainful employment. Dr Kerry had not referred to Mr N's EEG results and appeared to attribute his mental health problems to the stress of his former role. His view that Mr N would be capable of a less stressful role follows on logically from this. The Adjudicator was of the view that the decision maker required clarification from Dr Kerry as to the effect Mr N's declining cognitive functioning would have on his capacity for gainful employment.

- It may well have been that Dr Kerry was of the view that, even with the decline in cognitive functioning associated with underlying changes in his brain, Mr N would still have been expected to be capable of undertaking gainful employment (as defined). This was, however, not clear from his report and/or supplementary statements.

- CCC had made an effort to review Mr N's case in a proper manner but it then failed to engage properly with the IDR procedure. It had explained this was a result of seeking information from Dr Kerry and expressed regret. Nevertheless, it did amount to maladministration on CCC's part.

- The Adjudicator was of the view that CCC's failure to engage with the IDR procedure did not result in the kind of significant non-financial injustice to Mr N which warranted an award in line with the Ombudsman's current guidelines.

- The Adjudicator suggested CCC should ask Dr Kerry to clarify his view on the effect Mr N's declining cognitive function (as evidenced by the EEG result) would have been expected to have on his capacity for gainful employment. On receipt of Dr Kerry's further advice, CCC should consider whether it would have altered its decision. It should provide Mr N with its decision, together with a copy of Dr Kerry's advice and its reasons for reaching the decision.

- The Adjudicator noted Mr N's request to have his legal fees reimbursed. The Ombudsman does not make awards for costs charged by professional advisers, such as solicitors, as a matter of course. This is because it is possible to bring a case to the Ombudsman without professional help and free services, such as the Pensions Advisory Service, exist to help people. The Adjudicator considered whether there were exceptional circumstances in Mr N's case which might warrant a departure from this position. She was of the view that there were no such circumstances and an award for legal fees was not warranted.

20. CCC did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr N and CCC provided their further comments which do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Mr N and CCC for completeness.

Ombudsman's decision

21. In deciding that Mr N qualifies for Tier 2 benefits, CCC have concluded that, in 2011, there was a reasonable expectation that he would be capable of undertaking gainful employment before age 65.

22. As discussed above, that decision is for CCC to make. In order to do so, it must weigh up all of the available relevant evidence and come to a reasoned decision. As part of the decision making process, the employing authority, which makes the initial decision, is required to obtain an opinion from an IRMP. The LGPS regulations require that the IRMP is an occupational health specialist. However, this does not mean that either the employer or CCC is bound by the IRMP's opinion. This is something which the decision-maker for CCC acknowledged in her October 2015 decision. CCC had a responsibility to consider all of the available medical evidence even if it then determined to give some of it little or no weight.

23. I accept, as did my Adjudicator, that CCC's decision makers are lay people who do not have medical qualifications. It is appropriate that they should seek advice on medical matters. However, this is not to say that they should accept the IRMP's advice blindly or that they should not also consider medical evidence from other sources.

24. In Mr N's case, CCC had evidence not only from IRMPs but also the physicians treating him, who were specialists in his particular condition. It is entirely appropriate for the IRMP's opinion to be sought on the matter of Mr N's capacity for employment; this is his area of expertise. However, Mr N's case also requires a view to be taken as to the likely progress of his condition and his likelihood of recovery. Arguably, this is where his treating physicians are well placed to provide CCC with assistance. CCC had available to it reports from Dr Basu and a cognitive functioning assessment performed by a clinical psychologist. There was no discussion in the October 2015 decision as to what, if any, consideration had been given to this evidence. At the very

least, I would expect CCC to explain to Mr N what weight it had given to this evidence and its reasons for doing so. Instead, the October 2015 decision focuses on explaining why Dr Kerry's report had been preferred to that of Dr Kent.

