PO-15214

Ombudsman's Determination

Applicant	Mrs T
Scheme	Local Government Pension Scheme (**the Scheme**)
Respondent	East Dorset District Council (**the Council**)

Complaint Summary

Mrs T's complaint, in her capacity as the executor of her late husband's estate, is that Mr T was incorretly refused ill health retirement when his employment ended in 2011.

Summary of the Ombudsman's Determination and reasons

The complaint should upheld against the Council as it failed to make a properly informed decision on Mr T's ill health application.

Detailed Determination

Material facts

1. Mr T was employed by the Council as a full-time supervisior in a refuse and cleansing depot. He went on sickness absence in November 2009 with a functional neurological disorder. He briefly returned to work in November 2010 but was unable to manage working reduced hours and duties.

2. On 30 November 2010, Dr Hodges (Consultant Occupational Health Physician), wrote to the Council's Personnel Manager and said that she could not see Mr T regaining his LGV status. While he was fit to drive his own car, there were implications for him driving Council vehicles from an insurance point of view.

3. In December 2010, Mr T applied for ill health retirement. At that time the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (SI2007/1166) (as amended) (**the 2007 Regulations**), applied. Extracts from the relevant regulations are provided in Appendix 2.

4. In January 2011, Mr T enquired about the possibility of early retirement if his ill health application failed. The same month he was awarded a State Disability Living Allowance (**DLA),** care component at the lowest rate, by the Department for Work and Pensions.

5. Dr Gibbins, an independent registered medical practitioner (**IRMP**) at Dorset Community Health Services (**DCHS**), was asked to give his opinion on Mr T's ill health application. OH Pounberry say Dr Gibbins was given access to Mr T's Occupational Health file.

6. In his report Dr Gibbins said it was unlikely that Mr T would remain permanently incapable of fulfilling his supervisory role. His report and a summary of other medical evidence pertaining to Mr T's case is provided in Appendix 1.

7. On 1 March 2011, the Council wrote to Mr T informing him that it had been advised by DCHS that it did not consider at the present time that he met the necessary criteria for ill health retirement. Mr T did not appeal the decision.

8. In April 2011, Mr T's employment ended on grounds of incapability due to ill health and the Council approved Mr T's request for the early payment of reduced retirement benefits.

9. Mr T never worked again. Over subsequent years his illness got worse and other complications arose. In September 2012, he suffered an acute myocardial infarction and was hospitalised with pneumonia. Later he had valves inserted into his lung to treat emphysema. In August/September 2015, an aneurysm and cancer was discovered. Sadly he died on 5 October 2015.

Summary of Mrs T's position as represented by Mr H.

10. Mr H says:-

- Mr T accepted the Council's decision as he was a trusting individual with low academic achievement.
- When his employment was terminated it is clear that his treatment had not been exhausted and the investigation was not complete. But this was not taken into account by the Consultant Occupational Physician (Dr Hodges), or the Council.
- As the root cause of Mr T's condition was unclear Dr Hodges should not have assumed that it was a treatable condition. This is supported by the fact that Mr T never recovered.
- Dr Woollard's (Mr T's GP) opinion, in his letter of 20 December 2010, that it was impossible to say whether Mr T would be fit for his job in the future, does not appear to have been considered by Dr Hodges. If this caused Dr Hodges a dilemma between professionals she should have called for a further 'face to face' examination by a professional in January 2011, before sending all the evidence to Dr Gibbins.
- The Council's decision was invalid because it failed to obtain a certificate from Dr Gibbins, as required under regulation 20 (of the 2007 Regulations), prior to turning down Mr T's application. The case should therefore be referred back to the Council to consider again after obtaining the certified opinion of another IRMP.
- While Dr Gibbins stated that Mr T could have returned to work he did not take into consideration the definition of 'gainful employment'. If every doctor had been asked whether Mr T could have achieved gainful employment in January 2011, their responses would have differed from "Likelihood the condition will resolve at some point " (Mr Gibbs 29 June 2010), or "We should be optimistic about the future" (Dr Woollard 3 August 2010).
- It is not clear from Dr Gibbins' report that he correctly evaluated the term "discharging efficiently" the duties of Mr T's current employment. Dr Gibbins only used the words "permanently incapable". Mr T's job description (which was sent to Dr Gibbins) included, driving large Council waste lorries and machinery on the road and around the yard. To do that he required the appropriate LGV licence. But the medical evidence was that Mr T would not have been able to regain it.

