PO-4850

Ombudsman's Determination

Applicant	Mr J Cunningham
Scheme	Local Government Pension Scheme (**LGPS**)
Respondent(s)	Lothian Pension Fund (**LPF**) (Administrator) Scottish Public Pension Agency (**SPPA**)

Complaint summary

Mr Cunningham has complained that his application for the early payment of his deferred benefits on the grounds of ill health has not been considered properly.

Summary of the Ombudsman's determination and reasons

The complaint should be upheld against LPF and SPPA because they failed to consider Mr Cunningham's application for early payment of his deferred benefits in a proper manner.

Detailed Determination

Material facts

1. Mr Cunningham was employed by Midlothian Council (**Midlothian**) as a Horticultural Engineer until 4 May 2001. He had been on sick leave since 1999 with pain in both knees. Mr Cunningham applied for the early payment of his deferred benefits on the grounds of ill health in 2010.

2. As a deferred member under the 1998 Scheme, Mr Cunningham's benefits are governed by the Local Government Pension Scheme (Scotland) Regulations 1998 (SI1998/366) (as amended). The 1998 Regulations were revoked with effect from 1 April 2009. However, Regulation 5 of the Local Government Pension Scheme (Transitional Provisions) (Scotland) Regulations 2008 (SI2008/229) provides that they continue to have effect for deferred pensioners of the 1998 Scheme.

3. Regulation 30(6) provides that a deferred member who "becomes permanently incapable of discharging efficiently the duties of [his former] employment because of ill-health" may elect to receive immediate payment of his benefits. Regulation 96(2) provides that a first instance decision should be made by the Scheme employer who last employed the deferred member. Before making a decision as to whether a member may be entitled under regulation 30 on the grounds of ill-health, the Scheme employer must obtain a certificate from an independent registered medical practitioner (**IRMP**) who is qualified in occupational health medicine as to whether in his opinion the member is permanently incapable of discharging efficiently the duties of his former employment. "Permanently incapable" is defined as incapable at least until age 65.

4. Mr Cunningham was seen by Dr Saravolac, an IRMP at LPF's medical advisers, Capita Health Solutions (**Capita**), on 12 July 2010. She advised LPF that she would need to obtain a report from Mr Cunningham's GP before she could give an opinion. LPF notified Mr Cunningham that Capita were seeking a report from his GP. The GP wrote to Dr Saravolac on 28 August 2010. He said that Mr Cunningham had been in receipt of Incapacity Benefit since 2009. The GP said that Mr Cunningham active medical problems were renal colic, back pain, depression and high blood pressure. He said that Mr Cunningham had had depression since 2000 and had been under psychiatric in-patient care until 2005. The GP said that Mr Cunningham's mental health was stable on medication and his high blood pressure was well controlled. He said that there were no documented functional problems in Mr Cunningham's medical notes.

5. Dr Saravolac wrote to LPF on 7 October 2010. She said that the medical evidence confirmed "a history of few underlying health issues". Dr Saravolac said that Mr Cunningham remained on relevant treatment and his medical conditions were well managed. She said that the main medical condition at that time appeared to be pain in

his knee joints. She said that not all reasonable treatment options had been explored for a sufficient period of time. Dr Saravolac noted that the LGPS required Mr Cunningham to be permanently incapable of discharging effectively the duties of his former employment. However, she went on to say that she was also required to assess whether he was incapable of carrying out any regular full-time work.

6. Dr Saravolac expressed the opinion that there was not sufficient evidence to confirm that Mr Cunningham was permanently incapacitated either for his former employment or any other form of regular employment. She concluded,

> "In my opinion this decision is premature in light of further options of treatment available for his joints as well as stability on other conditions that he is suffering from through relevant and effective medical management. In the circumstances and on the balance of probabilities this gentleman does not satisfy the criteria for deferred benefits under the [LGPS] Regulations 1998."

7. On 11 October 2010, LPF informed Mr Cunningham that Capita had reviewed the evidence and had advised that he did not meet the criteria for the early payment of his deferred benefits on ill health grounds. LPF said that early payment would not be granted.

8. Mr Cunningham appealed. LPF acknowledged his appeal and said that they had asked Capita to request an up-to-date report from his GP.

