PO-4308

# Ombudsman's Determination

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| **Applicant** | Mr M Cooper |
| **Scheme** | Local Government Pension Scheme (**LGPS**) |
| **Respondent(s)** | Brighton & Hove City Council (**BHCC**) |

## Complaint summary

Mr Cooper has complained that BHCC failed to properly consider his eligibility for benefits under Regulation 20 of the LGPS (Benefits, Membership and Contributions) Regulations 2007. In particular, he disagrees with the decision to award him 'Tier 3' benefits.

## Summary of the Ombudsman's determination and reasons

The complaint should not be upheld against BHCC because they reached their decision in accordance with Regulation 20.

## DETAILED DETERMINATION

### Material Facts

1. Mr Cooper was employed by BHCC as a school caretaker until May 2013 when his employment was terminated on the grounds of ill health. He had been on sickness absence since October 2012 suffering from severe allergic reactions. Mr Cooper was awarded Tier 3 benefits under Regulation 20. The Regulation provides for three levels (referred to as Tiers) of benefit depending upon the degree of the member's incapacity. Tier 3 is the lowest level of benefit. Relevant extracts from the Regulation are provided in an appendix to this document.

2. Mr Cooper had been referred to a dermatologist by his GP and tests had shown that he was allergic to nickel, cobalt, balsam of Peru and epoxy resin. He was prescribed steroid medication and given an auto-injector (EpiPen) of adrenaline to use if he experienced a life-threatening allergic reaction.

3. Mr Cooper was reviewed by BHCC's occupational health advisers, Team Prevent UK Ltd (**Team Prevent**), in January 2013 and they recommended he be seen by one of their occupational health physicians.

4. On 25 January 2013, Dr F Emerson wrote to Mr Cooper in response to enquiries he had made about his condition. She is a GP with a specialist interest in dermatology working for Mr Cooper's local dermatology service. Dr Emerson said that Mr Cooper had an accurate understanding of his condition and no further treatment was required, other than to avoid the allergens he was sensitive to. She went on to say that it could be difficult to isolate the specific allergen causing reaction, but recommended that Mr Cooper avoid those allergens he had been shown to be sensitive to. Dr Emerson said that, should he have further episodes of acute allergic reaction, his local allergy clinic might be able to perform further tests to try and identify the allergens. She said that she hoped that this would not be necessary if he managed to avoid those allergens he knew he was sensitive to. Dr Emerson concluded by saying that she agreed that, once Mr Cooper had developed an allergy, she would not expect his condition to resolve and would advise a long term avoidance of the allergen

5. Mr Cooper's GP wrote an open letter on 13 February 2013 in which he explained that he had first presented with an episode of angioneurotic oedema in the middle of October 2012. The GP said that there had been a further episode a week later and Mr Cooper had been referred to the local dermatology service. He went on to confirm the allergens which Mr Cooper had tested positive for. The GP said that Mr Cooper carried an EpiPen and would require steroids, antihistamines and transfer to an A&E if exposed to these allergens. He said that they had no treatments which could mitigate Mr Cooper's symptoms or reduce his sensitivity. The GP also said that there were probably other substances, as yet unknown, which were causing Mr Cooper's symptoms. He recommended that all developments of symptoms should be treated as life threatening.

6. Mr Cooper saw an occupational health physician, Dr Sivayoganathan, at Team Prevent on 8 February 2013. He provided a report for the school's business manager on 19 February 2013. Dr Sivayoganathan said that Mr Cooper was allergic to a number of chemicals found in items, such as cleaning products, which were commonly used in the school environment. He said that, without using these items on a regular basis, Mr Cooper would be unable to perform his core activities as caretaker. Dr Sivayoganathan said Mr Cooper was unlikely to be able to protect himself from severe allergic reactions whilst working at the school. He said that Mr Cooper could reduce the risk of serious allergic reaction by early identification of symptoms and use of the EpiPen, but there was no standard treatment to control his symptoms on a daily basis. Dr Sivayoganathan recommended redeployment. He said that Mr Cooper would be suitable for jobs such as driving, landscape maintenance, care work "and a number of other roles which do not require the use of chemicals".