25. Having seen the Adjudicator's opinion, CCC asked Dr Kerry to comment on the question of Mr N's cognitive functioning. In his response, Dr Kerry said "at the time of his medical [Mr N's] cognitive function was good". He then went on to say an EEG did not measure cognitive decline and Mr N would require a full assessment by a memory clinic, including mental test scores, and MRI EEG scans to confirm significant cognitive decline. He said, only after such an assessment, would he be willing to change his opinion regarding Mr N's fitness to "undertake some type of employment before normal retirement age".

26. CCC has put Dr Kerry's response forward as evidence that it has given due consideration to Mr N's case. However, the response, in itself, raises further questions which CCC does not appear to have felt the need to consider. For example, Dr Kerry states Mr N's cognitive function was good yet the assessment undertaken by the clinical psychologist does not support this statement. The report referred to Mr N having deficits in attention, a relative weakness in verbal learning, poor verbal fluency, below expected levels of working memory performance (both verbal and visual), and his performance on tasks assessing visuo-spatial memory was lower than expected. Dr Kerry appears to have acknowledged this in his previous report where he refer to Mr N's working performance memory being below normal.

27. Dr Kerry stated that cognitive decline would not be measured by an EEG on its own. He then suggested Mr N would require assessment at a memory clinic. However, it is not clear what he thought the memory clinic would do which Dr Basu and the clinical psychologist had not already done. Dr Kerry appears to have thought that he was simply being asked to comment on the EEG results in Mr N's case. In fact, CCC had been asked to seek clarification as to the effects of Mr N's declining cognitive function on his capacity for gainful employment (as defined). The EEG results were simply cited as part of the available evidence relating to this.

28. CCC have placed considerable emphasis on the role which stress has played in Mr N's condition. Stress is an acknowledged trigger for the development and maintenance of the symptoms of Bipolar Affective Disorder. However, the cause of this condition is not yet established. It might be reasonable to say that the worsening of Mr N's condition over the period 2009 to 2011 was the result of stress. It does not follow that the removal or reduction in the levels of work-related stress would lead to an improvement in his condition. This is, to my mind, oversimplifying matters. It also ignores the fact that there were other factors at play in Mr N's case; as evidenced by the results of the cognitive functioning assessment undertaken by the clinical psychiatrist.

29. I note CCC's reference to Mr N's award of and continued receipt of ESA. He had provided evidence that he had been in receipt of ESA (support group) since leaving employment. I acknowledge that this, on its own, is not evidence that he meets the criteria for Tier 1 benefits. Mr N was given the opportunity to provide evidence of his ESA award because the previous IRMP had made specific reference to this in his report indicating it was relevant evidence he would consider. It is not, therefore, appropriate for CCC to then dismiss this evidence out of hand.

30. Whilst an award of ESA does not amount to evidence of *permanent* incapacity (as required by the LGPS regulations), it is evidence of Mr N's capacity for work at the time of the award. The fact that he had been awarded ESA in the support group indicated that, following a work capability assessment, the DWP had decided that his condition severely limited what he was able to do. The question for CCC then became one of Mr N's likelihood of recovery. It should have asked itself what was the likelihood of Mr N becoming capable of undertaking gainful employment for not less than 30 hours per week for not less than 12 months.

31. I do not find that the evidence shows that CCC have considered Mr N's eligibility for benefits under regulation 20 of the LGPS regulations in a proper manner. It has not shown that it has given due consideration to all of the available relevant evidence. Mr N has suffered injustice as a consequence because it is not yet clear that he is in receipt of the correct tier of benefits.

32. Therefore, I uphold Mr N's complaint.

Directions

33. I have given careful consideration as to what it would be appropriate for me to direct CCC to do in the circumstances. It remains the case that the decision is for CCC to make and the correct course of action is for me to direct it to review its decision.

34. In order to make a properly reasoned and supported decision, CCC requires relevant medical evidence. I acknowledge Mr N's concerns as to Dr Kerry's continued involvement. I do not find that further input from Dr Kerry is likely to assist CCC to reach a decision. I am not, therefore, directing CCC to seek any further comment from Dr Kerry.

