PO-4150

Ombudsman’s Determination

Applicant	Mr X
Scheme	Local Government Pension Scheme (**LGPS**)
Respondent(s)	The Council

Complaint summary

Mr X has complained that the Council have not properly considered his eligibility for ill health retirement.

Summary of the Ombudsman's determination and reasons

The complaint should be upheld against the Council because they failed to consider Mr X’s eligibility for benefits under Regulation 20 in a proper manner; in particular, they failed to make a decision under Regulation 20(1).

DETAILED DETERMINATION

Material Facts

1. Mr X is employed by the Council. He is currently working reduced hours (20 out of the 36 full-time hours). However, Mr X has been told that this reduction in hours cannot continue indefinitely.

2. In 2011, the Council reduced their department budget by 51% and the responsibilities of their Managers increased. They were asked to spend less of their time in the office and more time "out and about, inspecting and patrolling the quality and quantity of work in their given area".

3. The Council referred Mr X to their occupational health unit in December 2011. In their referral, they asked if retirement on the grounds of permanent ill health was likely to be appropriate. Ill health retirement under the LGPS is provided for in Regulation 20 of the LGPS (Benefits, Membership and Contributions) Regulations 2007 (SI2007/1166) (as amended). The decision making process is governed by the LGPS (Administration) Regulations 2008 (SI2008/239) (as amended). Extracts from the relevant regulations are set out in an appendix to this document.

4. Mr X was seen by Dr B in January 2012. In her report for the Council, dated 17 January 2012, Dr B said she had assessed Mr X for fitness for work and the possibility of meeting the criteria for ill health retirement under the LGPS. She said that he had provided copies of a report from his specialist, dated 27 November 2009, and a letter from his pain management consultant, dated 18 October 2011. Dr B said that Mr X had described a 14 year history of back pain and an MRI scan, in 1999, had shown degenerated discs which were assumed to be the cause of the pain. She described the treatment Mr X had received, including physiotherapy, acupuncture, TENS machine, various medication and an epidural injection. Dr B said that the 2009 report had said that surgical treatment was unnecessary and that Mr X was awaiting a course of pain management. She went on to say,

   "We discussed lifestyle changes that are needed to ensure optimum prognosis and the prevention of any health issues. Hopefully the pain management course will help manage his pain such that he is able to function better. In my opinion he has had no recent investigations and if the pain management is

> unsuccessful and the clinical picture appears to be different from before it may be sensible to have a further medical assessment …
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> [Mr X] is fit for work with present adjustments but needs to pace himself in order to achieve an acceptable attendance …
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> [Mr X] is not fit for his full hours in the workplace without the facility to work flexibly and work from home. He needs to use his annual leave to pace himself … He should continue with the current adjustments until the pain management courses are completed and its effect can be seen. Hopefully his absences should decrease with the benefits of the Pain Management Course. This is a long-term medical condition which affects his mobility and therefore should be considered as a possible disability under the Equality Act 2010 … As the pain management course has not been completed there are still untried treatment options he will need to be reviewed when sufficient time has elapsed from the completion of this course of treatment for a reasonable prognosis to be made."

5. Dr B also wrote to Mr X's consultant in pain management, Dr L. She said that she needed to assess whether Mr X had reached the point of "maximal medical improvement". Dr B said that she needed to assess whether, on the balance of probabilities, Mr X was unlikely to improve over the coming 19 years until his normal retirement age under the LGPS. She said that this would mean that a clear diagnosis had been made for his symptoms, all treatment options had been explored and sufficient time had elapsed since the completion of treatment for a reliable prognosis to be made.

6. In response, Dr L provided Dr B with a copy of a letter he had written to Mr X's GP on 9 March 2012. In his covering letter, Dr L said that he believed that Mr X had reached the point of maximal medical improvements because it appeared that he had exhausted medical options. He said that he had suggested that the way forward would be a combination of medication and lifestyle changes. Dr L concluded by saying that he believed that Mr X was permanently incapable of discharging the duties of his employment with the Council.

7. In his letter to Mr X's GP, Dr L outlined the results of a number of tests and gave details of Mr X's medication. He referred to an epidural given in 1999 and said that

this had not been helpful. Dr L said that Mr X had described his general health as good, but that he suffered from fatigue and poor concentration. He went on to say,

"Mindful of his previous assessment at the INPUT Pain Management Programme, I explored options for pain management at this hospital. We offer a similar cognitive behavioural oriented approach to pain management … In discussing his case I raised the issue of his motivation and potential to engage on our inpatient programme. I believe that overall when not at work, [Mr X] is coping reasonably well and in fact his work status is compromising his ability to cope … I believe that if [Mr X] was able to secure ill health retirement, his quality of life would substantially improve as he would be able to pursue greater health investment to help manage his pain. [Mr X] accepts that further medical interventions are unlikely to provide significant relief and that rather the approach he needs to adopt is one of changing lifestyle and routine."

8. Dr L concluded by saying that he had agreed with Mr X that there was little point in him attending an upcoming appointment at the pain clinic. He said that he believed that it might be helpful for Mr X to "disengage from medical services", pursue ill health retirement and engage in self-management strategies.

