PENSION SCHEMES ACT 1993, PART X
DETERMINATION BY THE PENSIONS OMBUDSMAN

Applicant	Mr Trevor Hill
Scheme	BAE Systems Pension Scheme (the **Scheme**)
Respondent	BAE Systems Pension Fund Trustees (the **Trustees**)

Subject

Mr Hill's complaint is that the Trustees refused to award him chronic ill health benefits from the Scheme.

The Pensions Ombudsman's determination and short reasons

The complaint should be upheld against the Trustees because they did not take steps to ensure that they had appropriate evidence upon which to base their decision.

DETAILED DETERMINATION

Provisions of the Scheme rules

Early Retirement from service on health grounds

1. There are two levels of pension payable on retirement from service in ill health under the Scheme. The first and lower level is payable on "Incapacity" – essentially a test of whether the person is permanently unable to work in their own occupation. The second is payable on "Chronic Ill Health", being where the person is permanently unable to work at all. They are referred to as an "ill health" pension and a "chronic ill health" pension respectively.

2. The definition of "Incapacity" under the Scheme rules (the **Rules**) is:

> "Incapacity means a physical or mental impairment which, according to the evidence of a registered medical practitioner and in the opinion of the Trustees, results in a Member being permanently disabled from undertaking his or her occupation".

3. The pension granted on the grounds of incapacity is calculated on the same basis as for any early retirement, including a reduction for early payment, though that can be waived at the discretion of the Trustees.

4. The definition of 'Chronic Ill Health' is:

> "…Incapacity which, in the opinion of the Trustees, results in a Member being permanently unable to undertake any regular work for an Employer or any other employer.
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> In forming their opinion the Trustees will have regard to (but will not be bound by) reports submitted by the Employer's medical adviser and/or the Member's general practitioner, and/or to such other medical evidence as they think fit."

5. The pension granted on the grounds of chronic ill health is calculated on the same basis as any early retirement, without the reductions for early payment, but with the addition of 50% or 66% of the prospective pension (i.e. the pension a member would have accrued from the date of retirement to normal retirement date) depending on whether the member has completed less or more than 10 years' service.

Early payment of deferred pension

6. Rule 10.2 begins:

> "A Member entitled to a preserved pension may, by giving notice to the Trustees, elect to receive a pension starting on the first day of any month before the Member reaches Normal Retirement Date. The pension cannot start before the member reaches age 55 (50 if he or she became a member before 6 April 2006), unless the Member is suffering from Chronic Ill-health or Incapacity or this would not constitute an unauthorised payment under the Finance Act 2004."

7. Rule 10.2 goes on to set out how the pension is to be calculated and includes discretion for the Trustees to alter the calculation if they are satisfied that the member is suffering from chronic ill health (as defined). There is no provision relating to variation for incapacity.

Material Facts

8. In June 2008, while still an employee of BAE Systems, Mr Hill applied for early retirement on the grounds of ill health. His application was rejected by the Trustees.

9. In March 2009 Mr Hill was dismissed by BAE Systems on ill health grounds. He appealed against the Trustees' decision and in April 2009 his appeal was considered under stage one of the Scheme's internal dispute resolution procedures (**IDRP**) and rejected. At that time he was 48 years old.

10. In late 2010, when he was 50, Mr Hill applied for a pension as a deferred pensioner on health grounds. I have not seen his application. However, it would have been Rule 10.2 (see paragraph 6) that applied in his circumstances and, as Mr Hill's membership began before 6 April 2006, there was nothing preventing a rule 10.2 pension being paid without an adjustment for chronic ill-health.

