PO-13922

Ombudsman's Determination

Applicant	Mrs K
Scheme	Local Government Pension Scheme (**LGPS**)
Respondent	Hertfordshire County Council (**HCC**)

Outcome

1. Mrs K's complaint against HCC is partly upheld, but there is a part of the complaint I do not agree with. To put matters right, for the part that is upheld, HCC shall pay Mrs K £500 for the significant distress and inconvenience she has experienced.

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

Complaint summary

3. Mrs K complains about the decision HCC has made regarding the tier of ill health early retirement (**IHER**) pension she is entitled to.

4. Mrs K has previously complained to The Pensions Ombudsman, and a final determination was issued directing HCC to reconsider Mrs K's claim. Mrs K's current complaint concerns HCC's decision on reconsideration.

Background information, including submissions from the parties

Background to the complaint

5. In November 2013, Mrs K referred her complaint to The Pensions Ombudsman. The facts surrounding this complaint have been determined and do not form part of this Determination.

6. On 18 September 2014, the previous Pensions Ombudsman, Mr Tony King, issued a final Determination upholding the complaint.

7. Mr King concluded that:-

- The independent registered medical practitioner (**IRMP**) who provided the medical certificate which certified that, in his opinion, Mrs K qualified for a Tier 3 benefit, had declared himself as being independent. However there was evidence that he had previously been involved in Mrs K's case.

- There was a lack of actual decision making by HCC. It seemed that HCC had blindly accepted the IRMP's opinion without knowing how the IRMP had reached his conclusion. The Ombudsman said:-

> "In order to give proper consideration to [Mrs K's] case, [HCC] would have needed to know more about Mr Bottrill's current views of a likely return to full time work. In his letter dated 9 October 2012 Mr Bottrill said that he hoped that with time [Mrs K] might return to full time duties but that she would need a careful phased return… He said that he hoped to get control of the vertigo in the fullness of time and I agree with [Mrs K] that it is unclear exactly what this term means.
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> By March 2013 he said that he doubted she would be able to achieve full time work within the next year but would hope "to be able to get her back into the work environment in the fullness of time…" But again it is not clear what he meant by this and whether getting her back into the work environment meant that he envisaged her working full time."

8. The Ombudsman, Mr King, made the following directions in his final Determination:-

> "I direct that, within 21 days of the date of this determination, [HCC] shall reconsider whether [Mrs K] was, at the time her employment ended, eligible for benefits under Regulation 20(2), obtaining the necessary certificate from an IRMP who meets the requirements under the 2008 Regulations. Having done so, they will provide [Mrs K] with a written decision setting out their reasons.
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> If [HCC] subsequently determine that [Mrs K] was eligible for Tier 1 benefits, she would be due the higher rate of benefit from 28 March 2013. [HCC] shall, therefore, pay her arrears (on the basis that she should have received Tier 1 benefit from 28 March 2013), together with simple interest at the rate quoted by the reference banks for the time being, from March 2013 to the date of payment.
>
> Within the same 21 day period, [HCC] shall also pay [Mrs K] £300 for the distress and inconvenience resulting from the failure to consider her for Tier 1 benefits in the proper manner."

9. Very shortly after the final Determination was issued, the 18 month Tier 3 benefit review fell due.

10. On 29 September 2014, HCC made arrangements to credit Mrs K's bank account with the £300 compensation which the Ombudsman had directed Mrs K be paid. However, around that time HCC learned that Mrs K was unable to attend an appointment with another IRMP until 18 December 2014. As such, HCC wrote notifying this Office that it would be unable to comply with the Ombudsman's direction to reconsider Mrs K's claim within 21 days of the date of the Determination.

11. Contemporaneous evidence suggests that in view of the requirement to reconsider Mrs K's eligibility for Tier 1 benefits, and carry out the 18 month review, HCC was trying to avoid the need for Mrs K to be inconvenienced by requiring her to attend two IRMP assessments.