9. Mr X was seen by his consultant in pain management, Dr K, in February 2012, and she wrote to his GP on 13 March 2012. Dr K said that she had previously seen Mr X to assess him for a pain management programme. She noted that he had had several investigations and interventions. Dr K referred to an MRI scan in 2009 which had revealed three level disc disease and noted that surgical treatment had not been recommended. She also noted that a caudal epidural had not given Mr X any relief. Dr K said that Mr X understood that there was no cure for his chronic pain. She said that he had been offered a placement on a residential pain management course but had been unable to attend. Dr K said that he was waiting to be assessed for a non-residential course. She concluded,

"Patients with chronic pain find that the pain itself has a significant impact on their quality of life. Similarly, [Mr X] has had this chronic pain having an impact on his quality of life for several years and has tried various ranges of medical interventions with little or no relief for his pain. The Chronic pain is explained as a result of central sensitisation of dysfunctional nervous symptoms for which currently there are no anatomical based interventions or a cure or further relief for this pain. The Pain Management Programme however does aim to improve quality of life despite this pain. Patients with chronic pain need

to pace their activity and may need some flexibility. He has already been offered a reduction of hours at work, with which he is coping currently well, and also his cooperative employer has allowed him to have two hours of work from home. I would support this working pattern as he seems to be coping with current 26 hours per week."

10. Dr B referred Mr X's case to another occupational health physician, Dr D. He saw Mr X, in April 2012, and subsequently wrote to Dr L requesting a further report. In his letter, Dr D said,

"You state that you explored options for pain management … and describe what this would involve. You go on to state, however that "I raised the issue of his motivation and potential to engage on our inpatient programme. I believe that overall when not at work, [Mr X] is coping reasonably well and in fact his work status is compromising his ability to cope."

You will appreciate that before I can find a condition likely to permanently prevent an individual from carrying out their duties, I need to be sure that they have exhausted all realistic treatment options. I am aware of the considerable evidence base for multidisciplinary, cognitive and behavioural approaches both in reducing pain scores long-term and in improving measured functional capability.

[Mr X] has understood from you however that such a course would not be appropriate for him as it would not significantly improve his work capability. I would be grateful if you could kindly give me a rational[e] as to whether a multidisciplinary programme is indicated and, if not reasons why it should not be considered."

11. In his notes from his assessment of Mr X, Dr D concluded,

"He clearly has non-specific low back pain. MRI scan did not show conditions which define the cause of his pain. History and examination do not suggest major pathology. Most significantly, has not undergone a multi-disciplinary pain management course, probably because it was felt he was not motivated to gain a positive functional outcome. None of this suggest that his condition is likely to permanently prevent him from carrying out his duties. I have, however written to his Psychologist asking for further advice on a pain management program …"

12. In response, Dr L said that he had formed the impression that Mr X would struggle to engage on their pain management programme which was "simply about the patient making changes to their routine and lifestyle". He said that it appeared to him the Mr X struggled to fulfil the duties of his employment when trying to adapt his routine. Dr L said that Mr X would struggle to gain meaningful and long lasting benefit from the pain management programme because, when not at work, he was able to effectively manage his pain by pacing his activity cycle. He concluded,

    "Of course, another Specialist may disagree with my opinion and it may be worth [Mr X] considering the INPUT Pain Management Programme … although I understand he previously declined this referral.

    I do not feel able to justify further consideration for the Pain Management Programme when my clinical reasoning leads me to believe that [Mr X] would not gain any meaningful benefit from such an intervention."

13. On receipt of Dr L's letter, Dr D signed a "Certificate of Permanent Incapacity" stating that, in his opinion, Mr X was not suffering from a condition which, on the balance of probabilities, rendered him permanently incapable if discharging efficiently the duties of his employment with The Council. In a letter sent to Mr X at the same time, Dr D explained that, in reaching a decision, it had to be clear to him that there was a significant underlying health problem which had substantially affected Mr X's ability to carry out his duties (usually reflected in substantial, long-term and ongoing sickness absence) and that all realistic treatment options had been exhausted or would be unlikely to result in a sufficient functional improvement to allow a return to effective working. He enclosed a copy of his notes. The Council have stated that they did not take Dr D's certificate into account in making their decision.

14. In June 2012, Mr X saw another consultant in pain management, Dr O, for an opinion on reducing his working hours. She subsequently wrote to his GP saying that Mr X should pace his activities to cope with his chronic pain. Dr O said that this should be a permanent (until age 65) reduction in hours to a maximum of 26 per week.

15. Mr X was referred to an occupational health specialist, Dr E, by his GP. In his referral letter, the GP mentioned that Mr X had been told that he would not benefit from a pain management course and that Mr X disagreed with this view. In a subsequent letter to Mr X, Dr E said that, given Mr X's motivation and attitude towards his pain and his professional approach to his work, he would continue to benefit from input from physiotherapists and psychologists. He said that this would enable Mr X to manage his pain and continue to work part time; he suggested a maximum of 20 hours per week.

16. Mr X's GP also referred him to a consultant psychologist, Dr H. In a subsequent letter to Mr X, Dr H said that they had discussed the appropriateness of attending an NHS pain management clinic, which Mr X would be willing to do. He said that this would have little benefit because, in his opinion, it would only re-iterate the techniques Mr X already knew. Dr H said that it had been agreed that Mr X would pursue a self-management plan and would continue to see him and a physiotherapist for help in applying the techniques. He expressed the view that a pain management course would not enable Mr X to return to full time work of more than 30 hours per week.