9. Mr Cunningham's case was reviewed by another occupational health physician at Capita, Dr MacKenzie. He wrote to LPF, on 3 May 2011, saying,

> "I have reviewed the medical information available on file including the initial medical report provided by Dr [Tam] dated 28 August 2010 and a further medical report provided by Dr S Sparrow dated 16 March 2011. Mr Cunningham also submitted details of a DLA award.
>
> It is readily accepted that Mr Cunningham experiences troublesome psychological and physical symptoms and functional limitations and that he remains under the care of his general practitioner taking appropriate long term medication.
>
> However it is felt that insufficient medical evidence is available to make a determination of permanent incapacity in accordance with the pension scheme regulations and I am therefore unable to support Mr Cunningham's appeal on this occasion."

10. LPF wrote to Mr Cunningham on 17 May 2011. They said that they had received another report from Capita and that they remained of the opinion that there was insufficient medical evidence to make a determination of permanent incapacity. LPF asked if Mr Cunningham wanted his appeal referred to an appointed person.

11. The appointed person issued a decision on 27 July 2011. He noted that Dr Saravolac had incorrectly referred to a requirement that Mr Cunningham be incapable of any regular full-time work. However, he did not consider this to be sufficient to dismiss her opinion because she had said that Mr Cunningham not permanently incapacitated for either his former employment or any other form of regular employment. The appointed person referred to Dr MacKenzie's report. He concluded,

> "Having considered the above I find that [LPF] has acted properly in terms of the Regulations in denying early payment of your deferred benefits on ill health grounds by obtaining the opinion of a suitably qualified medical practitioner before arriving at a decision on whether or not to pay your deferred benefits on grounds of permanent ill health. I also consider that [LPF] in obtaining a second medical opinion have acted beyond what is required under the [LGPS] Regulations in ensuring your application was given due and proper consideration. As such I must therefore dismiss your appeal."

12. Mr Cunningham appealed further.

13. The second stage of the appeal procedure is dealt with by SPPA. They wrote to Mr Cunningham, on 14 June 2012, saying that (amongst other things) that they were proposing to arrange for him to attend an independent medical examination.

14. Dr Reed, a consultant occupational physician at Workability Ltd, provided a report on 26 November 2012. He noted that Mr Cunningham had been employed by Midlothian as a Horticultural Engineer until 2001 and that he had been absent from work since 1999 with a knee problem. He noted that a determination had to be made as to whether, on the balance of probabilities, Mr Cunningham was permanently incapable of discharging efficiently the duties of his former employment.

15. Dr Reed said that Mr Cunningham had explained that he had not worked in any capacity since leaving Midlothian. He said that Mr Cunningham reported being able to walk for less than 100 metres at a time and that he struggled with day to day activities, including dressing and personal care. Dr Reed noted that Mr Cunningham took painkillers and anti-inflammatories as advised by his GP but had not had any input from orthopaedic specialists for many years. He said that he had not been referred to a pain clinic and had not had a recent scan. Dr Reed also mentioned that Mr Cunningham had described suffering from recurrent depression and continued to take treatment for this. He went on to say,

"The medical evidence confirms the previous assessments made of his knees around the time when his occupational difficulties emerged. The diagnosis is confirmed as above but it was noted even as far back as 2000 that he displayed "gross protective pain behaviour" by a specialist physiotherapist.

Examination at assessment revealed very clear signs of exaggerated pain behaviour and inconsistencies in examination, which was beset with variable levels of effort and movement depending on posture. For example Mr Cunningham was not able to bend his knees past about 30 degrees during the examination yet did bend them to 90 degrees when sitting/dressing. Actual examination of the knees themselves was generally unremarkable with a normal appearance, no evidence of pre-patellar bursitis, no joint margin tenderness and no instability. There was no muscle wasting which was inconsistent with the reported level of dysfunction. Patellar movement did generate some pain but there were no other positive findings.

The overall impression formed, taking into account all of the above, is that there is no objective medical evidence or examination evidence to adequately explain the degree of stated functional impairment in this case."

16. Dr Reed concluded that there was insufficient medical evidence to suggest that Mr Cunningham was permanently incapable of performing his previous occupation. He said that he rejected the appeal.