12. On 8 October 2014, HCC wrote to Mr Bottrill requesting clarification of his earlier reports dated 9 October 2012, and 9 April 2013.

13. On 10 November 2014, HCC received further explanation from Mr Bottrill. Mr Bottrill provided details of further clinical assessments which had been carried out, subsequent to those detailed in his reports dated 9 October 2012 and 9 April 2013. In relation to these assessments Mr Bottrill said, "I referred her [Mrs K] to our unit in Oxford to try and get some objective measures of her vestibular function as she did not seem to be responding as patients classically do."

14. Mr Bottrill went on to say:-

> "With specific regard to the questions in your letter, as you are more than aware, Meniere's disease is a very capricious condition and my general experience is that following successful Gentamicin therapy, most patients are able to return to work and the qualifying factor is dependent on how well they compensate from vestibular loss and the physicality of their job. In general, someone having a very sedentary occupation would calibrate reasonably well and be able to function but if someone has a high degree of movement involved in their job, such as her original job as a nursery nurse, then it is more troublesome for them to compensate to allow that degree of movement. I would be surprised if she is unable to fulfil a sedentary occupation for 30 hours per week… I think an independent review from your perspective would be welcome as indeed I have asked for an independent review from the medical perspective as she does not seem to be following a classical pathway following Intratympanic Gentamicin."

15. On 18 December 2014, Mrs K, accompanied by her husband, attended an appointment with a new IRMP, Dr Haslehurst, who had not been previously involved with her case.

16. Dr Haslehurst's report was dated 5 January 2015. However, because Mrs K had requested a copy of the report prior to it being sent on to HCC, it was not until 4 February 2015 that HCC received the report.

17. In addition to confirming Dr Haslehurst's opinion that the original award of a Tier 3 pension was correct, the report said:-

> "I have not received a formal written referral but a verbal instruction to review [Mrs K's] application for ill health retirement. She was granted a tier 3 ill health retirement pension in April 2013. The level of pension has been the subject of a review by the Pensions Ombudsman…
>
> Because of the new symptoms [Mrs K] has recently experienced, her treating Specialist, Mr Bottrill, has requested a second opinion from another ENT [ear, nose and throat] Specialist at the John Radcliffe hospital in Oxford. [Mrs K] was seen by him on 11.12.14. At that appointment she was also seen by a Neurologist who further assessed her symptoms. A CT scan is to be arranged to exclude any other underlying pathology.
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> … I suggest that Mr Bottrill's most recent report is provided to the Trustees at the same time as my report and [Mrs K] agreed to this verbally.
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> I expect that the Trustee will require an update once [Mrs K] has been reviewed by the Neurologist at John Radcliffe hospital following her CT scan and suggest therefore that a final decision on which tier pension she is eligible for is deferred until that information is available."

18. Dr Haslehurst's report did not however, declare that she was submitting her report in the capacity of an IRMP not previously involved with Mrs K's case. Further, no certificate was enclosed with the report confirming Dr Haslehurst's opinion that the original decision to award a Tier 3 IHER benefit was correct.

19. On 5 February 2015, HCC requested through its occupational health provider, Optima Health, that Dr Haslehurst provide the IRMP certificate. HCC has said that Dr Haslehurst indicated that she would provide the relevant certificate but that she was waiting for further information from Mrs K's most recent consultation before the situation regarding the 18 month Tier 3 review could be confirmed.

20. Further correspondence between HCC and Optima Health followed until 14 May 2015, when Optima Health contacted HCC to say that due to an administrative error, Dr Haslehurst had failed to appreciate that she was to review Mrs K in her capacity as an IRMP and, as she had now assessed Mrs K, it was no longer appropriate for her to issue an IRMP certificate.

21. On 15 May 2015, HCC instructed a further IRMP, Dr Irons, to undertake a paper based review of Mrs K's medical records and provide a report. HCC said this decision was taken as, "HCC was concerned that [Mrs K] should not be required to attend any additional appointments, especially given the length of time that had already elapsed."