17. In August 2012, the Council appointed Dr C as the independent registered medical practitioner (**IRMP**), required by the LGPS Regulations. Dr C, wrote to Dr B on 22 August 2012,

> "I note that this 47 year old gentleman is employed as a full-time Contract Manager for [The Council] and has applied for ill health retirement because of his long-standing history of chronic back pain.
>
> In my view, there is sufficient medical evidence to demonstrate that [Mr X's] symptoms are related to a chronic, ongoing underlying pathology, the severity of which has had and is having an adverse impact on his ability to undertake daily activities.
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> However, the key criterion that must be met in order for an application to be successful is that [Mr X] has a medical condition that on balance of probabilities permanently renders him incapable of discharging efficiently the duties of his employment. Since [Mr X] is approximately 18 years away from his normal retirement age, in my view, this criterion is not met and hence his application is declined."

18. Dr C listed the medical evidence she had reviewed. In addition to the reports from Dr D and Dr L, she referred to reports from Mr X's GP (Dr U 14, 22 and 25 June 2012), a consultant occupational health physician (Dr E 26 June 2012), a consultant in pain medicine (Dr O 20 June 2012), a consultant in trauma and orthopaedics (Mr S 9 December 2009), a clinical psychologist (Dr H 27 June 2012), a consultant in pain management (Dr K 9 May 2012) and a specialist occupational therapist (Ms P 18 May 2011). Extracts from the pre-2012 medical reports are contained in the appendix to this document.

19. Mr X has explained that when he had not heard, he telephoned the Council and their occupational health unit and was told that Dr C had declined his application. The Council say that their occupational health unit has no record of a telephone call from Mr X. Mr X appealed against this decision.

20. In September 2012, a registered counselling psychologist, Ms Kt, wrote to one of the pain management consultants involved in Mr X's care. She explained that he had had a multidisciplinary assessment in 2011 and had been offered a place on a residential pain management programme due to commence in January 2012. Ms Kt explained that Mr X had cancelled his place on the course because of commitments towards his new-born son.

21. In October 2012, Mr X was seen by a consultant in anaesthesia and pain relief, Dr Es. She subsequently wrote to his GP. Dr Es said that Mr X had been assessed for a pain management course but had felt unable to leave his wife and child to attend. She noted that he was trying to reduce his medication. Dr Es said that Mr X had benefited from reducing his hours and felt able to cope with his pain more positively. She said that, given the amount of pain he was in and had suffered from over the past several years, she found it difficult to believe that he would be capable of full time work (36 hours per week).

22. In November 2012, Mr X saw a consultant occupational physician, Dr Sg. In his subsequent report, Dr Sg said,

> "The records show that [Mr X] has engaged in pain management but with considerable caution regarding his body movements and has developed compensatory patterns to manage his pain. He has relinquished sports, going to the gym etc. As a result of the multi-disciplinary Input Pain Management assessment … he has been diagnosed with chronic pain syndrome …
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> The treatment for this condition is the adoption of a pain management programme which aims to improve the patient's quality of life … This doesn't offer a cure …
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> [Mr X's] fifteen year history of pain, coming on unrelated to specific trauma or back movement, is consistent with the diagnosis of chronic pain syndrome. [Mr X] has struggled to sustain his employment and is now engaged for twenty hours per week but this is for a restricted period only and his is a full time post requiring the occupant to work 36 hours per week.
>
> <u>OPINION</u>
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> [Mr X] is permanently suffering from a condition that, on the balance of probabilities, renders him permanently incapable of discharging efficiently the duties of his employment with his employer because of ill health. In the Regulations pertaining to LGPS, gainful employment means paid employment for not less than thirty hours in each week for a period of not less than twelve months."

23. Dr Sg also signed a pro-forma certificate stating that, in his opinion, Mr X was suffering from a condition which rendered him permanently incapable of discharging efficiently the duties of his employment with his employer because of ill health. He also said that Mr X had no reasonable prospect of being capable of undertaking gainful employment before his normal retirement age.

24. The Council submitted Mr X's case to another IRMP, Dr W. He provided a report on 27 January 2013. Dr W reported,

> "[Mr X] presents as a typical case of chronic pain syndrome, where acute back pain has progressed to chronic back pain. There are also typical features in the reports from his treating clinicians. All his clinicians have provided negative opinions about his lumbar spine, his symptoms and his prognosis.

He has had an MRI scan in 2008 and this shows normal degenerative changes. His back is normal for his age. There is no 'disease' as reported by several clinicians, and there is no evidence of any cause for his symptoms in the structures of his back. It is therefore unhelpful when treating clinicians state clearly that his back is the cause of his problems. I note that not all do this; some provide advice based on evidence and current understanding about pain.

Current evidence and understanding about chronic pain is based mostly on studies of fMRI which appear to show abnormal activities of brain function related to the experience of pain, and on behavioural issues seen in patients reporting pain. Chronic pain is believed to begin with an acute physical problem, but the patient responds inappropriately … the brain gradually adapts inappropriately … The situation often settles at a level … a state of equilibrium. Changes … will only arise if the brain processing changes, and this will only happen if the patient changes their behaviour.