17. SPPA issued a stage two decision on 29 November 2012. They said the question was whether, in terms of Regulation 30, Mr Cunningham was permanently incapable of discharging efficiently the duties of his former employment by reason of ill health. SPPA said that they had considered Dr Reed's report and enclosed a copy for Mr Cunningham. They referred to Dr Reed's comment that "there [was] no objective medical evidence or examination evidence to adequately explain the degree of stated functional impairment in this case". SPPA said that they had determined that Mr Cunningham was not permanently incapacitated and therefore not entitled to receive early payment of his benefits.

18. Mr Cunningham contacted the Pensions Advisory Service (**TPAS**) for assistance. They obtained further reports from Mr Cunningham's GP and his consultant psychiatrist, Dr Moffoot. The GP confirmed that Mr Cunningham had developed bilateral patello-femoral pain with patella tendonitis in 1999. He said that, as a result, Mr Cunningham had been unable to resume his employment and had developed a depressive illness. The GP said Mr Cunningham had been referred to Dr Moffoot in 2000 and again in 2005. He outlined the treatment Mr Cunningham had received for his depression and said he had also been diagnosed with high blood pressure in 2008 and renal colic in 2002. The GP said that Mr Cunningham still had chronic bilateral knee pain and

chronic mobility problems for which he was prescribed medication. He said he had thought Mr Cunningham's depression was related to his inability to work but other factors had triggered a more recent relapse. The GP concluded that, given the severity and longstanding nature of Mr Cunningham's chronic physical and mental health conditions, he thought it unlikely that he would be able to resume any form of employment in the foreseeable future.

19. Dr Moffoot confirmed that Mr Cunningham had been referred to him in 2000, had flare ups in 2005 and 2012, and was currently unwell. He said that each time Mr Cunningham had required a change of treatment and his illness had yet to go into remission. Dr Moffoot said that Mr Cunningham remained vulnerable to spells of morbid depression and, given the chronicity and severity, he thought it unlikely that he would be able to resume any form of employment in the foreseeable future.

Summary of Mr Cunningham's position

20. Mr Cunningham says that he had to leave his employment with Midlothian because he had "beat knee" which has since developed into osteoarthritis. He says that he has been unable to work since and is receipt of Employment Support Allowance (**ESA**) and higher rate Disability Living Allowance (**DLA**). Mr Cunningham says he also suffers from severe depression.

21. Mr Cunningham says that he does not believe that Midlothian took his medical evidence into account. He says that they did not refer to the fact that he lost his job as a result of his disability. Mr Cunningham says that the recent reports from his GP and consultant psychiatrist clarify his claim for a pension.

22. Mr Cunningham is particularly upset by certain comments made by Dr Reed concerning exaggerated pain behaviour. He equates this to hypochondria.

23. Mr Cunningham also says that the whole process took an unnecessarily long time. He says that he first applied for his pension in April 2010 but the decision was not made until December 2012. Mr Cunningham says that SPPA failed to keep him updated on the progress of his case.

Summary of LPF's position

24. LPF have explained that they are part of the City of Edinburgh Council's Corporate Governance Department. They provide pensions administration for (among others) Midlothian.

25. LPF say that their processing of ill health retirement assessments for the early payment of deferred benefits is in line with other Scottish local government administering authorities. They say that, because members leave employment some time before

applying for the payment of their benefits, contact with their former employer is lost. They say that, in such cases, Scottish administering authorities have always processed ill health applications on behalf of employers.

26. LPF have referred to Regulation 31 of the Local Government Pension Scheme (Benefits, Membership & Contributions) (Scotland) Regulations 2008 (SI2008/230) (as amended) (the **2008 Benefits Regulations**). This provides for the administering authority to decide whether to agree to an application for early payment. The reference to administering authority was inserted into the 2008 Benefit Regulations by SI2009/93 with effect from 1 April 2009.

27. LPF take the view that this is not a first instance decision. They say that the first instance decision was made by Midlothian when they terminated Mr Cunningham's employment in 2001.