22. On 1 July 2015, HCC received a copy of Dr Irons' report and certificate which were dated 18 June 2015. Relevant extracts from Dr Irons' report are provided in Appendix 1. In his report Dr Irons attested that he was acting in his capacity as an IRMP who had not previously been involved in Mrs K's case and that he had, "been asked to conduct a reassessment of this lady's pension decision from 28 March 2013."

23. On 21 July 2015, HCC issued its reconsideration decision. This was to decline Mrs K's application for Tier 1 benefits. Relevant extracts from HCC's decision letter are provided in Appendix 2.

Summary of Mrs K's position

24. The representative acting on Mrs K's behalf has made comprehensive submissions setting out Mrs K's position. However, it is not necessary to detail each individual point that has been made.

25. In summary, Mrs K considers that HCC has not followed the previous Ombudsman's final Determination and has not directed itself properly when reconsidering her IHER claim.

Summary of HCC's position

26. HCC's position can be summarised as:-

- HCC's reconsideration had to consider Mrs K's position as at 28 March 2013, therefore any subsequent deterioration in Mrs K's health is not relevant to the decision. Similarly any medical opinion subsequently received is only relevant insofar as it relates to the likelihood of Mrs K's future employment at the time her employment ended.

- HCC's new decision, based on Dr Irons' opinion, is that at the time Mrs K's employment ended, she would not have been capable of discharging efficiently the duties of her role and would not be capable of undertaking gainful employment within the next three years, but would, on the balance of probabilities, be likely to be capable of undertaking gainful employment at some point thereafter and before her normal retirement age.

- Mrs K's case was considered under the LGPS's two stage internal dispute resolution procedure (**IDRP**). The stage two IDRP decision, extracts from which are provided in Appendix 3, gave more detail about the rationale for HCC's decision.

Adjudicator's Opinion

27. Mrs K's complaint was considered by one of our Adjudicators who concluded that some further action was required by HCC. The Adjudicator considered that there were three main issues to consider:-

    1) Did HCC follow the directions set out in The Pensions Ombudsman's final Determination dated 18 September 2014?

    2) Did HCC direct itself properly when reconsidering the IHER decision?

    3) If HCC did not direct itself properly, has HCC subsequently redressed this maladministration or does HCC need to do more to put matters right?

28. The Adjudicator's findings are summarised briefly below:-

    Did HCC comply with the final Determination?

    - HCC has accepted that the Ombudsman's Determination was not followed insofar as the reconsideration was not completed within 21 days of the date of the Determination. HCC says this was due to circumstances outside of its control.

    - Shortly after the Determination was issued, HCC contacted Mrs K to pay the compensation and arrange for an assessment with another IRMP. However, it was not until 18 December 2014, after the 21 day deadline, that Mrs K was able to attend another appointment with the IRMP.

    - HCC's failure to reconsider Mrs K's claim before 9 October 2014, was not due to circumstances it could control. HCC started work to reconsider the claim before the deadline expired, so it was clearly HCC's intention to comply with the Ombudsman's directions and act in line with the spirit of the Determination.

    - Dr Haslehurst's report of the assessment with Mrs K on 18 December 2014, was produced on 5 January 2015. In view of the Christmas bank holidays this was not an excessive length of time to produce the report. Further, because Mrs K had requested a copy of the report prior to it being sent on to HCC, as she was entitled to do, HCC did not receive the report until 4 February 2015. This delay was outside of HCC's control.

    - Dr Haslehurst's report said, "I have not received a formal written referral but a verbal instruction to review [Mrs K's] application for ill health retirement." This does not set out the scope of what Dr Haslehurst was engaged to do and HCC has not produced any evidence of the specific instructions it gave Dr Haslehurst. Consequently it is unclear what HCC instructed the IRMP to do. Dr Haslehurst's report details the recent treatment Mrs K was having and recommended that HCC should wait for the results of the CT scan and Neurologist's report from the recent appointment Mrs K had at John Radcliffe Hospital. This is evidence that Dr Haslehurst was not clear on the fact that she was being required to make an assessment as to Mrs K's prognosis as at 28 March 2013, otherwise there is no

logical reason why Dr Haslehurst would take Mrs K's latest medical reports into consideration.