External input from treating clinicians cannot achieve this in isolation, the patient has to engage too … In most case where no improvement occurs it is because the patient takes a passive role … They will only get better if they change their behaviour, and this only happen if they believe that changing will work …

Beliefs play a major role, and where clinicians reinforce negative beliefs, for example stating that they have disease, or a problem that will never get better, or that they must never attempt certain activities, it is less likely that the patient will engage fully with treatment.

In order to be eligible for ill health retirement, an applicant must be considered permanently unfit for their employed role until normal retirement age, 65 years. In [Mr X's] case this represents the next 18 years or so. The decision falls to the employer, based on advise [*sic*] provided to the employer and on a certificate from an occupational physician who is appropriately qualified. An occupational physician is expected to give advice based on objective evidence. In the case of chronic pain there will be no clear objective evidence, making any decision difficult.

There is no evidence of any substantial disease in [Mr X's] spine. His spine is normal for his age, so he will not be harmed by any activity and there is no medical reason to restrict him from any activity. Any assessment of chronic pain is based entirely on what the patient says to the examining clinician, and

how they perform when being examined. Treating clinicians will believe the patient, assume what they are being told is true, and act as the patient advocate when asked to do so.

There are other sources of objective evidence. [Mr X] has been employed in his current role for a number of years without any apparent significant problems. He has had almost no recorded sickness absence. He did raise issues with his line manager at the end of 2011 asking for adjustments to his work pattern and hours and shortly after this he applied for ill health retirement. He has since been assessed by a variety of specialists who have based their assessment on what he has told them, and they have given advice on the basis of this. He has stated that he has very high levels of pain … Normally when patients describe pain at these levels they are severely incapacitated and usually hospitalised. A person would not normally be able to function in any form of work at pain levels of 6-8/10. His specialists expressed some surprise that he was still able to work. Nevertheless they acted as the patient advocate and recommended that he should not work at the levels he had previously coped with, and could never do so again. A more objective approach would have been to question the level of pain he described and the fact that he had clearly coped at work for many years with his symptoms. Furthermore, various specialists have suggested different hours that he is capable of working, all being very specific about these. There is no clear objectivity behind the numbers … These will have been based on what [Mr X] told the specialists he could cope with. The subjective statements of severity of pain did not match the observed spinal function and general function within the consulting room noted by both [Dr D and Dr Sg]. There is no record anywhere of his general fitness levels including BMI, which would be of significance in relation to his core muscle function and his likelihood of recovery.

It is well recognised that other external factors substantially influence a patient's description of pain, their ability to tolerate pain, and their approach to work. There are issues in [Mr X's] history that do not appear to have been considered important, yet are likely to have a substantial impact on his ability to cope with work and back pain. He was noted to live with his mother, but to have a wife and one year old child living at a significant distance away from home. This would be expected to play a major factor in his ability to cope with other pressures in life, and clearly affected his motivation to engage with treatment when offered a residential course. He was also noted by [Dr L] to have possible anxiety and probably depression, both of which can substantially affect perceptions of pain and the ability to engage with

treatment. Reported symptoms and capabilities are expected to be influenced by secondary gain, in this case his application for ill health retirement.

In summary, [Mr X] has no significant evidence of spinal disease to explain symptoms of chronic back pain. He was coping in his job for many years until recently when he has sought clinical treatment for worsening back pain and at the same time he applied for ill health retirement. There is evidence for significant lifestyle issues and personal stressors that are recent and would be expected to impact on his perception of pain. All specialist reports supporting his application for ill health retirement are recent, and based entirely on the history he has provided. There is evidence that the history he gives does not match the observed behaviour and reaction to pain. It has been noted by some that there is no hope of any recovery from chronic pain; this is simply not true. Compete resolution is unlikely but most patients are expected to improve both functionally and in their experience of pain. There is no obvious reason why [Mr X] should not experience some improvement in his ability to cope with work, and although he may well not cope with his current role for some time, perhaps even several years, there is no good reason why he should be unable to do so for the next eighteen years."

25. Two versions of Dr W's report were produced: one for the occupational health unit and one for the Council's "management". Mr X was asked to give his consent for Dr W's report to be sent to the stage one decision maker at The Council. There was some confusion regarding Mr X's consent and only the certificate signed by Dr W was sent to the decision maker.

26. The Council declined Mr Xs' appeal. In their letter to Mr X, the Council said that they had had regard to Regulation 20 (see appendix). They said that this provided that benefits could be paid early "if an [IRMP] certifie[d] that the member [was] permanently incapable of discharging efficiently the duties of the relevant employment because of ill health or infirmity of mind or body". The Council said that Dr W had certified that Mr X was not permanently incapable of discharging efficiently the duties of his employment and, consequently, they did not uphold his appeal.

27. Mr X was informed that he could submit a further appeal and he chose to do so.

28. Mr X underwent a further MRI scan on 17 February 2013. He was referred to a consultant orthopaedic surgeon by Dr Sg, who asked if there had been any

deterioration in his condition since the MRI in 2008. The orthopaedic surgeon, Mr Bl, responded,

> "Both scans show a 3-level degenerative disk disease at L3/4, L2/3 and L4/5. L4/5 is the most prominently affected level where he has a prominently bulging annulus with a constitutionally narrow spinal canal and some degree of impingement on the left of the L5 nerve root.
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> He also has degenerative changes which appear more advanced in the scans which were done two days ago. These are particularly seen at L3/4 and L4/5 where there is more disk dehydration as well as some facet joint changes …
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> His history and findings are entirely consistent with the progression of the degenerative change in his back. I feel that on the balance of probabilities, [Mr X] has exhausted all realistic treatment measures open to him that would enable him to work in a full time capacity until normal retirement age."