28. LPF say that, following Mr Cunningham's application for the payment of his pension, arrangements were made for him to attend an examination with their medical examiner. They say that the medical examiner, Dr Saravolac, was of the opinion that Mr Cunningham did not meet the criteria for early payment of his benefits and she was unable to support permanent ill health. LPF say that, on receipt of Mr Cunningham's appeal, his case was referred to Dr MacKenzie who agreed with Dr Saravolac. They say that, at stage two of the appeal, this view was further confirmed by Dr Reed.

29. LPF say that early payment of deferred benefits on the grounds of ill health cannot be awarded without an appropriate medical certificate and they did not obtain such a certificate. They have referred to Regulation 30(6) and Regulation 96(9). They say this is also SPPA's interpretation of the Regulations.

30. LPF say that Mr Cunningham was referred to Capita, in accordance with Regulation 96(9), and was seen on two occasions by different IRMPs. They say that the IRMPs' views were confirmed by the SPPA's IRMP. They point out that all three IRMPs were qualified as required by the Regulations

31. LPF say that they do not hold medical evidence for Scheme members. They have explained that Mr Cunningham would have signed a mandate authorising only Capita to access his medical records. They say that the IRMP provides a confidential service with only the member concerned.

32. LPF say that medical problems are outside their expertise and they must place a heavy reliance on the IRMP's opinion.

Summary of SPPA's position

33. SPPA disagree that they failed to properly consider Mr Cunningham's application for the early payment of his benefits under the appeal process. They consider that it was entirely reasonable for them to reach the conclusion they did on the evidence at their disposal and taking account of Mr Cunningham's age and the Scheme's normal retirement age.

34. SPPA say that the question for them to determine was whether, in terms of Regulation 30, Mr Cunningham was considered incapable of discharging efficiently the duties of his former employment by reason of ill health.

35. SPPA say that they considered Dr Reed's report and, in particular, his comment that "there is no objective medical evidence or examination evidence to adequately explain the degree of stated functional impairment in this case". They say that they accepted Dr Reed's advice and decided that Mr Cunningham was not permanently incapacitated and, therefore, not entitled to receive early payment of his benefits.

36. With regard to the length of time taken to make a decision, SPPA say that Mr Cunningham wrote to them on 25 January 2012 and they replied on the same day, asking him to complete a mandate and provide a copy of the stage one decision. They say that Mr Cunningham sent them the appeal form on 8 March 2012 and said that he would provide further medical reports. SPPA say that they followed this up on 2 April 2012 and received the additional material on 13 June 2012. SPPA say they received Mr Cunningham's mandate to obtain information from Midlothian on 20 June 2012. Mr Cunningham had an appointment with Dr Reed on 23 August 2012; after which Dr Reed requested additional information from Mr Cunningham's GP. Dr Reed wrote his report on 26 November 2012.

37. SPPA say that they have now changed to a provider who can provide a medical report within five days of receiving all the relevant information.

38. SPPA suggest that, rather than returning the case to the beginning of the process by referring the matter back to Midlothian, they should seek clarification from Dr Reed on the question of Mr Cunningham's protective pain behaviour.

39. SPPA suggest that they should be granted an extension to the usual timescales in order to seek this clarification from Dr Reed.

Conclusions

40. As a deferred member of the 1998 Scheme as at 1 April 2009, Mr Cunningham's entitlement to the early payment of his deferred benefits falls to be determined under the 1998 Regulations.

41. Regulation 30 provides for the early payment of deferred benefits where an individual becomes permanently incapable of discharging efficiently the duties of their former employment because of ill health. Permanently means lasting at least until normal retirement age.

42. Under Regulation 96(2), the decision as to whether Mr Cunningham's benefits should be paid early should have been made by Midlothian – as the Scheme employer who last employed him. I note that Regulation 31 of the 2008 Benefits Regulations refers to the administering authority. There seems to an anomaly in the 2008 Regulations because Regulation 52 of the Local Government Pension Scheme (Administration) (Scotland) Regulations 2008 (SI2008/228) (as amended) refers to the employer seeking the approval of the administering authority for its choice of IRMP "for the purposes of regulation … 31". If there is no decision for them to make under Regulation 31, there is no need for them to seek approval for their choice of IRMP. This, however, does not affect Mr Cunningham's case for the reason given above.