35. I have come to the conclusion that Mr N's case is one of the very small number where advice from a specialist in his particular condition is likely to be of most help to the decision maker. I therefore direct CCC to obtain an opinion from a psychiatrist, as to the expected progress of Mr N's condition in terms of his cognitive functioning and capacity for employment. The psychiatrist should be asked to consider all the available evidence relevant to Mr N's condition. He/she should be asked to give a view as to Mr N's prognosis and his likely capability of holding down a job of 30 hours per week for 12 months of the year prior to the age of 65, viewed from the standpoint of his condition as understood in 2011.

36. CCC shall take steps to obtain the required opinion within 14 days of the date of this determination. It shall review its decision within a further 14 days of receipt of this additional advice, taking into account **all** of the relevant evidence. It shall then provide Mr N with a reasoned notice of its decision indicating what evidence it has taken into account, what weight it attached to the evidence and its reasons for doing so.

Karen Johnston

Deputy Pensions Ombudsman
19 October 2017

Appendix

Medical evidence

Dr Kerry, (8 August) 11 November 2015

> "I have undertaken this medical based on his records. I did offer him a face-to-face consultation but he declined this.
>
> I have reviewed copies of reports from his GP, Consultant Psychiatrist, Dr Basu, Lyle County Court records and the Ombudsman's report.
>
> [Mr N] … had seen his GP with variable movement, impulse behaviour and low mood and had been referred to the Crisis Team and also saw Dr Basu, Consultant Psychiatrist. He had been taking medication including …
>
> I have reviewed a report from Dr Basu … dated 6th May 2011 which indicates the extensive treatment he had received for his condition and was then diagnosed as Bipolar Disorder.
>
> I have also reviewed a report from the Clinic Psychologist concerning his performance. His working performance memory was below normal.
>
> I have reviewed a report from Dr Edmonds [GP] … dated 17th February 2012 which confirms he suffered from a severe mental health problem and he had been seen by Dr Basu. Dr Edmonds was of the opinion that there was no prospect of him being fit to return to work before the age of 65.
>
> I have reviewed a report from Dr Basu dated 28th March 2012 which details his condition and treatment. Dr Basu was of the opinion it would be extremely difficult to find a new job due to his cognitive ability.
>
> I have also reviewed the reports from previous Occupational Consultants.
>
> Having reviewed the information by his Psychiatrist, GP, Psychologists and the previous occupational reports I am of the opinion that he would not be fit to return to his previous employment due to the stress of the job. However, he would be fit to undertake other types of duties with lower levels of pressure and stress in the job such as Administrative Assistant, shop work, unskilled and semi-skilled manual labour. I am therefore of the opinion that although he is not fit to return to his previous job there is a possibility that before normal retirement he would be fit to return to employment."

Dr Kent, 1 October 2015

> "I have read the reports forwarded to me in relation to this case … I conducted a consultation with [Mr N] …
>
> In [Mr N's] case the reports indicate he had a history of mood swings dating back to his student days. The severity and frequency of the swings had clearly

been increasing to a crescendo in the period 2009-2011. The attacks had rendered him unable to work and culminated in his medical retirement. Throughout this period he benefitted from the continuity of care from an experienced consultant psychiatrist, Dr Basu.

From my study of these documents and having consulted with [Mr N] it is clear that a diagnosis of bipolar affective disorder has been firmly established … In addition neurological investigations have shown the presence of EEG abnormalities which are also consistent with this diagnosis. In addition psychological testing … supports the subjective history from [Mr N] which stated that he had difficulty concentrating, planning and carrying out executive mental functions. Thus it would be reasonable to take as honest the expressed mental difficulties he expressed in other reports and meetings …

[Mr N] first presented in … 2009 with symptoms of depression, erratic behaviour and anger outbursts. His depression symptoms dated back 2 years at that time. He was referred urgently … to Dr Basu … As the case progressed Dr Basu changed his diagnosis from depression to Bi-polar affective disorder …

His symptoms … continued despite these various treatments …

After several attempts to return to work in both phased and reduced hours and duties his employment … was terminated on grounds of ill health …

… A report … by Dr Parker … supported the view that a "tier 2" pension would be appropriate. It cited Dr Basu's lack of training in occupational health and the potential therapeutic benefits of continued employment. I would note that while both of these comments might have generic veracity neither could they be shown to have specific pertinence to the specific circumstances of [Mr N's] case. It could equally be argued that Dr Parker had no training in psychiatry and that Dr Basu was the physician best placed to judge [Mr N's] prognosis.