  Dr Woollard said, in his letter of 17 June 2010, that Mr T was not well enough to work or drive. A 1 July 2010 email said, Mr T was still experiencing spasms. On 5 July 2010, Dr Hodges said that such illnesses were extremely difficult to treat. Dr Karadimova noted on 6 September 2010, that Mr T's "involuntary spastic movements", were made worse by "sensory overload". After briefly returning to

work the Personnel Officer commented, in an email to Dr Hodges dated 24 November 2010, that Mr T's spasms in his arms and hands had returned. On 29 November 2010, Dr Hodges said that Mr T's return to work was premature and the diagnosis had not changed. The next day, in a letter to the Council, she said she could not see Mr T regaining his LGV status and that undue stress was likely to aggravate his symptoms. On 20 December 2010, Dr Woollard noted that Mr T's twitches were quite severe and that he was totally unable to multitask and said it was impossible to say whether Mr T would be fit for his old job again in the future. On 28 January 2011, Dr Hodges wrote that Mr T had bizarre presentation and choreiform movements and when she had reviewed him on 3 November 2010, that he had said he had difficulty concentrating and could not do anything if there was any noise in the background.

- Dr Hodges' comments, in her letter of 28 January 2011 to OH Poundbury, would have tainted the independence of Dr Gibbins' opinion. Consequently, the only fair way forward is for the case to be re-examined without the new IRMP being led in any direction.

- There is disparity in the medical evidence presented to Dr Gibbins. The Personnel Officer's letter, of 24 January 2011 to OH Poundbury, said that Mr T had briefly returned to work in November 2010, after being absent since November 2009, his condition had been diagnosed as a functional neurological disorder and enclosed a copy of Mr T's absence history for the last three years. But it appeared from Mr T's occupational health file that it was in 2006 and before that he had begun to suffer health problems. Dr Gibbins only appeared to have had the last three years of notes when making his assessment and therefore was not aware of Mr T's earlier medical history. In particular that, in 2006, Mr T had been suffering from emphysema, had had shortness of breath on exertion for over five years, and had been diagnosed with hyper-structive pulmonary disease with irreversible areas of obstruction.

- The medical evidence that Dr Gibbins considered appeared to have been limited to letters from the summer of 2010, not the most up to date reports on Mr T's condition. These would not have mentioned Mr T's other ailments and history going back to 2006, or commented on his relapse (as the commenting doctors would have been unaware of it).

- Dr Gibb's and Dr Woollard's comments on recovery refer to "persuasion treatment". Both were following medical procedure rather than giving a long term prognosis. This was misunderstood by the Council and therefore wrongly weighted. Mr T's treatment had not concluded and he had not been fully diagnosed.

Summary of the Council's position

11. The Council says:-

- Mr T died of conditions other than the condition which caused him to be unable to do his job. It could not predict these other conditions or his life expectancy.

- Mr T's GP said he could not say whether Mr T's condition would improve or not. However, the Occupational Health advisor felt it would improve to do some form of work. While Mr T was employed as a driver of a vehicle; and as such there were much tighter restrictions, that was not to say that Mr T could not have performed another job, not including driving, at a future date.

- The Occupational Health advice it received was clear. Mr T had been off work for a very long time and it was following its lengthy process, a decision had to be made.

- It always takes Occupational Health advice over GP advice as the former is more understanding of the role an employee undertakes.

- The case review falls outside of the timescales criteria (this is now 6 years later) and Mr T's intelligence level should not be a consideration.

- Its process was followed and Mr T had the right of appeal. Each step was explained to him and his wife, who was present at some of the meetings that took place.