- It is likely that Dr Haslehurst's misunderstanding stemmed from HCC's failure to provide a clear instruction of what it required her to report on. This view is supported by the fact that Dr Haslehurst did not declare that she was acting in the capacity of an IRMP and that the report was not accompanied by the appropriate medical certificate.

- HCC should have directed Dr Haslehurst properly in the first instance, preferably in writing. However in this case it is not clear that she was given clear instructions. The failure by HCC to provide a clear instruction to its IRMP amounts to maladministration.

- HCC has said Dr Haslehurst was subsequently unable to certify that she was acting as an IRMP. This, HCC says, resulted in the need to commission a further report from another IRMP, Dr Irons. However this could have been treated as an administrative oversight at the time, with Dr Haslehurst being asked to provide a certificate based on her previous assessment. There is nothing in the Regulations which would preclude HCC from seeking clarification of an IRMP's opinion or requesting a certificate be completed if this has been overlooked.

- HCC issued its reconsideration decision around three weeks after receiving Dr Irons' report on 1 July 2015. This is not an unreasonable length of time in which to consider all of the evidence and make the decision.

- HCC's maladministration, which resulted in the need to appoint a further IRMP, caused an avoidable delay between 4 February 2015, when HCC received Dr Haslehurst's report and 1 July 2015, when it received Dr Irons' report. This delay, of nearly five months, is bound to have caused Mrs K significant distress and inconvenience.

Did HCC direct itself properly when reconsidering the IHER decision?

- The Ombudsman's final Determination directed HCC to reconsider Mrs K's claim as at 28 March 2013. This means that any deterioration (or indeed improvement) in Mrs K's condition after this date is an irrelevant factor and cannot be taken into account when reconsidering the decision. Further, the Ombudsman was explicit in setting out his expectations of HCC saying, "in order to give proper consideration to [Mrs K's] case, [HCC] would have needed to know more about Mr Bottrill's current views of a likely return to full time work" and, "it is not clear what he meant by this and whether getting her back into the work environment meant that he envisaged her working full time."

- HCC did take appropriate steps to seek clarification from Mr Bottrill. It wrote to him on 8 October 2014, asking him to clarify the comments made in his reports dated 9 October 2012 and 9 April 2013. Relevant extracts from HCC's letter are provided in Appendix 4.

- Mr Bottrill replied in November 2014 saying, "With specific regard to the questions in your letter…" he then goes on to explain that his, "general experience is that following successful Gentamicin therapy, most patients are able to return to work". In relation to Mrs K, Mr Bottrill said, "I would be surprised if she is unable to fulfil a sedentary occupation for 30 hours per week."

- Although Mr Bottrill opined on Mrs K's ability to work for 30 hours per week, he did not also pass comment on her ability to work this number of hours, for at least 12 months, which is the definition of 'gainful employment' in the Regulations. But the Ombudsman's Determination did not direct HCC to obtain Mr Bottrill's opinion on whether he considered Mrs K met the threshold for 'gainful employment' under the Regulations. Further, Mr Bottrill's opinion was not solicited in the role of an IRMP, so in providing his opinion, he was not required to make a statement as to whether or not Mrs K would meet the IHER conditions under Regulation 20, that is a matter for the IRMP appointed by HCC. In any case however, HCC did provide Mr Bottrill with a definition of what gainful employment is, under the Regulations, so his response needs to be considered in the context that he was aware of what the relevant definition was.

- Mr Bottrill's report dated 9 April 2013, said, "We are continuing to monitor her on a three monthly basis and she may well require further Gentamicin injections if her disease activity is not controlled." This statement is indicative of the fact it was Mr Bottrill's expectation, in April 2013, that further Gentamicin injections could be expected to bring Mrs K's condition under control. The evidence suggests that at this stage, Mr Bottrill had no reason to suspect that Mrs K would not follow the usual path to recovery which would be expected following Gentamicin treatment.