7. Mr Cooper was provided with a copy of Dr Sivayoganathan's report. He commented that the EpiPen was not used to reduce risk but to relieve symptoms in life threatening situations. Mr Cooper said that he had been told that the only way to reduce risk was to avoid the allergens in question. He expressed concern at Dr Sivayoganathan's suggestion that redeployment to roles such as driving, landscape maintenance and care work. Mr Cooper said that he envisaged coming into contact with the allergens in question in all of these roles. He asked that his comments be

passed to Dr Sivayoganathan. In response, Dr Sivayoganathan said that he was aware that an EpiPen was used to treat severe reactions. He confirmed that he had seen the letters from Dr Emerson and the GP. Dr Sivayoganathan said that, in his view, redeployment was a viable option, but that any suggested roles would have to be risk assessed. He said that, should there be no suitable role, ill health retirement could be considered.

8. Dr Emerson wrote to Dr Sivayoganathan on 1 March 2013. She said that Mr Cooper was getting episodes of facial swelling approximately twice a week despite daily antihistamines. Dr Emerson said that Mr Cooper had told her that the school was trying to make adjustments but he was still having significant problems. She said that, in the light of the new information, there was little possibility of him returning to his job as caretaker "in the near future". Dr Emerson recommended retirement on medical grounds unless an alternative position could be found. Dr Sivayoganathan referred Mr Coopers' case to an independent registered medical practitioner (**IRMP**), Dr Rost. He informed the school's Business Manager that he had forwarded Mr Cooper's occupational health and medical records to Dr Rost.

9. Dr Rost completed a certificate, as required by the LGPS Regulations, on 26 March 2013. She certified that, in her opinion, Mr Cooper was suffering from a condition which rendered him permanently incapable of discharging the duties of his employment at the school efficiently and had a reduced likelihood of being capable of undertaking gainful employment before his normal retirement age. Dr Rost ticked the box on the form indicating that she thought that Mr Cooper was likely to be capable of undertaking gainful employment within the next three years.

10. In her covering report, Dr Rost said Mr Cooper was suffering from a severe form of angioedema and it appeared that the school environment triggered his symptoms. She said that she understood that the school had made every effort to eliminate the allergens in question and she deemed Mr Cooper permanently incapable of working in that environment. Dr Rost concluded,

> "Redeployment was unsuccessful and it will be difficult for him to find work that does not constitute a risk to his health. However Mr Cooper is fit to undertake gainful employment although his options are very limited. Under Local Government Pension Legislation we are requested to base our

recommendations on medical facts only and we must not take the employment situation into consideration. I am therefore recommending a Tier III reward and I have signed the forms accordingly."

11. Team Prevent sent a copy of Dr Rost's report and certificate to Mr Cooper and to BHCC. Mr Cooper said that he wished to appeal against a Tier 3 award. He said that he would be at risk when working in an environment in which he was exposed to the numerous allergens which triggered his symptoms. Mr Cooper said that he felt that Dr Rost had not taken this risk into account. He referred to Dr Rost's comment that she should not take the employment situation into account and said that it was not a question of him not being able to obtain gainful employment because of a lack of available jobs. Mr Cooper said that he was not able to obtain gainful employment because of the prevalence of allergens to which he was sensitive within most working environments. He also noted that Dr Rost had not offered any suggestions of roles he might undertake which did not pose a threat to his health. Mr Cooper also said that he felt that the Tier 3 criteria applied when an individual had a condition which was expected to resolve within three years. He pointed out that his was expected to be a lifelong condition.

12. Mr Cooper also referred to Dr Sivayoganathan's previous report and explained why he did not think he would be able to avoid the allergens in question when working as a carer, driving or landscape gardening. He said that he suffered angioedema attacks two to three times per week and symptoms often took one or two days to subside. Mr Cooper said that he did not feel that he could secure gainful employment of 30 hours per week taking this disruption into account. He also pointed out that these attacks occurred despite him living a restricted lifestyle and he would expect deterioration if exposed to the allergens in a workplace.

13. BHCC asked Team Prevent to reconsider the level of award for Mr Cooper. They said that he still suffered from frequent allergic reactions in his home environment and would be a risk of suffering the symptoms of angioedema in a working environment. BHCC said that the severity of Mr Cooper's reaction was of great concern. They referred to the GP's recommendation that all developments of symptoms should be treated as life threatening and his comment that there may be

other allergens which had not been identified. BHCC said that the medical evidence indicated that symptoms were not expected to improve in Mr Cooper's lifetime.

14. BHCC informed Mr Cooper that they had asked Team Prevent to reconsider his case and that they would write to him confirming the level of benefit once they had a response. BHCC said that, if it was still Tier 3, Mr Cooper would have to go through the dispute process.

15. On 19 April 2013, BHCC wrote to Mr Cooper saying that Dr Rost had recommended that his employment be terminated on the grounds of permanent ill health and that the severity of his ill health had been classed as Tier 3.