A report by Dr N Kerry on 8th August 2015 merely recites the medical records attached to the case. He does not attempt to demonstrate his reasoning or clearly review to [*sic*] facts of the case. There was no examination of [Mr N]. The conclusions are thus open to doubt.

My consultation with [Mr N] lasted over one hour. At interview he gave a coherent account of his illness consistent with the various reports cited above. He remains on treatment with … These make him drowsy and he is not able to stay awake all day and maintain full concentration throughout. He has some mild cognitive difficulties and finds it difficult to take in detailed information. At times he became weepy and emotional as he described his mental health symptoms. These included depression anxiety and panic attacks. He told me he had tried to apply for low skilled jobs such as shelf stacking or postal work

etc. However due to panic attacks he had not been able to attend for interviews. He remains subject to relapses of his depression …

[Mr N] suffers from an enduring and serious mental illness in the form of Bi-polar affective disorder. He is unable to discontinue treatment … without the risk of relapse. The medication continues to cause him significant side effects …

It is clear on my current assessment of [Mr N] today in 2015 that he remains unfit for work due to Bipolar-affective disorder. However the debate regarding which "tier level" of retirement he should receive relates to medical and other evidence available at the time of his retirement in 2011.

In reaching my opinion I have considered the following

1, [Mr N] was awarded ESA following an all work test in 2011. This was an independent and contemporary medical opinion. He continues to receive this award.

2, The clinical picture available to Dr Basu was of a patient with life long symptoms of mental health problems consistent with bipolar affective disorder which had increased in both severity and frequency in the period 2009-2011. Medical treatment was problematical due to side effects and compliance. It would not have been reasonable to anticipate an on going improvement of his condition in the period 2011 to 2024.

3, The test of gainful employment for 30 hours per week for 12 months would require a patient to be free of relapses and compliant with medication for 12 months. This had not been the case in the preceding 2 years that Dr Basu had known [Mr N].

4, The clinical psychology report indicated on going cognitive and functional impairment in the period 2009-2011. While not intended as an employment assessment as such, the skills tested were relevant to employability in all fields of work.

5, The several attempts to return to work in the period 2009-2011 which both failed and caused relapses in [Mr N's] mental health indicate not only that he was unfit for work but that to attempt to work would put his mental health at risk. This is an important consideration when assessing a patient's ability to rehabilitate back to work in the future as the risk in [Mr N's] case included a suicide attempt.

Taking these points into consideration at the time of the determination of [Mr N's] pension award I believe that there was no likelihood of him returning to the post of … Nor would he have been capable of working in a similar … capacity.

> At the time there was little or no possibility of been [*sic*] capable of gainful employment … in any other type of work until his retirement age of 65 years.
>
> This opinion was shared at the time by his psychiatrist in full understanding of his diagnosis, prognosis, compliance with treatment, psychological impairment and risk of relapse …"

Dr Kerry, 31 August 2017

> "Further to your letter concerning this gentleman's EEG, at the time of his medical his cognitive function was good. An EEG does not measure cognitive decline and for a measure of cognitive decline, this gentleman would require a full assessment by a Memory Clinic including mental test scores, MRI scan and possible EEG. Once he has undergone the full investigations by a Memory Clinic to confirm significant cognitive decline would I be willing to change my opinion regarding his fitness to undertake some type of employment before normal retirement age. An EEG on its own would not be used to diagnose cognitive decline."