29. Mr X saw Dr B on 26 February 2013 following a referral for a return to work assessment. She reported that he had a positive attitude to life and work but felt that he was limited in how long he could work for. Dr B said that Mr X had asked her to consider evidence from a new specialist before deciding on his fitness to increase his hours. She said that Mr X was fit for the full range of duties described but felt he could only sustain them for four hours per day. Dr B said he should avoid heavy lifting, pulling, pushing or repetitive bending and that this was likely to be permanent. She advised a risk assessment for Mr X's driving position and routes. Dr B said that the Equality Act 2010 should be considered because chronic back pain was long term and significantly impacted on day to day activities and mobility. She noted that he had been working 20 hours per week since 2012 and expressed the view that he may be able to increase his hours at some stage in the future. Dr B said that Mr X had tried to increase his hours to provide cover at weekends but had had to increase his painkillers to do so. She noted that he had experienced drowsiness as a result which made driving unsafe.

30. Dr Sg provided a supplementary report in which he commented on Dr W's report. He disagreed with Dr W's view that Mr X's spine was normal and referred to the MRI scans done in 2008 and 2013. Dr Sg referred to Mr Bl's findings; in particular, he referred to Mr Bl's finding that Mr X had a constitutionally narrow spinal canal.

31. The Council referred Mr X's case to another IRMP, Dr Sh. In his report, Dr Sh noted that Mr X had had symptoms of back pain for many years and had been fully investigated by MRI scans and specialist opinions. He noted the discovery of degenerative changes in Mr X's back and said that these were consistent with his age group. Dr Sh said that many people had few or no symptoms with such changes, but some had significant symptoms. He went on to say that the imaging was frequently not consistent with reported symptoms but that the individual's attitude could have a significant effect on their on-going wellbeing.

32. Dr Sh noted that Mr X had been managing his condition by pacing. He said that, "At some point in probably late 2009", Mr X's attitude to his pain became more negative and he began to manage it less well. He said that Mr X had "clearly coped with his work until the end of 2011"; he acknowledged that some adjustments had been agreed with management to help him cope up until then.

33. Dr Sh noted that the orthopaedic surgeons had not recommended surgery. He said that the remaining options were: active rehabilitation (which was not available on the NHS) and pain management. Dr Sh noted that Mr X had been offered the latter but declined "ostensibly because of family commitments that would conflict with the preferred residential course". Dr Sh then referred to a clinical psychology opinion which suggested that Mr X would not effectively engage with such a course. He went on to say that this opinion reflected an assessment of whether the individual "really wants to commit their best efforts to overcome their pain". Dr Sh commented that, when cognitive responses to pain had been altered, increased levels of exercise frequently led to improvements in symptoms and capability. He also commented that a failure to engage was often due to "clinicians giving inappropriate or unhelpful advice". Dr Sh also commented that an assessment of pain was based entirely on what the patient told the examining clinician and how they performed when examined. He noted that two of the occupational physicians who had examined Mr X held differing opinions; albeit he noted that there was six months between them. Dr Sh commented that treating clinicians "tend to believe the patient, assuming that what they are being told is true, and act as the patient advocate when asked to do so".

34. Dr Sh noted,

> "In order to be eligible for ill health retirement, an applicant must be considered permanently unfit for their employed role until normal retirement age, 65 years. In [Mr X's] case this represents the next 17 years. The decision falls to the employer, based on advice provided to the employer and on a certificate from an occupational physician who is appropriately qualified. An occupational physician is expected to give advice based on objective evidence. In the case of chronic pain there will be no clear objective evidence, making any decision difficult. In [Mr X's] case, the objective evidence does not support that he permanently unable to work in his current role."

35. Dr Sh went on to comment that individuals who had had frequent and repeated investigations and negative medical comments from treating health professionals often became "medicalised" and to believe that they had permanent and incurable problems. He suggested that this had happened with Mr X. Dr Sh went on to say that, in his opinion, Mr X had not completed all reasonable interventions and, in particular, he had not attended a pain management programme. He suggested that, if Mr X did so and positively engaged with the course, he "would have significant resolution of his reported symptoms".

36. Dr Sh noted that eligibility for ill health retirement required the applicant to be permanently unfit for their role until normal retirement age. He noted that, in Mr X's case, this meant for the next 17 years. Dr Sh also noted that an applicant would have to be able to work for at least 30 hours per week for a period of not less than 12 months. He commented that Mr X "feels that he can work 20 hours and has persuaded a number of medical practitioners to support this restriction".

37. Dr Sh concluded that, in his opinion, Mr X was not permanently incapable of discharging efficiently the duties of his employment and he did not recommend ill health retirement.

38. The Council declined Mr X's appeal. They said that they had regard to Regulation 20 (see appendix) and had taken account of the fact that Mr X's medical condition had been considered by three IRMPs, who had determined that he had not met the requirements of the regulation. The Council said that the first stage appeal decision maker had been entitled to rely on the certificate provided by Dr W. The second

stage decision maker said that he had taken account of Dr Sh's conclusion that Mr X was not permanently incapable of discharging efficiently the duties of his employment. In particular, he referred to Dr Sh's opinion that the changes shown in the MRI scans were frequently found in Mr X's age group. The decision maker also referred to Dr Sh's view that Mr X had not exhausted all treatment options and that a pain management course, including cognitive behavioural therapy, and exercise therapy could lead to improvement in capability.