- From further correspondence, it seems apparent that by 2014, Mr Bottrill had identified that Mrs K was not, "following a classical pathway following intratympanic Gentamicin." However for the purpose of HCC's reconsideration decision this was 'new' knowledge insofar as in March 2013, it was anticipated that Mrs K's condition would improve with Gentamicin treatment. Whilst unfortunate, the fact that Mrs K's condition did not improve following Gentamicin therapy only came to light after 28 March 2013, this being the relevant date for consideration. Consequently the fact that Mrs K did not respond to the treatment is an irrelevant factor that cannot be taken into account by HCC. Thus it is reasonable for HCC to have interpreted Mr Bottrill's statement that he would be surprised if Mrs K would be unlikely to work for 30 hours per week in a sedentary role, against his general understanding of a typical person with Meniere's vertigo.

- In addition to seeking clarification from Mr Bottrill, HCC also appointed another IRMP, Dr Irons, to review Mrs K's file. In his report, Dr Irons attested that he was an IRMP with no prior involvement in Mrs K's case. Dr Irons also set out that he had, "been asked to conduct a reassessment of [Mrs K's] decision from 28 March 2013." Dr Irons therefore met the requirements of Regulations and applied the correct test.

- Dr Irons conducted a paper based review of Mrs K's medical notes, as opposed to examining her in person. But, because Dr Irons was considering the position as at March 2013, it is likely he had sufficient information available to come to a well-reasoned opinion. If this was not the case however, and Dr Irons did not feel able to come to an opinion on Mrs K's likely prognosis without a physical examination, it is likely that he would have requested an appointment with Mrs K.

- Dr Irons considered Mrs K's prognosis using only information that was available at the time of the original IHER claim. Unlike Dr Haslehurst's report, Dr Irons did not rely on information which came to light, subsequent to Mrs K's dismissal, when forming his opinion.

- Much like the original IRMP report, which was subject to a complaint and Determination by the Ombudsman, Dr Irons identified that Mr Bottrill considered that, "a more sedentary office based job may well be a possibility for [Mrs K] once her disease process is under control," and that, "in the fullness of time [Mrs K] may be able to get back into the work environment." Dr Irons also commented, "…it would appear that the treating clinicians were hopeful that improvement in [Mrs K's] symptoms could be achieved and which would allow a return to duties although some suggestions regarding restrictions, at least in the initial phases would be advisable."

- Dr Irons concluded that although Mrs K was considered, in March 2013, to be permanently incapable of discharging the duties of her employment, she was likely to be able to undertake gainful employment before her normal retirement age. The relevant test for eligibility for Tier 1 benefits under the Regulations is that there is, "no reasonable prospect of being capable of undertaking any gainful employment before normal retirement age." So Dr Irons' view that Mrs K did not qualify for Tier 1 benefits is consistent with the interpretation of the Regulations.

- In determining whether there is "no reasonable prospect" of the individual being able to carry out gainful employment before their normal retirement age, the decision maker is required to apply an objective test on the balance of probabilities. It is not a test of whether relevant work is likely to be available in the current market, but it does require an assessment of the personal abilities and disabilities of the particular individual and a consideration of how those affect their ability to do work for which they are or could become skilled.

- In 2013, the general medical consensus was that Mrs K would respond, as patients typically do, to Gentamicin treatment. On this basis it was reasonable for Mrs K's prognosis to be assessed in line with how Mr Bottrill and Dr Irons would expect a typical person with Meniere's Vertigo, undergoing Gentamicin treatment, to respond. Both Mr Bottrill and Dr Irons report that the usual prognosis is that symptoms will dissipate over time and that with successful treatment a return to work, albeit into a role which is sedentary in nature, is possible. On this basis it was not necessary for HCC to give thorough consideration to the efficacy of any untried treatments.