11. In June 2011 in a report to the Trustees, a Dr Coles of Medigold said:

> "…At the time that I saw him I was not aware of the intention for him to be referred for cognitive behavioural therapy and psychometric testing. Clearly the outcome of those two measures is likely to be of crucial importance in determining whether Mr Hill has any chance of returning to work and indeed what his overall prognosis is likely to be regarding the main issues which seem to be preventing his returning to work.
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> …Whether he could ever return to it appears quite doubtful and I would be prepared to accept that in all probability he is never going

> to be able to return to that type of work. However, there does seem to be potential scope for some improvement at least in his depression which is one of the major obstacles to his returning to any form of work at present. If he responds to cognitive behavioural therapy I can see no reason why he should not be able to undertake some form of work albeit not of the same level as he had previously undertaken. The result of psychometric testing may provide better evidence on which to base an opinion as to what type of work Mr Hill might be capable of undertaking in the future.
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> I think we can reasonably conclude at the moment that the probability is that Mr Hill is permanently unfit to return to his previous employment but that there are potential opportunities in his proposed future treatment which would allow a return to some other form of work. This therefore suggests to me that he can meet the criteria for earning capacity but not for chronic ill health."

12. The Trustees granted Mr Hill what was described as an ill health pension, which commenced payment on 1 August 2011. It was the same as the pension that would have been paid if he had made an election to receive a pension under rule 10.2 not in chronic ill-health. He appealed the Trustees' decision on the grounds that he believed he satisfied the definition of chronic ill health as stated in the Rules.

13. On 24 November 2011, a Dr Swan reported to the Trustees that he had seen and assessed Mr Hill on 17 November 2011. Dr Swan said that he had undertaken a full file review including reports from Dr Cole dated 7 June 2011, a report from a Dr Marcus dated 29 March 2010 and a Dr Booth (who later changed her surname to Keeling) dated 19 September 2011. Dr Swan stated that the comments made by Dr Booth appeared to suggest that there was a potential prospect that Mr Hill's cognitive function may improve with an improvement in his mental health. Dr Swan added that based on the evidence available, in his opinion, Mr Hill would not be fit to resume any work at present and he would not be fit for the foreseeable future to undertake the role of an engineer. However, there remained a reasonable prospect that with further treatment Mr Hill might be fit to resume some form of work at some time in the future. He said that, in his opinion, Mr Hill continued to meet the criteria for incapacity but not for chronic ill health pension benefits.

14. On 29 November 2011 Dr Keeling wrote to Dr Swan stating that Mr Hill had asked her to write to clarify the findings from a neuropsychological assessment he undertook between July and September 2011. Dr Keeling said:

> "I appreciate that the recent neuropsychological assessment showed a rather inconclusive picture. However, it does indicate a level of decline in function in a number of areas, particularly visual working memory, auditory memory and speed of processing, with mild difficulties noted with attentional processes and cognitive flexibility.
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> …In which case, these areas of reduced function are unlikely to improve.
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> …
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> I also raised the possibility that depression might be playing a role on his cognitive function; however, I do not believe that this is the sole reason for his current cognitive complaints."

15. On 15 December 2011 Dr Swan wrote to the Trustees informing them of Dr Keeling's report of 29 November 2011 and stating that it did not alter his opinion and recommendations as set out in his earlier report.

16. The Trustees reviewed Mr Hill's appeal and on 4 January 2012 informed him that their decision remained unchanged.

17. Mr Hill continued to pursue the matter and in June 2012, represented by Thompsons Solicitors (**Thompsons**), Mr Hill raised a complaint under the Scheme's internal dispute resolution procedure (**IDRP**).

18. On 3 December 2012 Mr T, the Scheme's Pension Director, wrote to Mr Hill informing him that his complaint had been considered under stage one of the IDRP and, while it was accepted that based on the evidence presented there was no prospect of him returning to the role in which he was previously employed, it was not accepted that based on the evidence supplied and the advice from their medical advisers, that he was permanently unable to undertake any type of work in the future. Mr T added that the correct criteria had been applied under the Rules; there was no evidence to suggest that any errors had been made during the decision making process; consideration had been given to all the evidence that was available at the time each decision was made; reports submitted by his various medical advisers were considered; and additional medical information recently supplied, via his solicitors, were taken into account and concluded that this would not have resulted in a different decision if the information had been available when the case was originally considered.