12. Various medical evidence has been submitted pertaining to Mr T's health after he left the Council. As it does not refer to his condition around the time of his dismissal from the Council it is not relevant to the complaint that The Pensions Ombusman has agreed to investigate.

Conclusions

13. Firstly, it is not my role to review the medical evidence and come to a decision as to Mr T's eligibility for payment of ill health retirement benefits under the 2007 Regulations. I am primarily concerned with the decision making process. The issues considered include: whether the relevant rules have been correctly applied; whether appropriate evidence has been obtained and considered; and whether the decision is supported by the available relevant evidence. The weight which is attached to any of the evidence is for the Council to decide, including giving some of it little or no weight. But if the decision making process is found to be flawed, the appropriate course of action is for the decision to be remitted for the Council to reconsider.

14. It is accepted that Mr T could not do his job when he was dismissed. However, to be eligible for ill health retirement at that point, regulation 20 required the Council to decide, after obtaining the certified opinion of an IRMP, whether Mr T passed a two-stage test. Namely, on the balance of probabilities, he had to be deemed:

- permanently (that is to age 65) incapable of discharging efficiently the duties of his employment with the Council; and
- have a reduced likelihood of being capable of undertaking gainful employment (paid employment of not less than 30 hours per week for a period of not less than 12 months) before his normal retirement age. The level of benefit (that is Tier 1, 2 or 3) is subject to the prospect of his obtaining gainful employment before age 65.

15. The Council says it always takes Occupational Health advice over GP advice as the former is more understanding of the role an employee undertakes. While it is open to the Council to prefer evidence from its own medical advisers it should not do so blindly, or if there is a cogent reason why it should not, or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant rules by the medical adviser.

16. Mr Smith says Dr Hodges' comments, in her letter of 28 January 2011, would have tainted Dr Gibbins' opinion. But this is mere conjecture. The fact that Dr Gibbins did not support Mr T's application is not evidence that his opinion was tainted by Dr Hodges' comment, that it had been explained to Mr T that his application for ill health retirement was very weak.

17. Dr Gibbins does not appear to have certified his opinion. This is contrary to the requirement under regulation 20(5), before an Employing Authority makes its decision.

18. His report, of 28 January 2011, is very brief.

19. OH Poundberry say Mr T's Occupational Health file was made available to Dr Gibbins. But it is not clear from the report that he considered all the available medical evidence. In the report he says his assessment has been undertaken with reference to reports from Mr T's Consultant Occupational Physician, General Practitioner, two Consultant Neurologists and a Consultant Psychiatrist. However, he does not name the doctors, or list or date the reports he considered.

20. Dr Gibbins notes that Mr T has been troubled by intrusive and distressing symptoms which have adversely affected his ability to undertake his normal duties and responsibilities and have led to his sickness absence. That there is no evidence of any serious underlying organic cause for his diagnosed functional neurological disorder and that a spontaneous improvement in his condition was not sustained. Dr Gibbins then says it is difficult to give any prognosis but, as there remained a further ten years before Mr T reached his normal retirement age, on balance he did not consider Mr T would remain permanently incapable of being able to fulfil his supervisory role.

21. However, Dr Gibbins did not explain why he was of that opinion and the Council did not ask him. Consequently, the Council accepted Dr Gibbins opinion without knowing

why he considered Mr T would be capable of resuming his duties at some point before age 65.

22. An integral part of Mr T's job was driving Council vehicles (waste lorries and machinery) on the road. When he briefly returned to work his LGV license had not been renewed. Following his return to sickness absence Dr Hodges said to the Council's Personnel Manager that she could not see Mr T regaining his LGV status. It is therefore unclear why Dr Gibbins considered Mr T would be capable of resuming his supervisory duties before age 65.

23. The Council say the Occupational Health advisor felt Mr T's health would improve to a sufficient extent to enable him to be capable of some form of work. But Dr Gibbins opinion did not go that far. His opinion was that Mr T would be capable of returning to his supervisory role. He did not comment on Mr T's capability for other work.