39. Since the Council's final appeal decision, Mr X's GP referred him for a pain management course. He underwent a review by a senior physiotherapist and a consultant clinical psychologist in August 2013. They noted that he had seen several health practitioners over the years but had not attended a formal programme to consolidate and implement the advice he had received. They commented that there did not appear to be any significant motivational barriers to Mr X participating in and fully engaging with their programme.

40. Mr X's case was also reviewed by an occupation health physician, Dr Wd. In her report of 22 August 2013, Dr Wd noted that Mr X had not yet attended a programme to consolidate and implement the advice he had been given and had accepted a place on such a course. She said it would be in appropriate to state that no further improvement was possible or that his condition would permanently impact on his ability to undertake his normal employment until he had completed the course and adequate time had been allowed to assess any benefits.

41. Mr Bl wrote an open letter on 29 August 2013 in which he said that the MRI scans had shown degenerative disc disease with a constitutionally narrow spinal canal. He said that he was not Mr X's treating physician and had been asked to review the treatment he had received. Mr Bl said that he could confirm that the pattern of pain was likely to get progressively worse and it was adversely affected by Mr X's narrow spinal canal.

42. Mr X attended a two-week functional restoration programme with Real Health in October 2013. In their discharge letter to Mr X's GP, the pain management course said that Mr X had engaged well with the course and had been well motivated. With regard to his future functioning, the pain management course said that he could improve his functioning at home and at work. However, they also said that that it was more likely than not that he would find it difficult to sustain working hours significantly greater than the 20 hours per week he was then working.

Summary of Mr X's position

43. Mr X says that the Council failed to make a proper decision. He says that they failed to ask all the relevant questions. In particular, Mr X says that the Council failed to ask Dr Sh why cognitive behavioural therapy (**CBT**) would be a realistic treatment for him when Dr L had said, in 2012, that it would not make any difference to his condition.

44. Mr X points out that he has undertaken a pain management course at his own expense and that the assessment at the end of the course was that he would not be able to improve his pain management sufficiently to enable him to carry out his role on a full time basis.

45. Mr X says that Dr B said he was permanently unable to do his job because he is permanently unable to manage the driving element of the role.

46. Mr X says that there were inappropriate references to the fact that he had 18 years to go before his normal retirement age in the referrals to the IRMPs. He considers that this was an attempt to influence the doctors' opinions.

47. Mr X says that he has tried to continue working but this has been very difficult. He says that he found the appeal process stressful.

Summary of The Council's position

48. The Council say they referred Mr X's case to their occupational health unit with the specific question – "Is retirement on the grounds of permanent ill health likely to be appropriate?" They say that this question can only be commented on by an IRMP.

49. The Council refer to the decisions made at stage one and two of the appeal process.

Conclusions

50. For Mr X to receive a pension under Regulation 20, the Council must decide to terminate his employment on the grounds that he is permanently incapable of discharging efficiently the duties of his employment with them and that he has a reduced likelihood of being capable of undertaking any gainful employment before his normal retirement age. Before making such a decision, they are required to obtain a certificate from an IRMP as to whether, in his opinion, Mr X meets these criteria. However, the IRMP is only being asked to give an opinion; it is for the Council to determine whether to terminate Mr X's employment with them under Regulation 20.

51. In making this decision, the Council are, first of all, required to make a finding of fact as to whether Mr X meets the criteria set out in Regulation 20(1). It is for them to weigh up the available evidence and come to a decision. They may give more weight to some of the evidence, including the opinions expressed by the IRMPs, provided that they have given due consideration to all of the relevant available evidence. The fact that evidence has come from another medical practitioner is not good reason, in itself, for that evidence to be set aside. Nor are the Council bound by an opinion expressed by an IRMP; they can be expected to actively review such an opinion and seek clarification when appropriate. It may be rare for an employer to come to a different opinion to that of the IRMP, but they should not simply accept the IRMP's recommendation blindly. At the very least, they can be expected to satisfy themselves that the IRMP has considered all the relevant evidence, has not overlooked any relevant facts and has correctly applied the Regulations.

52. In Mr X's case, there is no evidence that the Council made the initial decision. For example, they did not write to Mr X after Dr C had reviewed his case. Mr X says he came to know that his application had been unsuccessful by telephoning the occupational health unit. The Council say that the occupational health unit have no record of this call. However, there is no evidence that Mr X came to know of the decision by any other means.

53. In her letter to Dr B, Dr C acknowledged that the evidence demonstrated that Mr X's symptoms were related to an underlying pathology. She also acknowledged that the severity of his condition had had and was having an adverse impact on his ability to undertake daily activities. Dr C then referred to the first criterion in Regulation 20(1) and concluded that, "Since [Mr X was] approximately 18 years away from his normal retirement age", the criterion was not met. She did not give any other reason why Mr X did not meet the criteria set out in Regulation 20(1). This, in itself, is not sufficient reason for Mr X's application to be declined. Had the Council given proper consideration to Mr X's eligibility under Regulation 20, they would have needed to seek further clarification from Dr C. However, Dr C went on to say that "hence his application is declined". This further reinforces the conclusion that The Council failed to make a decision under Regulation 20(1). This amounts to maladministration on their part.