- Although HCC's decision to decline Mrs K's IHER claim was not irrational nor was it was unsupported by, or contrary to, the available appropriate evidence, HCC's reconsideration decision, dated 21 July 2015, provided little in the way of explanation as to how its decision had been reached. The decision merely repeats Dr Irons' opinion without any demonstrable evidence that HCC has made its own decision, similarly there was no explanation of the rationale for HCC's decision. HCC did not properly explain the reasons for reaching the decision it came to, which amounts to maladministration.

Has HCC provided adequate redress for its maladministration?

- The stage one IDRP decision correctly identified that any subsequent deterioration in Mrs K's health is not relevant to the decision. Further, that any medical opinion subsequently received is only relevant insofar as it relates to the likelihood of Mrs K's future employment at the time her employment ended. However the stage one response provided little more explanation for how HCC had made its decision.

- The stage two IDRP decision did provide further detail about the rationale for HCC's decision. From the IDRP stage two response it is clear that HCC had weighed up all of the relevant evidence (and nothing irrelevant) and had come to an independent decision as to Mrs K's eligibility for Tier 1 benefits. Mr Bottrill and Dr Irons' opinions that eventual recovery and a return to work being likely was qualified by the fact that in 2012, Mrs K was able to undertake a phased return to work following what had been a successful course of treatment. So HCC has explained why it had preferred Mr Bottrill and Dr Irons' opinions over the views of Mrs K's GP and hearing therapist.

- HCC also referenced the fact that the usual prognosis for most Meniere's patients is a recovery and commented that in view of Mrs K's age and her time to normal retirement age, that it considered it likely that Mrs K would be able to undertake gainful employment. Thus, HCC adequately explained why, on balance, it reached the decision it did.

- The stage two IDRP decision provided adequate redress for HCC's maladministration caused by its failure to properly explain its reasons, on reconsideration, for declining Mrs K's IHER claim. However, HCC had also acted in maladministration by causing an avoidable delay in appointing a new IRMP to

reconsider Mrs K's claim. This caused Mrs K significant distress and inconvenience and suitable redress had not been provided, the Adjudicator recommended that HCC pay Mrs K £500 in recognition of this.

29. Mrs K did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mrs K provided her further comments, which are summarised below:-

- Mrs K accepts the finding of maladministration in relation to the delay in obtaining the IRMP report and issuing the reconsideration decision. She accepts the £500 compensation recommended by the Adjudicator in recognition of this. However, Mrs K considers that further compensation ought to be awarded to reflect HCC's failure on reconsideration, and at stage one of the IDRP to properly explain the reason for its decision.

- HCC's comment that Mrs K was, "able to undertake a phased return to full time duties following an initially successful course of treatment" is incorrect. Mrs K was not able to successfully return to work, she was unwell during this period with her condition worsening to the point that she was unable to work and was dismissed.

- In the stage two IDRP decision, HCC has relied on the opinion of Dr Haslehurst who was not properly instructed by HCC and who based her opinion on evidence which came to light after 28 March 2013, this being the relevant date for consideration. HCC is incorrect to, on the one hand take Dr Haslehurst's opinion into consideration but, on the other, to ignore the evidence provided by Mrs K which came to light after March 2013.

- HCC has not sufficiently questioned the inconsistencies with Dr Irons' report which were identified by the Adjudicator in his initial view about the complaint.

- HCC has not asked the correct questions of Mr Bottrill when it asked him to clarify his report dated 9 October 2012. It ought to have identified that when Mr Bottrill referred to, "the fullness of time" this was in fact linked to the phased return to work which failed.

- The Adjudicator's Opinion does not address the evidence provided by Dr Crewe-Brown which provides an independent assessment of Mrs K's condition at the time of her dismissal in March 2013.

30. Mrs K's further comments do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Mrs K for completeness.

Ombudsman's decision

31. My role is not to replace HCC as the decision maker and decide whether Mrs K is eligible for IHER. My role is to decide whether the correct process has been followed resulting in a reasonable decision.