24. On balance it is not clear that Dr Gibbins gave proper consideration to Mr T's application before giving his opinion. Equally, by accepting Dr Gibbins opinion without asking the IRMP to confirm the medical evidence he had considered, clarify his opinion and submit his certification, the Council failed to make a properly informed decision.

25. Consequently, I remit the matter back to the Council to reconsider its decision.

Directions

26. Within14 days of the date of this determination, the Council shall request the opinion of another IRMP as to whether Mr T satisfied the criteria for an ill health pension when his employment was terminated.

27. Within 28 days of receiving the IRMP's opinion, the Council shall notify Mrs T of its decision with reasons.

Anthony Arter

Pensions Ombudsman
22 November 2017

Appendix 1

Summary of the medical evidence

Dr Lovett (Consultant Neurologist), report typed 10 December 2009 to Dr Jones (Consultant Vascular Physician)

28. Dr Lovett diagnosed: “Generalised choreiform movements, possibly psychogenic “

29. Dr Lovett observed abnormal movements predominantly affecting Mr T’s head and neck with occasional tremor of the right hand and abnormal movements in his arms, looking choreiform in nature. She noted that Mr T could be distracted from it and when it was at its worse he tended to have some dysarthria and stuttering of his speech. Dr Lovett commented that Mr T’s reflexes were all globally quite brisk but his plantars appeared to be downgoing. She said the rest of the neurological examination was normal with no sensory findings, incoordination or weakness.

30. Dr Lovett commented that most likely this was psychogenic, particularly in view of Mr T’s previous illness 17 or 18 years ago, but at this stage felt that some organic causes needed to be ruled out, which could sometimes appear very psychogenic in their presentation.

31. Dr Lovett said she would therefore arrange for an MRI, and EEG, blood screening for copper, caeruloplasmin, urine copper excretion, tupus and antiphospholipids screen, thyroid function testing, blood screen for acanthocytes and send off genetics for Huntington’s.

32. While waiting for these results Dr Lovett said it would be worth pre-empting a possible psychiatric cause and course of treatment and strongly recommended that Mr T’s GP refer him to a psychiatrist.

Dr Matthews (Consultant Psychiatrist – SHO to Dr Karadimova), 27 January 2010 assessment

33. Dr Matthews noted that Mr T had seen Dr Lovett and he had essentially normal MRI and CAT scans of his head and an extensive range of tests to exclude an organic cause for the sudden onset of involuntary movements.

34. Dr Matthews noted that Mr T had chronic obstructive pulmonary disease and high blood pressure and had been prescribed Lorazepam to take for his involuntary movements but he had found it of no benefit.

35. On examination Dr Matthews noted abnormal choreiform movements mainly in Mr T’s right arm, girdle and face. She noted at times both arms and his trunk were affected and that his speech was intermittently affected. In between episodes, particularly when distracted he was free from abnormal movement

36. In summary Dr Matthews said:

> "This is a 55 year old man who has experienced 2 previous episodes of neurological symptoms where no physical cause has been found. Given that he has a further outpatient appointment with Dr Lovett to exclude any neurological cause, I am reluctant to diagnose his problems as being somatoform in nature.
>
> However I got a sense from [Mr T] today that he is not particularly inclined to think psychological about his problems in the past. He is however willing to try medication if we believe it will help."

37. Dr Matthews said if Mr T continued to be troubled by his movements once he had all the results of the physical investigations he should be referred again if he felt it would be of benefit.

Dr Ross-Russell (Clinical Assistant), letter dated 13 May 2010 to Mr Gibb (Consultant Neurologist)

38. Dr Ross-Russell asked Mr Gibb for a second opinion on Mr T's generalised choreiform movements of unknown nature.

39. Dr Ross-Russell advised that Mr T had seen Dr Lovett and all investigations that she had arranged including copper screen, autoimmune profile, antiphospholipids and genetics for Huntington's had all been negative. His EEG showed no diagnostic epileptiform activity.