19. On 19 March 2013 Thompsons appealed the stage one IDRP decision.

20. On 12 April 2013 Dr Swan wrote to the Trustees in response to Thompsons' letter of 19 March 2013, stating:

> "He [Mr Hill] had previously been assessed by my colleague, Dr Coolican, on 17 October 2008, who concluded "On the present level of evidence I would have to state that I would agree that there is not enough medical evidence to state that Mr Hill is medically unfit to return to work on a permanent basis and therefore the initial decision with regard to his pension application would seem to be the most reasonable…"
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> Mr Hill was also assessed by Dr Coles on 24 May 2011, who concluded "I think we can reasonably conclude at the moment that the probability is that Mr Hill is permanently unfit to return to his previous employment, but there are potential opportunities in his proposed future treatment which would allow him to return to some other form of work. This therefore suggests to me that he can meet the criteria for earning capacity pension, but not for chronic ill health".
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> …
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> Dr Williams provided a further report following a file review on 28 September 2012 and Dr Williams noted that he was on a relatively low dose of antidepressant medication and it was also noted that "His psychological health is negatively impacted upon by the ongoing dispute he has regarding his pension application for ill health retirement" and Dr Williams noted that he would expect an improvement in his wellbeing once there had been a resolution to this matter.
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> …
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> With regard to the issue raised in the letter from [Thompsons] I am aware that the evidential test was based on the likelihood and "more likely than not".
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> I would have to say that I do acknowledge that the prognosis for a successful return to work after such a lengthy period of absence from the workplace is guarded, irrespective of the cause, but I do remain of the view that there is considerable further psychiatric treatment that Mr Hill could potentially benefit from.
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> I do note the relevant pension definitions:
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> …
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> My opinion also takes into account his relatively young age and time up to his normal age of retirement.
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> I appreciate that it is now well over a year since I reviewed Mr Hill and I do note the indication that there has been a decline in his function and I would of course be happy to review any further information as instructed by the Pension Trustees.
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> …"

21. On 16 May 2013 the Trustees informed Thompsons that Mr Hill's appeal had been considered under stage two IDRP and was rejected.

Summary of Mr Hill's position

22. Dr Swan's report of 12 April 2013 places weight on a report from:

- Dr Coolican of October 2008, written three years before the decision to grant ill health retirement, and which they have never seen;
- Dr Williams of 28 September 2012, which appears to have been written without seeing Mr Hill, and which they have never seen; and
- Dr Coles of 24 May 2011, which it appears may previously have been passed to Mr Hill but which they have not seen.

23. Despite the fact that Dr Swan's letter of 12 April 2013 appears to have been written in response to their IDRP complaint of 19 March 2013, he did not respond to a single point they raised in it, save for the question of whether he was aware of the correct 'evidential test'. It is not sufficient or satisfactory for a doctor to be aware of the correct evidential test or even refer to it if he does not actually apply it, as it is apparent from his reasoning that he did not in this case.

24. Dr Swan in his April 2013 report accepts that the prognosis for a successful return to work is guarded after such a lengthy absence from the workplace. Mr Hill went off sick from work in May 2007 and was retired on grounds of ill health in March 2009. This was not a point Dr Swan adverted to in his reports of 24 November 2011 or 15 December 2011. To say a return to the workforce should be guarded after six years but not after four and a half years is inconsistent, illogical and not supported by any evidence or reasoning.

25. It would appear that the Trustees relied upon Dr Coles' report in making their initial decision to reject Mr Hill's second application for ill health retirement. The key conclusions from that report show that the Trustees based their decision on incomplete and inconclusive evidence. They also note that the issue for Dr Coles was not whether Mr Hill was 'likely to be able to return to work' but rather whether he had 'any chance' of being able to return to work. Like Dr Swan, Dr Coles was not applying the correct test of 'likelihood' but was instead

considering only the 'possibility' of returning to work in some capacity in the future and any decision made in reliance on these views is likewise flawed.