54. Mr X appealed and his case was referred to another IRMP, Dr W. There were two versions of the report provided by Dr W: one for the occupational health unit and one for the Council's "management". However, the stage one decision maker only saw the certificate signed by Dr W because there was some confusion over Mr X giving consent for the release of the report. For the reasons I have already mentioned, it is unwise for an employer to proceed to a decision on the basis of the IRMP's certificate alone. The Council needed to know the reasons behind Dr W's opinion in order to satisfy themselves that, for example, there were no misunderstandings or omissions of fact affecting that opinion. Mr X also needed to know what Dr W's reasoning was so that he could either accept the decision or, if not, be in a position to properly prepare an appeal.

55. The decision maker said that he had had regard for Regulation 20. He then went on to say that the Regulation meant that benefits could be paid early "if an [IRMP] certifie[d] that the member [was] permanently incapable of discharging efficiently the duties of the relevant employment because of ill health or infirmity of mind or body". This is incorrect. Benefits may be paid under Regulation 20 if the employer determines that the member's employment is to be terminated on the grounds that ill health has rendered him permanently incapable of discharging efficiently the duties of that employment and he has a reduced likelihood of being capable of

undertaking any gainful employment before his normal retirement age. As I have explained, it was for the Council to make that decision. Mr X's appeal was not, therefore, properly considered at the first stage of his appeal. I find this to be further maladministration on The Council's part.

56. Mr X appealed further and his case was referred to Dr Sh. By this stage, Mr X had obtained a number of further medical reports in support of his application, including those from Dr Sg, Dr Es, and Mr Bl. These, together with the earlier medical evidence, were made available to Dr Sh.

57. It is clear from the stage two decision maker's report that Dr Sh's opinion was very influential in the outcome of Mr X's appeal. For this reason, it is appropriate to look at it in some detail. It is open to The Council (and the appeal decision makers) to rely on the advice they receive from the IRMPs but, as I have said, they should not do so blindly and must have regard for all the available relevant evidence.

58. Dr Sh expressed the view that the degenerative changes shown in the MRI scans were consistent with Mr X's age. He acknowledged that some people had significant symptoms with such changes but went on to say that the attitude taken by the individual could have a significant effect on their on-going wellbeing. This is consistent with the views expressed by other doctors in Mr X's case. Dr Sh commented that Mr X had been managing his condition by pacing. He then went on to say that at some point in "probably late 2009" Mr X's attitude to his pain became more negative and, consequently, he began to manage it less well. It is unclear where Dr Sh got this impression from. Dr Sh said that Mr X had "clearly coped" with his work until the end of 2011. He did, however, acknowledge that this had been with agreed adjustments. Dr Sh did not refer to the organisational changes introduced in 2011.

59. Dr Sh said that, since surgery was not recommended, the remaining treatment options for Mr X were active rehabilitation and pain management. He then noted that Mr X had been offered pain management but had declined it "ostensibly because of family commitments that would conflict with the preferred residential course". Dr Sh went on to say that to a clinical psychology opinion had suggested that Mr X would not effectively engage with such a course. This appears to be a

reference to Dr L's report to Mr X's GP in March 2012. In this report, Dr L said that he had discussed a pain management course with Mr X and "raised the issue of his motivation and potential to engage on our inpatient programme". Dr Sh appears to have taken this to mean that Dr L was of the view that Mr X lacked motivation. However, in a subsequent letter, Dr L explained that he had formed the view that Mr X would struggle to engage in a course which was about making adjustments to routine and lifestyle when he thought Mr X struggled to fulfil his duties when trying to adapt his routine.

60. Dr Sh seems to have taken the view that Mr X lacked motivation to engage with pain management; he implied that there were reasons other than family commitments which led to Mr X declining a residential course. This view is inconsistent with that expressed by other doctors and, had the Council actively reviewed Dr Sh's report, they could have been expected to seek clarification as to why he had come to such a different view.

61. Like Dr W before him, Dr Sh took a somewhat negative view of the opinions expressed by Mr X's treating physicians. He pointed out that an assessment of chronic pain is based entirely on what the patient told the examining clinician and how they performed when examined. Dr Sh then said that treating clinicians "tend to believe the patient, assuming that what they are being told is true, and act as the patient advocate when asked to do so". He went on to say that an occupational physician was expected to give advice based on objective evidence. Dr Sh subsequently said that Mr X had "persuaded" a number of medical practitioners that he could only work for 20 hours per week. This is coming very close to saying that the views expressed by Mr X's treating physicians should not be taken into account. It is one thing for an IRMP to disagree with the views expressed by a member's treating physicians; it is another for them to cast doubt on the veracity of those opinions and of the member's own account of his symptoms. The Council must ignore any such inappropriate comments on the part of an IRMP.

62. Dr Sh concluded that Mr X was not incapable of discharging efficiently the duties of his employment. This view was largely based upon the fact that Mr X had not undertaken a formal pain management course. Dr Sh expressed the view that, if he were to do so, Mr X could expect a "significant resolution of his reported symptoms". However, Dr Sh did not explain what Mr X could expect to gain from attending a formal course of pain management which he had not already gained from the input of the pain management specialists he had already attended. Those pain management specialists had formed that view that Mr X was already managing his chronic pain as well as he could through pacing and exercises, coupled with medication. Before relying on Dr Sh's report in reaching the decision to decline Mr X's appeal, it would have been prudent for the decision maker to seek further clarification from him.