40. Dr Ross-Russell said when she reviewed Mr T in April his symptoms were if anything worse. This had coincided with a period of profound family stress as his wife had been diagnosed with cancer and was undergoing chemotherapy. While he accepted that his symptoms were affected by stress neither he nor his wife was happy at the suggestion that the aetiology may be psychogenic.

Dr Hodges (Consultant Occupational Physician), letter dated 29 June 2010 to the Council

41. Dr Hodges informed the Council that she was in receipt of a report from Mr T's GP, but regrettably it added no more information than they had. Since late November Mr T had been suffering frequent choreiform movements of unknown etiology and since seeing Dr Lovett had now been referred to another Neurologist for a second opinion. There was some concern whether his movements were psychogenic (mood related), which his family were not happy with, hence the second opinion. The GP confirmed that Mr T was not well enough to work or even drive.

Dr Gibb (Consultant Neurologist), report dated 29 June 2010 to the Neurology Dept Salisbury District Hospital

42. Dr Gibb noted the diagnosis of functional neurological disorder and understood that comprehensive investigations had found no abnormalities. Dr Gibb commented that Mr T's current movements consisted of intermittent tonic posturing of one or both

hands, distortions of facial expression with platysmal contraction and some distortion of head posture. He said the movements were not present initially but developed when Mr T was in the consulting room. He understood from Mr and Mrs T that his movement can be normal and when his wife was in hospital for cancer treatment he was able to function much better and look after the family. Dr Gibb said the dynamic nature of Mr T's symptoms underlined the likelihood that his condition would resolve at some point. He said there was a strong suggestion that previous illnesses had been due to functional disorder.

43. Dr Gibb noted that Mr T had wondered whether his condition may relate to work-related stress, but said this would not account for his continued symptoms. Dr Gibb said it was important for Mr T to emphasise to his employer that the condition was likely to resolve and it would be wise to discuss the possibility of a staged return to work.

Dr Hodges, letter to the Council dated 5 July 2010

44. Dr Hodges notified the Council that Mr T had been diagnosed with a functional neurological disorder. He had been told that there was no treatment for this, but Dr Hodges said she felt a trial of CBT would be certainly worthwhile. After confirming his condition she suggested that Mr T may now agree to a psychiatric assessment. Nevertheless such illnesses were extremely difficult to treat and the symptoms often persist indefinitely. Consequently, there remained no prospect of Mr T's return to work.

Dr Woollard (GP), letter dated 3 August 2010 to Dr Hodges

45. Dr Woollard enclosed a copy of Mr Gibb's report and advised that Mr T had been referred to a Clinical Psychologist. Dr Woollard said he was unable to give a firm prognosis or date of return to work but was optimistic about the future.

Dr Hodges, report dated 29 August 2010 to the Council

46. Dr Hodges informed the Council that Mr T had been found to have no abnormalities and had been referred for psychological help, but this was likely to take months to set up and then months of treatment.

47. Dr Hodges said that Mr T had been diagnosed as having a functional neurological disorder and that there was a strong suggestion that his previous illnesses had been due to this condition. Dr Hodges said Mr T had been told that the condition was likely to resolve completely and that he should be able to return to work on a phased basis. Dr Hodges said there was no prospective date for Mr T's return to work and regrettably he did not meet the requirements for ill health retirement.

Dr Karadimova (Consultant Psychiatrist), report typed 7 September 2010 to Dr Woollard

48. Dr Karadimova did not think that Mr T met the criteria for a mental health disorder – either anxiety or depression or associative disorder.

49. Summarising Dr Karadimova said:

> "The overall progress of his condition is that it has improved and the prognosis from the neurological point of view has been that he would be able to go back to work. However, no one has been able to give a timeframe.
>
> In terms of ongoing stresses, [Mrs T] was diagnosed with cancer just before Christmas and underwent a course of chemotherapy but is now better. [Mr T] is also coming to the end of his one year sick leave. He is realistic that he may be dismissed from work but is not unnecessary worried about it and is hopeful that he would be able to find another job when his symptoms improve.
>
> He told me that he has come to see me today as he is prepared to take up any help that might be offered ie further medication or as you have suggested to him 'hypnotherapy'".