43. LPF say that they process applications for the early payment of deferred benefits on the grounds of ill health because contact has been lost with the former employer. They have explained that this is the approach taken by all Scottish administering authorities. I can see the logic in their argument but this is not what the Regulations require. It would be possible for Midlothian to delegate their responsibility for making the decision to LPF but they have not done so.

44. I find therefore that LPF should have referred Mr Cunningham's application for the early payment of his deferred benefits to Midlothian in the first instance. I note LPF's argument that this is not a first instance decision. When Mr Cunningham's employment with Midlothian ceased, he became a deferred member with an entitlement to benefits payable at his normal retirement age. Whether he is entitled to benefits under Regulation 30 is a separate decision and Midlothian should make this further decision in the first instance. Having determined that LPF were not the correct decision maker, I find that it was maladministration for them to proceed to make the decision.

45. In and of itself, this might not have caused Mr Cunningham any injustice if LPF made the decision in a proper manner and if it is more likely than not that Midlothian would have made the same decision. In those circumstances, Mr Cunningham would be in the position he ought to be regardless of the maladministration. It remains therefore to consider whether LPF did, in fact, make the decision in the proper manner.

46. Following receipt of Mr Cunningham's application, LPF sought the opinion of an IRMP. It is not the case that benefits cannot be paid early under Regulation 30 without a certificate from an IRMP to the effect that the member is permanently incapable of discharging efficiently the duties of their former employment because of ill health. Rather, the decision cannot be made until a certified opinion from an IRMP is obtained.

Neither Midlothian nor LPF would be bound by the IRMP's opinion. There are public sector schemes which specifically provide for the medical advisor's decision to be final but the LGPS is not one of them. Midlothian and/or LPF are required to seek an IRMP's **opinion** before they make the decision. They cannot make a decision before obtaining the IRMP's opinion but they are not obliged to accept that opinion once obtained.

47. It may be rare for an employer or administering authority to disagree with the IRMP but this is not to say that they should accept the opinion blindly. The Regulation 30 decision must be made after all available, relevant evidence (including but not exclusively the IRMP's opinion) has been carefully weighed up by the appropriate decision maker. Of course, the weight that the decision maker gives to any of the evidence is for them to decide and it may be that they prefer the opinion from the IRMP. They would be entitled to do so unless there is good reason why they should not. I fully understand LPF's concern that they (or rather Midlothian) are being asked to make a decision on medical matters. However, this is what is required of them under the Regulations. They are being asked to weigh up the advice from the doctors and come to a decision as to which of the possibly competing views is best supported by the available evidence. For this reason, it is not acceptable for them to view the IRMP's opinion only. They must make the appropriate arrangements for the decision maker to review all the appropriate, relevant evidence.

48. The first opinion was provided by Dr Saravolac. She based her opinion on her consultation with Mr Cunningham and the report from his GP. Dr Saravolac noted that Mr Cunningham's medical conditions were well managed and I take her to mean his depression and high blood pressure. She said the main condition appeared to be the pain Mr Cunningham had in his knees. Dr Saravolac went on to say that not all reasonable treatment options had been explored for a sufficient period of time. It was for this reason that she did not think that Mr Cunningham met the criteria for early payment of his benefits. However, Dr Saravolac did not say which treatment options she had in mind. Nor did she say whether she thought that treatment was, more likely than not, going to improve Mr Cunningham's knee pain to the extent that he would be able to discharge efficiently the duties of his former employment. LPF may have assumed that this is what Dr Saravolac meant but it would have been prudent for them to check. Without the additional information, LPF were not in a position to review Dr Saravolac's opinion properly. Nor was Mr Cunningham in a position to understand the basis for LPF's subsequent decision so that he could either accept it or properly prepare an appeal.

49. The second opinion was provided by Dr MacKenzie. If anything, his report was even briefer. He accepted that Mr Cunningham experienced troublesome psychological and physical symptoms and had functional limitations. Dr MacKenzie then said that there was insufficient medical evidence available to make a determination of permanent incapacity. It is unclear from this whether Dr MacKenzie thought the evidence itself was insufficient to determine permanent incapacity (as in he thought it did not suggest permanent incapacity) or whether he thought more evidence was required. If it was the former, he did not explain why. If it was the latter, he did not say what additional evidence should be sought before a decision was made. Either way, the decision maker (and Mr Cunningham) needed further clarification.