16. In a subsequent letter, Dr Rost said that she did not have a copy of the GP's letter but she did not think that it would make a difference to her view. She said that she had already stated that it would be difficult for Mr Cooper to find work which did not constitute a risk to his health but it should not be impossible. Dr Rost said that she understood that Mr Cooper experienced allergic reactions in his home environment and expressed the view that the risk should not be greater in a carefully assessed work environment. She said that BHCC were welcome to seek another medical opinion. Dr Rost also said that they made recommendations on the basis of medical evidence which could be "overridden by the pensions department on the background of limited employment options".

17. Mr Cooper submitted an appeal under the internal dispute resolution (IDR) procedure. He also submitted a further letter from his GP dated 8 May 2013. The GP said that Mr Cooper had developed "anaphylactic allergic responses to many industrial chemicals that he would come across in any employ". He said that the only strategy was to remove Mr Cooper from possible exposure. The GP said it was not a treatable condition and Mr Cooper was likely to be at risk in whatever work he might undertake. Mr Cooper also referred to Dr Rost's comment that she had not had sight of the GP's previous letter which he felt contained significant medical evidence. Mr Cooper said that Dr Rost should have requested a copy of this letter when she was asked to review his case by BHCC. He also referred to Dr Rost's comment that her role was to make a recommendation which could be overridden. Mr Cooper said that BHCC had failed to act on their opinion that the tier

recommendation was incorrect. He also disagreed with Dr Rost's view that the risk of symptoms arising in a work environment would be no greater than the risk he faced at home.

18. Team Prevent wrote to Mr Cooper on 14 May 2013. They said that Dr Rost had not changed her opinion and any formal appeal process would be managed by the administering authority, East Sussex County Council.

19. Mr Cooper also contacted the Pensions Advisory Service (**TPAS**) who wrote to BHCC on his behalf. Amongst other things, TPAS asked if BHCC had reviewed all the medical evidence themselves. BHCC responded that they had and that they had referred the matter back to Team Prevent for a second opinion. BHCC said that Mr Cooper's case had been reviewed by Dr Rost in error and they had now asked for it to be referred to an IRMP who had not previously been involved.

20. On 28 June 2013, Dr Smith at Team Prevent wrote to BHCC stating that, having reviewed all the evidence and medical reports, he was of the opinion that a Tier 3 award was fair and reasonable at this stage.

21. On 14 July 2013, Dr Ratti at Team Prevent also provided a report. He noted that the diagnosis was angioneurotic oedema and that this had been confirmed by a specialist. Dr Ratti noted that allergy testing in January 2013 had revealed that Mr Cooper had significant allergies to nickel, cobalt, balsam of Peru and epoxy resin. He noted that skin prick tests and patch testing had been carried out but that he did not have details of the severity of the reactions. Dr Ratti said "the full European battery of patch tests which include fragrances was negative"[1]. He noted that the advice was to avoid all contact with these allergens, which he described as understandable.

22. Dr Ratti went on to say that "a conclusion seems to have been made that as certain tests were positive these must be responsible for the angioedema attacks". He then said that this was not necessarily always the case. Dr Ratti then referred to a report from Dr Emerson dated February 2013. He noted that Dr Emerson had anticipated that Mr Cooper would be able to return to work with some adjustments, although

[1] This is a reference to the European Standard series of patch tests carried out to identify allergens.

they had not been able to isolate any allergens which might be found in the school's hydrotherapy pool. He noted that Dr Emerson had been reluctant to recommend retirement on medical grounds unless no solution could be found for Mr Cooper.

23. Dr Ratti said that he found the frequency of Mr Cooper's attacks very concerning given that he was away from the workplace. He noted that Mr Cooper was or had been on antihistamines but he did not know the type or dose. Dr Ratti said,

> "This opens up the clinical situation to look at either improving treatment with possible proactive doses of steroids and antihistamines at increasing doses or other possible diagnosis with such a frequency of acute reactions despite the background history of confirmed allergens."

24. Dr Ratti said that the allergens identified and the acute reactions produced were not disputed. He described Mr Cooper as "an atopic individual with significant life threatening reactions which can cause a lot of underlying anxiety". Dr Ratti said that the on-going frequency of Mr Cooper's attacks and the reactions seen in the school environment where exposure to the allergens may not have occurred raised the question of whether the diagnosis should be idiopathic angioedema with a background of certain allergens. He said that this was important because, if the allergens were the cause, the attacks should be reduced with controlled lack of exposure; whereas Mr Cooper reported on-going problems. Dr Ratti concluded,

> "Clearly, Mr Cooper's immune system needs to be dampened down and a proper course of steroids and combination of anti-histamines, at the necessary doses needs to be adhered to over a period of time to see what beneficial effects are achieved.
>
> I have seen plenty of cases of a similar nature benefit from such an approach and *return to work*."