32. I acknowledge that Mrs K's phased return to full time duties was unsuccessful insofar as she was ultimately dismissed. However nothing turns on this point. It was not disputed that, at the time of her dismissal, Mrs K was incapable of carrying out her duties. Indeed she was awarded Tier 3 benefits on this basis. What matters is whether there was any reasonable prospect of her being capable of gainful employment before reaching her normal retirement age.

33. In this case both Mrs K's own specialist physician and HCC's IRMP were of the view that a return to gainful employment would be possible. On this basis I cannot conclude that HCC has reached a decision which no reasonable decision maker would come to when provided with the same facts.

34. I agree that HCC was incorrect to take Dr Haslehurst's opinion into consideration when issuing the stage two IDRP decision. Dr Haslehurst based her opinion on information which came to light after the relevant date for consideration. Consequently this is irrelevant for the purposes of HCC's decision. However, I do not find that the fact it did so, renders its eventual decision incorrect. In Batt v Royal Mail [2011] EWHC 900 (Ch), Mr Justice Briggs concluded that procedural irregularities do not necessarily invalidate the eventual decision.

35. The Adjudicator initially considered that Dr Irons' report ought to have considered the alternative treatments available to Mrs K and the efficacy of such treatments. But I do not consider this to be relevant. In March 2013, the medical consensus was that a typical person with Meniere's vertigo would respond positively to Gentamicin treatment, such that a return to work would be possible. To award Tier 1 benefits, HCC would need to be satisfied that there was no reasonable prospect of Mrs K being able to return to work before her normal retirement age. So, although Dr Irons identified that Mrs K was, "resistant to treatment," I do not find that HCC was wrong to conclude that a return to work may be possible.

36. I am satisfied that HCC's request clearly set out the points it wanted Mr Bottrill to elucidate, provided a suitable definition for 'gainful employment' and made it clear that Mr Bottrill was to provide his opinion based on what was known in March 2013. I do not find that HCC has directed itself improperly in this regard.

37. I do not find that HCC should have taken into consideration the evidence of Dr Crewe-Brown. This is dated 11 July 2017, so evidently will not have been available to HCC at the time of the reconsideration decision or at the time of the IDRP.

38. I note Mrs K's comments that she ought to be compensated for the HCC's failure on reconsideration, and at stage one of the IDRP to properly explain the reason for its decision. However, I conclude that, taking everything into consideration, £500 is adequate compensation for the overall distress and inconvenience Mrs K has suffered.

39. Therefore, I uphold Mrs K's complaint in part.

Directions

40. To put matters right for the part of the complaint which is upheld HCC shall, within 14 days of the date of this Determination, pay Mrs K £500 for the significant distress and inconvenience that she has suffered.

Anthony Arter

Pensions Ombudsman
18 December 2017

Appendix 1

Relevant extracts from Dr Iron's report dated 18 June 2015

"In a report dated 9 April 2013 Mr Bottrill is advising that her condition is "proving very difficult to control" and "it is impossible to predict in the long term how long this is going to settle, but a job that requires a lot of physical movement such as dealing with young children will prove extremely challenging whereas a more sedentary office based job may well be a possibility for [Mrs K] once her disease process is under control." Mr Bottrill did not think this was achievable within the next year, but felt that "in the fullness of time she may be able to get back to the work environment."

It seems that by this stage it was apparent [Mrs K's] symptoms were proving difficult to treat and the prospect of her returning in a meaningful capacity to her original role was unlikely.

It is the nature of her diagnosed condition that her symptoms may settle and diminish, however, it is difficult to predict when this will occur. Symptoms can fluctuate meaning that attendance and absence can be both sporadic and unpredictable. At this point she had now had debilitating symptoms for a number of years which were resistant to treatment. Although recovery is not accurately predictable with this condition the enduring nature of her symptoms would lead me to believe that this is now a long term condition. If further treatment options were considered and were successful there would still be significant recovery and rehabilitation required.