50. Dr Karadimova recommended that Mr T remain on Citalopram, as it had clearly improved his moved. He felt Mr T may benefit from a psychological assessment and said he would refer him to a Clinical Psychologist with their team for assessment and further recommendations. He agreed that Mr T would be able to return to work and advised a carefully graded return if possible to his usual role to test out his ability to cope with stress. He said he would see Mr T in three months to review the outcome of the psychological assessment and his trial return to work if offered.

Dr Lovett, letter to GP surgery typed 7 October 2010

51. "I reviewed this gentlemen in clinic today and he tells me that over the two months he has dramatically improved and is considering going back to work shortly. I saw no abnormal movements in clinic today and he tells me that most of them have almost completely resolved. I was very pleased to hear this and consequently discharged him from clinic."

On 8 October 2010 D Woollard signed a Statement of Fitness for Work effective from 17 October 2010.

52. "Fit to resume normal work duties including driving"

Dr Hodges, letter to Dr Woollard dated 8 December 2010

53. Dr Hodges advised that Mr T's return to work on 1 November 2010 had not lasted. He had gone off sick a few days later with a return of his functional neurological condition. Dr Hodges advised that the Council was likely to move to termination of employment on medical grounds and said she was doubtful that he would be eligible for ill health retirement noting that it would have to be shown that Mr T was permanently unfit for his current duties until age 65. Dr Hodges asked Dr Woollard had any further relevant details about Mr T's health.

Dr Karadimova, report typed 13 December 2010 to Dr Woollard

54. Dr Karadimova said he had met Mr and Mrs T in outpatient clinic. Since his September report Mr T had seen the Clinical Psychologist, who agreed that there was no evidence of mental health problems and as such no therapy could be of benefit. A referral to Wellbeing was not on the cards as there was no evidence of depression or anxiety.

55. Dr Karadimova understood that Mr T had attempted to return to work but when the environment got very busy and stressful he was unable to cope. He said this seemed to be stress related and not explainable by a mental illness.

56. Dr Karadimova noted that Mr T was continuing to struggle with involuntary movements which caused him an amount of discomfort. He said he was not in a position to comment whether Mr T would be able to return to work as he did not know enough about his role and such a report would need to be commissioned independently.

Dr Woollard, report to Dr Hodges dated 20 December 2010

57. In a follow-up report, Dr Woollard provided a copy of a letter from Mr T's Neurological Consultant and his psychiatric assessment and reports.

58. Commenting on Mr T's unsuccessful return to work he said Mr T's twitches were more in evidence when his work got busy or when there was any noise. In fact it became evident that any noise or interruption would affect him to the extent that he was totally unable to multi-task. By 15 November it was obvious that he was not fit enough to work and was signed off sick.

59. Dr Woollard said Mr T understood that the Council was likely to terminate his employment due to the unknown prognosis which goes with functional neurological disorders. He said it was impossible to say whether Mr T would be fit for his job again in the future.

Dr Hodges, letter to the Council dated 10 January 2011

60. Dr Hodges said she was in receipt of a report from Mr T's GP, who was of the opinion that it was impossible to say whether he would be fit for his old job in the future.

61. Dr Hodges said that while she was happy to support Mr T's application there was little if any evidence to show that he was permanently unfit for his job or other work before age 65.

Dr Hodges, letter to Occupational Health Department dated 26 January 2011

62. Dr Hodges submitted relevant medical reports for consideration by an IRMP. She said that Mr T had been diagnosed with a "functional neurological disorder" for which

there was no treatment and that he had recently been assessed by a Psychologist who did not think that his condition was treatable.