25. Dr Ratti said that he was concerned about the clinical situation presented and therefore thought that compliance with a prolonged course of steroids in combination with antihistamines should be considered before any reassessment of Mr Cooper's ill health award should be made. He suggested that this should be done under the care of an immunologist to exclude any other possible causes for Mr Cooper's angioedema. Dr Ratti said,

"A Tier 3 award does suggest the possibility of improvement within 3 years of leaving their employment and finding some gainful employment, which with an optimised management plan this may be certainly possible."

26. Mr Cooper was provided with a copy of Dr Ratti's report. In response, he asked whether Dr Ratti had seen his GP's letter of March 2013 because he felt it contained significant information. Mr Cooper also expressed concern that Dr Ratti was suggesting that there was another cause for his angioedema. He also commented that Dr Ratti had referred to Dr Emerson's view in February 2013 but not to her change of opinion in March 2013.

27. Dr Ratti was asked to provide further comment. In response, he said it was "highly unusual" to be involved in further correspondence following an IRMP assessment. Dr Ratti said that he had read all the OH notes, including all the letters referred to. (He described this as "not a relevant concern".) He went on to say,

"It is important to understand the IMP has to look at the condition and the treatment of. The opinion of doctors who have written reports on ill health cases is to a large degree irrelevant. This should **not** influence the outcome.

So in that context it does not matter if the GP in his letter of the 8th May makes such comments as quoted by Mr Cooper.

This approach is further underlined by the surprising situation surrounding the specialist, Dr Emerson, who initially stated, 'I would be reluctant to recommend retirement', in her letter from Feb 2013, and only a few weeks later is suggesting retirement, irrespective of further exploration of further treatment options.

Therefore, ill health decisions are based on through (sic) examination of **all** presented material but also on evidence based principles and not subjective opinions expressed in received reports."

28. Dr Ratti went on to say that he had acknowledged that Mr Cooper had developed allergies to various substances; although he said that the exact nature of the original exposure was unclear. He said that the diagnosis was angioedema in the absence of urticarial responses with a background history of confirmed allergens. Dr Ratti said that this was a complex immunological condition which he could expand on "with various medical explanations" but he thought that was out of the

remit of his letter. He said he would give a basic approach to help BHCC understand his "objective thinking". He also said that he had worked closely with the immunological department at his workplace in treating and improving such cases on numerous occasions. Dr Ratti then described the usual way of assessing cases – an immunological reaction based on the presence or absence of a skin reaction called urticaria (hives). He said that, in Mr Cooper's case, there appeared to be "only one recorded mention of a skin response from the information [he had], approximately 9 years, which was isolated". Dr Ratti said that there was no mention of this response in any of the information her had viewed. He said that this was why he had questioned the management of Mr Cooper's condition. Dr Ratti expressed the view that, "irrespective of the opinions from GPs and Dr Emerson", Mr Cooper's condition had not been thoroughly assessed and needed an immunologist to ensure that there was no other cause for his reactions.

29. Dr Ratti went on the say that, irrespective of the cause, Mr Cooper's condition required consideration of appropriate, regular prophylactic treatment. He said that Mr Cooper was not on regular treatment. Dr Ratti said that he had, that week, seen a lady in his clinic with an allergy based history leading to past anaphylactic reactions who was on such a treatment regime and was working.

30. BHCC wrote to Dr Emerson on 13 August 2013. They explained that Mr Cooper had been assessed by an IRMP as permanently incapable of efficiently performing the duties of his employment, having a reduced likelihood of being capable of undertaking any gainful employment before normal retirement age, and likely to be capable of undertaking gainful employment within three years of leaving his employment. BHCC explained that the first two criteria triggered the payment of ill health retirement benefits and the third determined the level of benefits. They explained that they had sought opinions from two further IRMPs as to Mr Cooper's likelihood of undertaking gainful employment and both were of the opinion that he was likely to be capable of doing so within three years. BHCC said that one of the IRMPs had suggested that Mr Cooper would benefit from seeing an immunologist to ensure that there were no other causes for his reactions. They said that Mr Cooper had confirmed that he was not currently under the care of an immunologist but had previously had blood test which showed that he did not have hereditary

angioedema. BHCC asked Dr Emerson to comment on the IRMPs opinions and give a view as to his future capability of undertaking gainful employment.