26. No reference has been made to Dr Marcus' report in Dr Coles' report, despite the unequivocal view expressed within it.

27. The Trustees having made their decision to grant incapacity retirement, but not chronic ill health retirement, then sought medical advice from Dr Keeling. It should be noted that no advice was sought from Dr Keeling by Dr Swan on whether the psychometric testing indicated that his overall prognosis was likely to indicate a return to the workplace. Nor was cognitive behavioural therapy recommended by Dr Keeling. These issues had been identified by Dr Coles as 'critical' in determining whether Mr Hill had any chance of returning to work.

28. Dr Keeling made it clear in her second report that areas of reduced function were unlikely to improve and that depression was not the sole reason for Mr Hill's cognitive complaints.

29. It is plain that the medical evidence, properly interpreted, suggests that at the date on which Mr Hill's application for chronic ill health retirement was rejected, it was not 'likely' that his condition would improve to the extent that he would be able to re-enter the workforce.

Summary of the Trustees' position

30. The medical evidence provided at the time Mr Hill was awarded an ill health pension in 2011 meant that he did not fulfil the criteria for a chronic ill health pension. They based their decision on the evidence presented to them at that time. The medical evidence after this date, relating to Mr Hill's present medical condition, cannot be used to change their decision when the pension was first awarded.

31. They were made aware of Dr Keeling's unsolicited report which was received after the Medigold report was prepared on 24 November 2011. This is evidenced by the letter from Dr Swan dated 15 December 2011. Medical evidence provided after the award of incapacity pension, relating to Mr Hill's current medical condition, cannot be used to change the Trustees' decision made when the pension was first awarded.

32. Dr Swan incorrectly believed that there was a possibility of the Trustees moving Mr Hill's pension to the chronic ill health benefit level but now realises that at the time of the claim, the Trustees have to make a decision on one permanent definition of ill health. This is why Dr Swan offered to see Mr Hill again, but now understands that this is not possible under the Rules.

33. The test under the Rules is on a balance of probabilities. In order for the doctors to give an opinion that a return to work is more likely than not, which they repeatedly did, they must have inevitably considered the likelihood of the treatment being effective. They had received at least two medical reports explicitly stating the view that Mr Hill did not meet the chronic ill health test because on the balance of probabilities he would be fit to carry out some sort of work.

Conclusions

34. The criteria for receiving a chronic ill health benefit under the Scheme are that the member must be prevented permanently from following his normal occupation or be permanently unable to undertake any work with another employer. It is for the Trustees to decide whether or not the member meets the criteria and the Rules provides for the Trustees to have regard to reports submitted by the medical advisers and/or the member's general practitioner, but not necessarily being bound by them, in coming to a decision.

35. It is not my role to agree or disagree with the Trustee's decision or the prognosis of the medical adviser. My role is to consider whether the correct process has been followed in assessing Mr Hill's claim for a chronic ill health pension. There are some well-established principles which decision makers are expected to follow. Briefly they must:

- take into account all relevant matters and no irrelevant ones;
- ask themselves the correct question;
- direct themselves correctly in law (in particular, they must adopt a correct construction of the Rules); and
- not arrive at a perverse decision.

36. The Trustees seem to have approached the matter as if Mr Hill had made an application from active service, rather than deferment. That is, they considered

whether he met the definition of chronic ill health or, in the alternative, incapacity. But incapacity had no relevance. As of right under Rule 10.2 Mr Hill could have received the same benefit as he is now receiving and which the Trustees awarded him as an "ill health" pension.

37. The Trustees say that the decision to award Mr Hill an ill health pension, and not a chronic ill health pension, was based on the medical evidence presented to them at the time they made their decision.

38. The Trustees' decision to pay Mr Hill an "ill health" pension from 1 August 2011 was based on the report they received in June 2011 from Dr Coles. Dr Coles' report (which was dictated but not signed by him) said that Mr Hill met the criteria for an 'earning capacity pension' but not for chronic ill heath pension. ('Earning capacity' appears to be a mishearing from the dictation of 'an incapacity' and nothing turns on the phrase.)