Dr Gibbins (IRMP), 17 February 2011 report

63. In a short report Dr Gibbins said his assessment had been undertaken with reference to medical reports from Mr T's Consultant Occupational Physician, GP, two Consultant Neurologists and a Consultant Psychiatrist. Dr Gibbins then said:

"Whilst it is clear that [Mr T] has been troubled by intrusive and distressing symptoms which have adversely affected his ability to undertake his normal duties and responsibilities and which have led to long term sickness absence, it is also apparent that [Mr T] has been fully medically investigated and there is no evidence of any serious underlying organic cause for his condition which has been diagnosed as a functional neurological disorder.

There is evidence that [Mr T] has undergone spontaneous improvement which unfortunately was not sustained. However, although it is difficult to give any precise prognosis but as there remains a further ten years before [Mr T] reaches a retirement age of 65, I do not consider that on the balance of probabilities he will remain permanently incapable of being able to fulfil his supervisory role.

In summary therefore, based on the medical evidence available, I consider that [Mr T] does not, at the present time, meet the necessary criteria for ill health retirement."

Appendix 2

The Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007

64. As relevant regulation 20 says:

> "(1) If an employing authority determine, in the case of a member who satisfies one of the qualifying conditions in regulation 5 -
>
> (a) to terminate his employment on the grounds that his ill-health or infirmity of mind or body renders him permanently incapable of discharging efficiently the duties of his current employment; and
>
> (b) that he has a reduced likelihood of obtaining any gainful employment before his normal retirement age,
>
> they shall agree to his retirement pension coming into payment before his normal retirement age in accordance with this regulation in the circumstances set out in paragraph (2) [Tier 1], (3) [Tier 2] or (4)[Tier 3], as the case may be.
>
> (2) If the authority determine that there is no reasonable prospect of his being capable of undertaking any gainful employment before his normal retirement age, his benefits are increased -
>
> (a) as if the date on which he leaves his employment were his normal retirement; and
>
> (b) by adding to his total membership at that date the whole of the period between that date and the date on which he would have retired at normal retirement age.
>
> (3) If the authority determine that, although he is not capable of undertaking gainful employment within three years of leaving his employment, it is likely that he will be capable of undertaking any gainful employment before his normal retirement age, his benefits are increased -
>
> (a) as if the date on which he leaves his employment were his normal retirement age; and
>
> (b) by adding to his total membership at that date 25% of the period between that date and the date on which he would have retired at normal retirement age.
>
> (4) If the authority determine that it is likely that he will be capable of undertaking gainful employment within three years of leaving his employment, or before reaching normal retirement age if earlier, his benefits-
>
> (a) are those that he would have received if the date on which he left his employment were the date on which he would have retired at normal retirement age; and

(b) unless discontinued under paragraph (8), are payable for so long as he is not in gainful employment. (5) Before making a determination under this regulation, an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine as to whether in his opinion the member is suffering from a condition that renders him permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that condition he has a reduced likelihood of obtaining any gainful employment before reaching his normal retirement age.

(5) Before making a determination under this regulation, an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine ("IRMP") as to whether in his opinion the member is suffering from a condition that renders him permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that condition he has a reduced likelihood of being capable of undertaking any gainful employment before reaching his normal retirement age.

…

(7)

(a) …, once [Tier 3] benefits under paragraph (4) have been in payment to a person for 18 months, the authority shall make inquiries as to his current employment.

(b) If he is not in gainful employment, the authority shall obtain a further certificate from an independent registered medical practitioner as to the matters set out in paragraph (5).

…

(11)

(a) An authority which has made a determination under paragraph (4) in respect of a member may make a subsequent determination under paragraph (3) [Tier 2] in respect of him.

…

(b) Any increase in benefits payable as a result of any such subsequent determination is payable from the date of that determination.

…

(14) In this regulation-

"gainful employment" means paid employment for not less than 30 hours in each week for a period of not less than 12 months;

"permanently incapable" means that the member will, more likely than not, be incapable until, at the earliest, his 65th birthday; and

"qualified in occupational health medicine" means-

(a) holding a diploma in occupational medicine (D Occ Med) or an equivalent qualification issued by a competent authority in an EEA State; and for the purposes of this definition, "competent authority" has the meaning given by section 55(1) of the Medical Act 1983; or

(b) being an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA State.”