31. In her response, Dr Emerson confirmed that Mr Cooper was allergic to nickel, cobalt, balsam of Peru and epoxy resin. She said that she had discussed his case with a consultant dermatologist who was the clinical director of the local dermatology service. Dr Emerson said that he had confirmed that epoxy resin allergy in particular could cause the kind of extreme reaction which Mr Cooper experienced. She explained that a reaction could develop within 200 metres of the source of the epoxy resin because it is an airborne allergen and only required a few particles to trigger a reaction. Dr Emerson said that Mr Cooper's experience indicated that he was clinically much better at home where he could control the environment, which is what she would expect from an allergy triggered angioedema. She said that she understood that Mr Cooper had been screened for hereditary angioedema and she did not see the necessity for him to be under the care of an immunologist when he had a known allergic trigger for his condition. Dr Emerson concluded,

> "Mr Cooper will never be able to work again in an environment where he is exposed to the allergens causing his reaction, in particular epoxy resin. These jobs would include anything that would involve woodwork or caretaking at schools."

32. In response to further enquiries from BHCC, Dr Emerson said that the most important factor enabling Mr Cooper to avoid an adverse reaction was to avoid the allergens he responded to. She said that, if a reaction occurred, treatment with steroids, antihistamines and an EpiPen might be appropriate depending on the severity of the reaction. Dr Emerson said,

> "Mr Cooper's medical condition should not prevent him from being capable of any gainful employment within three years, provided he works in an environment that does not expose him to epoxy resin and his other allergens."

33. BHCC confirmed Mr Cooper's award at Tier 3. They gave the following reasons:

- The IRMP had certified that he was, on the balance of probabilities, permanently incapable of discharging efficiently the duties of his employment;
- The IRMP had confirmed that he had a reduced likelihood of being capable of undertaking any gainful employment before normal retirement age;
- The IRMP had stated that there is no doubt that, with further medical assessment and management of his condition, he would be capable of undertaking gainful employment within three years of leaving employment;
- Two other IRMPs had confirmed that a Tier 3 award was appropriate;
- His consultant had stated that his medical condition should not prevent him from being capable of gainful employment within three years, provided that he worked in an environment which did not expose him to epoxy resin or his other allergens.

34. Mr Cooper unsuccessfully appealed.

**Summary of Mr Cooper's Position**

35. Mr Cooper says that he does not feel that BHCC has considered all the medical evidence. He says that they only refer to the IRMPs' opinions in their decisions. Mr Cooper says that he has not been given an explanation as to why Dr Emerson's and his GP's reports appear to have been ignored and the IRMP's opinion accepted.

36. Mr Cooper argues that BHCC failed to make a decision based on their own opinion of his capability and instead chose to accept the IRMP's recommendation. He suggests that BHCC must have felt that a Tier 3 award was incorrect because they asked an IRMP to review it. Mr Cooper argues that BHCC should have followed the LGPS Regulations and made the tier decision they considered appropriate. He says that, during the appeal process, one IRMP "was dismissed" because she failed to read all the medical evidence and, when prompted to do so, declined on the grounds it would make no difference. He also says that Dr Smith provided no

reasons for his recommendation. Mr Cooper has pointed out that no alternative work suggestions were made by the IRMPs; only by Dr Sivayoganathan.

37. Mr Cooper says that clear warnings have been given by his GP and consultant that his angioedema is both lifelong and life threatening. He refers to Dr Emerson's statement that he is capable of working if he avoids the allergens in question. Mr Cooper argues that it is impossible to safely comply with this condition because of the number of allergens he must avoid and their prevalence in the working environment. He has pointed out that Dr Emerson has stated that his condition is clinically better at home. He also says that she stated that it was not necessary for him to be under the care of an immunologist and that his condition cannot be cured.

38. Mr Cooper says that most people reading Dr Emerson's statement with an understanding of his condition and the knowledge that practically all working environments expose him to allergens, would consider that he would not be able to secure gainful employment without risk to his health (and life). He feels that the council have ignored the second part of Dr Emerson's statement.

39. Mr Cooper says that he has been placed in the Support Group for Employment and Support Allowance and is not expected to secure gainful employment[2]. He feels that this underlines the fact that he is not considered able to work because of his condition. Mr Cooper says that individuals are not usually placed in the Support Group because the majority have conditions which are expected to resolve with time.