39. Mr Hill appealed the Trustees' decision not to grant him an a chronic ill health pension and they considered reports from Dr Swan dated 24 November and 15 December 2011, both of which had considered reports from Dr Marcus (dated 29 March 2010) and Dr Keeling (dated 19 September and 29 November 2011). Dr Swan had concluded in both his reports that Mr Hill did not meet the criteria for a chronic ill health pension from the Scheme.

40. Thompsons have commented that the reports from both Dr Coles and Dr Swan made no reference to other medical adviser's reports (i.e. Dr Coles' report makes no reference to Dr Marcus' report); places weight on certain reports (i.e. Dr Swan's report of 12 April 2013 places weight on reports by Mr Coolican, Dr Williams and Dr Coles); further advice should have been sought (i.e. from Dr Keeling by Dr Swan); and are flawed because they applied wrong test of 'possibility' and not the correct test of 'likelihood'.;.

41. I accept that Dr Coles' report does not make reference to Dr Marcus' report. However, Dr Swan's report does refer to Dr Marcus' report and the Trustees' decision was based on Dr Swan's report.

42. The weight to be placed on the various reports by Dr Swan when forming his own opinion in his report of 12 April 2013 was a matter of his judgment. However, Dr Coolican's report of October 2008 was provided when Mr Hill made his initial application in 2008 for an ill health pension. I would therefore

agree that this report may not be relevant to Mr Hill's appeal under stage two IDRP, which was for a chronic ill health pension. But I can see no reason why Dr Swan should not have placed the weight he did on the reports from both Dr Williams and Dr Coles. It is reasonable for Dr Williams to have conducted his review from previous reports without seeing Mr Hill. In addition, the Trustees are entitled to base their decision on Dr Swan's report without having to pass on copies to Thompsons of the reports various he relied upon. I therefore do not consider that the Trustees were wrong to base their decision on Dr Swan's report.

43. I agree that Dr Keeling in her report of 29 November 2011 states that areas of reduced function were unlikely to improve and depression was not the sole reason for Mr Hill's cognitive complaints. However, the report does not say whether the areas of reduced function were likely to prevent Mr Hill from undertaking any work with another employer. In addition, the report states that the "neuropsychological assessment showed a rather inconclusive picture". Dr Swan's opinion was that Dr Keeling's report did not change the recommendation he made in his earlier report, i.e. that Mr Hill did not meet the criteria for a chronic ill health pension.

44. Thompsons' suggest that the wrong test was applied by Dr Coles and Dr Swan because they both had considered only the 'possibility' rather than the 'likelihood' of Mr Hill returning to work. The words in quotation marks are theirs, and in his report of June 2011, Dr Coles does not use the word 'possibility'. He states that there are 'potential opportunities' in Mr Hill's proposed future treatment which would allow him to return to some form of work. Dr Swan in his report in November 2011 states that with future treatment Mr Hill might be fit to resume some form of work at some time in the future, even though in his report in April 2013 confirms that he is aware that the test is based on likelihood. Overall, I do not see anywhere in their reports a clear explanation of why they believed that he probably would recover so that he was able to work in some capacity. In particular, neither doctor specified, and the Trustees failed to clarify with them, how likely the future treatment was to be effective in that after having the treatment Mr Hill was likely to be able to return to some form of work. The Trustees suggest that it is clear that the doctors must have believed that the treatments would probably be effective. But I do not

think it is safe to infer from their findings that they must have gone beyond the fact that there were future treatments, to decide how likely those treatments were to work. The tenor of, for example, Dr Coles' conclusions quoted in paragraph 11 do not support such an inference.

45. The Trustees say that they received medical reports which stated that on the balance of probability Mr Hill was fit to carry out some work and therefore did not meet the criteria for a chronic ill health pension. Neither of the reports from Dr Coles or Dr Swan on which the Trustees based their decision states that on the balance of probability Mr Hill was fit to carry out some work.