50. When Mr Cunningham's case reached SPPA, they too sought the opinion of an IRMP. They did not ask why LPF had made the decision in the first place.

51. The IRMP opinion was provided by Dr Reed. His report was the most detailed of the three IRMPs. Dr Reed focused on Mr Cunningham's problems with his knees; although he did mention that he also suffered from recurrent depression for which he continued to take treatment. Dr Reed noted that Mr Cunningham was taking painkillers and anti-inflammatories as prescribed by his GP but had not seen an orthopaedic specialist or been referred to a pain clinic. He then described the results of his examination of Mr Cunningham's knees. Dr Reed referred to gross protective pain behaviour which, I understand, Mr Cunningham finds offensive. He believes that he is being accused of hypochondria. In fact protective pain behaviour is a medical description for the kinds of behaviours adopted by people in response to pain; it is not a criticism of the individual. Dr Reed simply believed that Mr Cunningham had adopted certain protective behaviours in response to his pain which were not in proportion to the actual condition of his knees.

52. Dr Reed took the view that the objective medical evidence, including his examination, did not explain the degree of functional impairment Mr Cunningham experienced. It was for this reason that he did not consider that Mr Cunningham was permanently incapable of performing his previous occupation. However, Dr Reed did not say whether Mr Cunningham's protective pain behaviour itself could be addressed. He mentioned that Mr Cunningham had not seen an orthopaedic specialist or been referred to a pain clinic. Dr Reed did not, however, say whether he thought these options might result in Mr Cunningham's pain management improving to the extent that he could discharge efficiently the duties of his former employment.

53. Unless Dr Reed was of the view that Mr Cunningham was already able to discharge the duties of his former employment (which he did not say), he needed to assess the likelihood of this being the case before he reached age 65. That assessment would

have had to have addressed Mr Cunningham's protective pain behaviour. SPPA did not ask Dr Reed for further clarification before declining Mr Cunningham's appeal.

54. In view of the omissions in the medical reports provided by the IRMPs, it was not safe or fair for LPF or SPPA to rely on them in reaching a decision in Mr Cunningham's case. In these circumstances, I find that Mr Cunningham has suffered injustice because LPF (and SPPA) failed to consider his application for early payment of his deferred benefits in a proper manner.

55. It is not my role to review the medical evidence and come to a decision as to whether Mr Cunningham's benefits should be paid early under Regulation 30. Having determined that the decision has not yet been made in a proper manner, the correct course of action is for me to remit it for reconsideration. In effect, to set aside the decisions made to date and begin the process afresh. LPF should refer the matter to Midlothian in the first instance.

56. SPPA have suggested that, instead of beginning the process again at the beginning with a review by Midlothian, they should seek clarification from Dr Reed. This would shorten the review process for Mr Cunningham which is to be welcomed. My reservation is that it would remove the opportunity to have a fresh medical review of the case. An alternative would be for SPPA to refer the matter to an IRMP who has not previously been involved. I am of the view that Mr Cunningham should be given the option to decide which approach he would prefer.

57. Mr Cunningham has also complained that the process took too long. Whilst I recognise that the process did take a long time, I have not identified any unnecessary delays on the part of LPF or SPPA. Where there were periods when there was little progress, these were largely down to waiting for the doctors to respond or, it has to be said, waiting for Mr Cunningham. Having said that, Mr Cunningham is now faced with the fact that the whole process has to start again. I find that the unnecessary stress and inconvenience this will inevitably cause should be recognised by payment of some modest compensation. I do not agree that SPPA should be allowed more time in which to process his case.

Directions

58. I direct that, within 14 days of the date of my final determination, LPF will refer Mr Cunningham's case to Midlothian for them to seek the opinion of an IRMP who has not previously been involved. Alternatively, if Mr Cunningham prefers, SPPA are to refer the matter to Dr Reed or another IRMP for review whichever option Mr Cunningham elects for.

59. Within 21 days of the date of the final determination, LPF and SPPA will each pay Mr Cunningham £250 in recognition that the failure to properly consider his application previously has resulted in unnecessary stress and inconvenience.

Jane Irvine
Deputy Pensions Ombudsman

30 March 2015