40. Mr Cooper has referred to guidance for IRMPs provided by the Department for Communities and Local Government which he does not feel has been taken into account. In particular, he has referred to the statements that,

> "Medical incapacity could arise, not only because of disability resulting from the employee's illness, but also if there was a serious risk that a job could exacerbate the employee's illness. For example, an employee with allergic occupational asthma might need to avoid exposure to the sensitising agent."

[2] DWP Leaflet DWP015 (Oct 2014) explains that an individual is placed in the Support Group if they have a condition that severely limits what they can do. They will not be expected to look for work or to take part in any work-focused interviews.

> "The salary that would be paid for jobs that the employee could undertake in the future is not an issue here for the IRMP. For example, if a Chief Executive had suffered a head injury in a road traffic accident leading to mental impairment, but would be capable in the future of working for 30 hours or more hours per week at other work such as a car park attendant, then he/she should be reported by the IRMP as having a reasonable prospect of being medically capable of obtaining gainful employment. However, in such circumstances, it might help the employer if you indicated the type of work for which the employee would be capable."

41. Mr Cooper says that the Council have based their decision on flawed advice from the IRMPs and that this is not fair or accurate.

42. Mr Cooper says that he has recently been admitted to hospital having experienced an anaphylactic episode. He says that his symptoms were similar to those of a stroke but tests confirmed that this was not the case and he had experienced an anaphylactic episode.

**Summary of BHCC's Position**

43. BHCC say that they passed all relevant medical evidence to their IRMP and it was considered by the Council when recommendations were made. They confirm that Dr Emerson's report was considered along with all the other medical evidence.

44. BHCC do not dispute that Mr Cooper's angioedema is lifelong and can be life threatening. However, they refer to Dr Emerson's statement that his condition should not prevent him from being capable of gainful employment within three years, provided that he works in an environment which does not expose him to epoxy resins and the other relevant allergens. BHCC appreciate that Mr Cooper will be restricted in the type of work he is able to undertake but they point out that none of the medical evidence stated that he is unable to work.

45. BHCC say that further IRMP opinions were sought because Mr Cooper challenged the Tier 3 award. They say that, in order to make an informed decision, they also wrote to Dr Emerson.

## Conclusions

46. It is agreed between the parties that Mr Cooper's condition renders him permanently incapable of efficiently performing his duties as a school caretaker and that he has a reduced likelihood of being capable of undertaking gainful employment before his normal retirement age. This entitles Mr Cooper to the early payment of his pension under Regulation 20. The disagreement lies in the level of pension which should be paid.

47. The decision as to the level of benefit which should be paid to Mr Cooper was for BHCC to make. Before making any decision under Regulation 20, BHCC were required to seek an opinion from an IRMP. Mr Cooper's case was reviewed by Dr Rost at Team Prevent. She thought that Mr Cooper was fit to undertake gainful employment but did acknowledge that his options would be very limited. Dr Rost did not actually give any examples of the kind of gainful employment which she thought Mr Cooper might undertake. Some suggestions had previously been made by Dr Sivayoganathan – driving, care work and landscape gardening. Mr Cooper had provided reasons why he disagreed that he would be able to undertake any of these occupations.

48. BHCC did not ask Dr Rost to elaborate on her view before adopting her recommendation for a Tier 3 award. Nor did they explain to Mr Cooper why they did not agree with his objections. As Dr Rost, herself, later pointed out, BHCC are not bound by the IRMP's opinion. They are required to come to a decision of their own under Regulation 20. It is open to BHCC to accept the advice that they receive from the IRMP, unless there is a cogent reason why they should not, and I imagine that it is rare for an employing authority to go against the advice of the IRMP. However, they should not accept the advice blindly; they are expected to weigh up all the available, relevant evidence and reach their own decision. If Dr Rost was of the view that there remained employment options available to Mr Cooper despite the restrictions of his condition, she should have been able to say what these were.

49. I note that Mr Cooper also expressed concern that Dr Rost had not seen his GP's letter of 13 February 2013. It is not clear why this was not sent to Dr Rost along with the rest of the medical evidence. When asked about the GP's letter, Dr Rost said

that she did not think it would make any difference to her recommendation. It is, to a large extent, a matter for Dr Rost's professional judgement whether she wishes to see a particular letter or report. Having seen the GP's letter, it does not appear to me to contain any information which was not available to Dr Rost from other sources. I am inclined to find that Dr Rost's decision not to see the GP's letter made little difference to the outcome of Mr Cooper's case and that BHCC were not at fault for not pursuing the matter further.