Given the above, and taking into consideration this lady's age at the time of IHR [ill health retirement] assessment, I believe it is reasonable to come to the conclusion that she would not be capable of undertaking gainful employment within the next three years, but is likely to be able to undertake gainful employment at some time thereafter and before her normal retirement age. This would equate to a Tier 2 award."

Appendix 2

Relevant extracts from HCC's reconsideration decision dated 21 July 2015

"On behalf of the Council, as your former employer, I have considered the medical evidence, in particular a report and certificate from Dr Greg Irons, an Independent Registered Medical Practitioner for the purposes of the Regulations dated 18 June 2015. I have decided that at the date of termination of your employment (28 March 2013) on the balance of probabilities you were incapable, due to ill health or infirmity of mind or body, of discharging efficiently the duties of your former employment and were not capable of undertaking gainful employment within the following three years, but were likely to be capable of undertaking gainful employment at some time thereafter and before your normal retirement age.

This means that you meet the criteria for Tier 2 ill health retirement benefits, Therefore the 28 March 2013 will be treated as your normal retirement date and from that date 25% extra membership will now be added to your total membership of the LPGS Pension Scheme between that date and the date on which you would normally have retired.

I will therefore inform the London Pensions Fund Authority ("the LPFA") of this outcome and ask them to put your pension in payment backdated to 29 March 2013."

Appendix 3

Relevant extracts from HCC's stage two IDRP decision

"Having carefully reviewed the medical information available, I consider that on balance, the evidence does not demonstrate that, at the Relevant Date, you had no reasonable prospect of returning to gainful employment at some date before your normal retirement age, I am basing this conclusion on:

- The fact that in 2012, some 4 years or so after your initial diagnosis, you were able to undertake a phased return to full time duties following an initially successful course of treatment.
- The information and prognosis provided by Mr Bottrill (Consultant Otolaryngologist) that the prognosis for most sufferers of Menieres Disease, following a period of treatment is a return to work albeit in generally sedentary occupations.
- The report provided by, Dr Jill Haslehurst that it is the usual prognosis of Menieres Disease for the symptoms that cause distress (nausea, vertigo etc.) to dissipate over time.
- Dr Haslehurst's view is that it was not possible to state that your symptoms are permanent and would continue until your normal retirement age.
- The Report and Certificate of Dr Irons who set out that although any recovery from Menieres Disease is not accurately predictable give [sic] your age at the date of assessment, it was likely that you would be able to undertake gainful employment before your normal retirement age.

I have balanced these views with the views expressed by both Sue Bryan, who has stated that: your recovery and rehabilitation would be prolonged; that it would be difficult to state how long it would take before there was any significant improvement and that you may never manage a 30 hour contract.

I have also considered the views of your GP (Dr M Ojo-Aromokudu) who has said that you will find it difficult to find gainful employment and in support of your current IDRP 2 application that 'it is unlikely that [you] will be able to return to gainful employment in the future'."

Appendix 4

Relevant extracts from HCC's letter to Mr Bottrill dated 8 October 2014

"I would like to further clarify if possible your letters of 9th October 2012 and 9th April 2013 where you say you hope she may return to work in 'the fullness of time'. Did you think that was likely on balance to be within the next three years (from April 2013), or between three years and normal retirement age, or after normal retirement age. Please note by work, I refer to any work and at least 30 hours per week for a year. We acknowledged that a return to her former role was unlikely.

I note in October 2012 you confirmed that she is not capable of performing her job as a full time nursery nurse but with time you would hope her balance system recalibration will take effect but she will need a careful phased return to full duties. You referred also to 'in the fullness of time' in getting control of the vertigo. Are you able to say on balance whether you thought this likely to be within the following three years?

…

We have arranged independent review of the decision and are seeking clarification of the points above regarding timescale for 'fullness of time' as this was raised by the pension ombudsmen [sic] as a point.

Please note all decisions refer to her at March 2013."