46. I therefore find that it was maladministration on the part of the Trustees not to have clarified the future treatment with either Dr Coles or Dr Swan. I uphold the complaint against the Trustees. Their decision was based on evidence which did not allow them to decide whether, on the balance of probability, Mr Hill would be able to return to work, merely that it was possible that he could.

47. There was further maladministration that Mr Hill could not have easily identified. He did not complain directly to me about it, because he did not know, and because the way that the Trustees approached the matter had the effect of concealing it (though not deliberately, I am sure). Thompsons, acting for Mr Hill, are aware that I have raised the matter and the Trustees have had the opportunity to make submissions on it (albeit after I had expressed a preliminary view) so I consider that due process has been observed.

48. The point is this. Mr Hill is receiving a pension at lower level than he wanted and which is the same as the pension that he could have claimed as of right, although he was not told that. Payment of it did not follow automatically from the Trustees' decision that he was not in chronic ill health. Mr Hill should have been told that he did not have to accept it. He might have wished to defer it – possibly in the hope that deteriorating health would later qualify him for the pension that he wanted. (I am not suggesting that the Trustees should have advised him to do that, merely that they deprived him of the option.)

49. Putting this right is extremely difficult, but in my judgment if Mr Hill is not awarded a chronic ill health pension following my first direction below, he should be allowed to reapply now saying when, in his view, his health had changed by comparison to August 2011 so as to justify a conclusion that he would have

qualified for a chronic ill health pension. On his doing so the Trustees will have to consider whether at that point, or any later point before the present time, Mr Hill would have qualified for a chronic ill health pension.

50. I have considered whether an adjustment should be made for the fact that Mr Hill has received the lower pension when, to retain a right to qualify for a chronic ill health pension, he would have had to forego it. I have decided that no reduction should be made, in view of the distress it would cause and the facts that Mr Hill is not in any way at fault and is likely to have relied on receiving it in his every day expenditure. In substance he will have received money payable through a mistake, not through his making, believing it was his and which he is likely to have spent irrecoverably.

51. I also consider that Mr Hill should be given the option (which may not be attractive) of foregoing his future pension at the present level in order to leave open the possibility of a future application for a chronic ill health pension.

52. Finally, I have given some thought to the effect the maladministration described above will have had on Mr Hill. I find that it will have caused him a measure of distress and inconvenience and that this should be recognised.

Directions

53. I direct that, within 14 days of the date of this determination, the Trustees shall ask Dr Coles and Dr Swan to clarify the treatment available to and untried by Mr Hill, saying how likely it was to be effective, or how soon after having the treatment he was likely to be able to return to some form of work. Within 14 days of receiving this information from Dr Coles and Dr Swan, the Trustees will review Mr Hill's application.

54. Within 14 days of reviewing Mr Hill's application, the Trustees shall write to Mr Hill with their decision.

55. I also direct that, within the same 14 days, the Trustees shall pay Mr Hill the sum of £200 in recognition of the distress and inconvenience he has suffered as a result of the maladministration I have identified.

56. If the Trustees decide Mr Hill does not meet the criteria on review of their original decision, then Mr Hill may make a new application for a chronic ill-health pension on the grounds that his health had changed at a date between August

2011 and the present, giving the earliest date when he considers the application would have been justified by such a change. If the Trustees decide that he met the criteria then or later and that such a pension should be paid, his pension will be increased from the date on which they consider he met them.

57. Simple interest is to be paid on past instalments at the base rate for the time being payable by the reference banks, calculated form the due date of each instalment to the date of payment.

58. If no chronic ill-health pension is payable as a result of the above directions, Mr Hill may give the Trustees notice that he wishes to relinquish his present pension and will then have the right to apply for a chronic ill-health pension at any time thereafter, until age 65.

59. No deduction shall be made from a chronic ill-health pension or normal retirement pension in relation to payments of incapacity pension made before such pension became due.

Tony King
Pensions Ombudsman

26 January 2015