50. In response to Mr Cooper's challenge to their Tier 3 award, BHCC referred his case back to Team Prevent. They have explained that the intention was for it to be reviewed by another IRMP. Initially, the case went back to Dr Rost but BHCC did subsequently obtain opinions from Drs Smith and Ratti. Mr Cooper has suggested that this action indicates that BHCC were unhappy with Dr Rost's recommendation and should have come to a different decision. It does not follow that simply seeking further information from another IRMP means that the employing authority is unhappy with the initial recommendation. It was entirely appropriate for BHCC to seek further advice in response to a challenge to their decision.

51. I think it would be fair to say that Dr Smith's response was rather brief. He endorsed the recommendation for a Tier 3 award but gave no reasons. However, BHCC did receive a more comprehensive response from Dr Ratti. He noted that Mr Cooper had significant allergies to nickel, cobalt, balsam of Peru and epoxy resin but said that he did not have details of the severity of his reaction to the patch tests. Dr Ratti then referred to the full European battery of patch tests which he said was negative. This is somewhat contradictory since the European Standard series of patch tests includes cobalt chloride (cobalt), nickel sulphate (nickel), myroxylon pereirae resin (Balsam of Peru) and epoxy resin; all of which Mr Cooper had been tested for and found to react to adversely. I note, however, that Dr Ratti is neither an immunologist nor a dermatologist.

52. Dr Ratti said that it had been assumed that, because Mr Cooper had tested positively for certain allergens, these were the cause of his angioedema. He pointed out that this was not necessarily always the case. It is true that there are other causes for angioedema; it can also be drug-induced and hereditary. It can also be

described as idiopathic, that is, having no discernable cause. The first two had been eliminated in Mr Cooper's case. Dr Ratti suggested that a diagnosis of idiopathic angioedema with a background history of confirmed allergens should be considered. He suggested that this was important because, if the allergens were the cause of Mr Cooper's angioedema, his attacks should have been reducing as exposure was controlled. It was Dr Ratti's view that Mr Cooper should be assessed by an immunologist and undergo a regime of prophylactic medication in the form of steroids and antihistamines. He noted that Mr Cooper was or had been on antihistamines but said he did not know what type or dosage. What was not clear from Dr Ratti's report was whether he had taken account of the fact that the recommended treatment for idiopathic angioedema is the same as for allergic angioedema.

53. Dr Ratti gave his recommendation of Tier 3 benefits on the basis that such a treatment regime would result in Mr Cooper's condition improving within three years of leaving employment. He said he had seen "plenty of cases of a similar nature benefit from such an approach and *return to work*".

54. BHCC were then in the position of having to weigh up the advice they had received from Dr Ratti (and the other IRMPs) against the views expressed by Mr Cooper's treating physicians. Where an IRMP's comments on the diagnosis and treatment of the member's condition are at variance with his treating physicians, it is prudent for the employing authority to tread warily; particularly when those comments have been made without seeing the member and without the benefit of some of the relevant information. BHCC took the precaution of seeking further advice from Dr Ratti (despite his being somewhat reluctant to give it) and contacting Dr Emerson. This was an entirely appropriate response on their part.

55. Dr Ratti assured BHCC that he had read all the occupational health notes and all the relevant letters. He described this as "not a relevant concern". In fact, it was a perfectly legitimate concern on the part of both BHCC and Mr Cooper. Dr Ratti then said that the opinions expressed by doctors who have written reports in ill health cases were largely irrelevant. This is an inappropriate comment by an IRMP. All medical opinions are relevant to the case and it is for BHCC to weigh up the various

pieces of evidence. Such comments should not be taken into account by BHCC. Dr Ratti then pointed to Dr Emerson's initial view that she would be reluctant to recommend retirement and the fact that a few weeks later she had revised her opinion. He seemed to be suggesting that this was reason to discount Dr Emerson's opinion. However, he did not appear to take into account the fact the Dr Emerson revised her opinion on the basis of new information.

56. Dr Ratti then provided a very brief description of the way in which allergens are identified. He said that, in Mr Cooper's case, he had only seen one mention of a skin reaction and this was why he was questioning the management of the case. Dr Ratti set out what he considered to be the appropriate treatment regime for such a case and noted that Mr Cooper was not on any regular treatment. He stated that he had seen someone in his clinic on such a regime who was able to work and, on that basis, confirmed his recommendation of Tier 3. It is difficult to be sure that Dr Ratti had given proper consideration to Mr Cooper's case. He refers to there being only one mention of a skin reaction and yet the occupational health notes and correspondence from Dr Emerson and Mr Cooper's GP confirm that patch tests were carried out to confirm his allergies. Dr Ratti also gave his view as to the appropriate management of Mr Coopers' condition despite not being a specialist in the field, not having seem Mr Cooper and not having all of the relevant information to hand (namely, the reactions to the patch tests).

57. In the circumstances, it was very sensible for BHCC to approach Dr Emerson for her view. She confirmed that Mr Cooper had been found to be allergic to nickel, cobalt, Balsam of Peru and epoxy resin by patch test investigation. Dr Emerson expressed the view that it was unnecessary for Mr Cooper to be under the care of an immunologist when he had a known allergic trigger for his angioedema. She stated that he would not be able to work in an environment where he was exposed to the allergens in question; particularly epoxy resin. However, Dr Emerson subsequently said that Mr Cooper's condition should not prevent him from being capable of gainful employment within three years of leaving BHCC, provided that he was not exposed to epoxy resin and the other allergens.

58. BHCC were then faced with the task of weighing up these varying medical opinions in order to come to a decision as to the level of benefit to award. They confirmed the Tier 3 award on the basis that:

- The IRMP had stated that there is no doubt that, with further medical assessment and management of Mr Cooper's condition, he would be capable of undertaking gainful employment within three years of leaving employment;
- Two other IRMPs had confirmed that a Tier 3 award was appropriate;
- Mr Cooper's consultant had stated that his medical condition should not prevent him from being capable of gainful employment within three years, provided that he worked in an environment which did not expose him to epoxy resin or his other allergens.

59. Mr Cooper argues that BHCC have failed to come to a decision of their own and have merely adopted the IRMP's recommendation. He suggests that the views of his GP and Dr Emerson were ignored. I do not find this to be the case. BHCC took appropriate steps to obtain evidence from Dr Emerson as well as considering the advice they received from the various IRMPs.

60. There were flaws in the advice BHCC received from the IRMPs, but it has to be recognised that their advice did not differ from that of Dr Emerson on the matter of whether Mr Cooper should be able to undertake gainful employment within three years of leaving BHCC's employment. Dr Emerson added the caveat that Mr Cooper should avoid exposure to his known allergens, particularly epoxy resin. All the doctors and BHCC recognised that Mr Cooper's options for employment may be severely restricted but none (including Dr Emerson) went so far as to say that he would be incapable of gainful employment. I note Mr Cooper's reference to the fact that he has been placed in the Support Group for ESA. It may well be considered a strong indicator that Mr Cooper faces difficulties in undertaking gainful employment. However, the eligibility criteria for ESA are different to those set out in Regulation 20 and BHCC must come to a separate decision.

61. It is not the role of the Ombudsman to review the medical evidence and come to a decision as to Mr Cooper's eligibility for a benefit under Regulation 20. Rather, it is to look to see how the employing authority have reached their decision. For example, have they interpreted the Regulation correctly, have they obtained sufficient appropriate evidence on which to base a decision and is the decision supported by the available evidence.

62. I recognise that Mr Cooper disagrees that he is capable of undertaking gainful employment and has argued his case with BHCC. However, I find that BHCC have taken their decision in the proper manner. They sought evidence from both an IRMP and from the doctors treating Mr Cooper. They have understood and interpreted Regulation 20 correctly. The decision they reached is supported by the evidence they collected. It is agreed by all concerned that Mr Cooper's condition is permanent and also that it is potentially life-threatening should he suffer an anaphylactic episode (as evidenced by his recent admission to hospital). However, this is not the same as saying that he is not capable of gainful employment.

63. I do not uphold Mr Cooper's complaint.

**Jane Irvine**

Deputy Pensions Ombudsman

20 March 2015

**PO-4308**

## Appendix

## The Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (SI2007/1166) (as amended)

### Regulation 20

### Early leavers: ill-health

**20.**—(1) If an employing authority determine, …

(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 being capable of undertaking 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), (3) or (4), 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 …

(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 …

(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 normal retirement age if earlier, his benefits … 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

… 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 ("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.

…

(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
““an independent registered medical practitioner (“IRMP”) qualified in occupational health medicine” means a practitioner who is registered with the General Medical Council and —

(a) holds a diploma in occupational health 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) is an Associate, a Member or a Fellow of the Faculty of Occupational Medicine or an equivalent institution of an EEA state.”.