63. Whilst it was open to stage two decision maker to accept Dr Sh's view over that of the doctors treating Mr X, he must have a reason for doing so other than simply that he is the IRMP. If the decision maker did have another reason for preferring Dr Sh's view, he did not explain what it was in his decision letter. This, coupled with the fact that no clarification was sought from Dr Sh, leads me to conclude that the decision maker did not actively consider the available evidence. Instead, Dr Sh's recommendation was accepted without question. I do not find that Mr X's second stage appeal was properly considered or that it addressed the maladministration I have identified at the earlier stages. I uphold his complaint.

64. Mr X's case is slightly different to the majority of LGPS ill health retirement cases which I see in that he has continued to work for the Council; albeit on a part time basis. Under Regulation 20, Mr X cannot receive a pension until his employment is terminated; that has not yet happened. Because Mr X has remained in the paid employment of the Council in the interim, he has not suffered any financial loss as a result of their failure to make a decision as to his eligibility under Regulation 20 in the proper manner.

65. It is not the role of the Ombudsman to review medical evidence and come to a decision as to the member's eligibility for benefit under Regulation 20. The proper course of action would normally be for me to remit the decision for the employer to

reconsider. However, in Mr X's case, this is not appropriate. Instead, it would be more appropriate for the Council to take a fresh decision bearing in mind my findings in this determination. In effect, to set aside the decision they previously made and begin the process of deciding whether the terminate Mr X's employment on the grounds that ill health has rendered him permanently incapable of discharging efficiently the duties of that employment afresh. This will necessitate the Council obtaining an opinion from an IRMP who has not previously been involved in the case. There is no reason why this IRMP should not be provided with all of the previous medical evidence. However, in view of the elapse of time, it would be appropriate for more up to date evidence to be sought as well. The Council should also allow Mr X to submit any more recent medical reports he wishes to.

66. The fact that I have upheld Mr X's complaint should not be taken to mean that I have reached a view as to what the outcome of such a review should be; I have not. The decision as to whether Mr X's employment should be terminated on the grounds of ill health under Regulation 20 is to be made by the Council.

67. Mr X has explained that, following the rejection of his appeal, he paid for a pain management course himself. He has also explained that he found the appeal process stressful. Mr X's decision to pay for a pain management course was, undoubtedly, prompted by the rejection of his ill health retirement application, but I do not find that the Council required such a step. I do not find that they should be required to reimburse Mr X for this expense. I do, however, find that it would be appropriate for Mr X to receive some modest compensation for the stress he experienced as a result of the failure to consider his eligibility under Regulation 20 in a proper manner.

Directions

68. I direct that, within 21 days of the date of my final determination, the Council will refer Mr X's case to an IRMP who has not previously been involved in case. The IRMP is to be provided with copies of all the available medical evidence. On receipt of the IRMP's certified opinion and report, the Council will consider whether to terminate Mr X's employment under the terms of Regulation 20.

69. Within the same timeframe, the Council will pay Mr X £250 in recognition of the stress caused by the way in which they dealt with his original application.

Jane Irvine

Deputy Pensions Ombudsman

23 February 2015

Appendix

Local Government Pension Scheme Regulations

Regulation 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; …

(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.” …”

Regulation 55

“(1) Any question concerning the rights or liabilities under the Scheme of any person other than an employing authority must be decided in the first instance by the person specified in this regulation.

…

(6) Any question whether a person is entitled to a benefit under the Scheme must be decided by the employing authority which last employed him …”

PO-4150

Regulation 56

“(1) Subject to paragraph (1A), an independent registered medical practitioner (“IRMP”) from whom a certificate is obtained under regulation 20(5) of the Benefits Regulations in respect of a determination under paragraph (2), (3) or (4) of that regulation (early leavers: ill-health) must be in a position to declare that -

(a) he has not previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested; and

(b) he is not acting, and has not at any time acted, as the representative of the member, the employing authority or any other party in relation to the same case,

and he must include a statement to that effect in his certificate.

(1A) Paragraph (1)(a) does not apply where a further certificate is requested for the purposes of regulation 20(7) of the Benefits Regulations.

(2) If the employing authority is not the member’s appropriate administering authority, it must first obtain that authority’s approval to its choice of registered medical practitioner for the purposes of regulation 20 … of the Benefits Regulations.

(3) The employing authority and the IRMP must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation, and -

(a) in the case of the employing authority, when making a determination under regulation 20 of the Benefits Regulations; or

(b) in the case of the IRMP, when expressing an opinion as to the matters set out in regulation 20(5) … of those Regulations.”

Pre-2012 medical reports

Mr X was seen by Mr Sheard (consultant in trauma, orthopaedic and spinal surgery) in December 2009. He recorded that an MRI scan had shown three level disc disease but that there was no surgical treatment for Mr X's back pain. Mr Sheard had said that Mr X did not want treatment for his leg pain and he had not arranged to see him again. A specialist registrar in trauma and orthopaedics, Mr Shaerf, also wrote to Mr X's GP confirming that he had multilevel disc disease and explaining that surgery had not been offered because "the risks would far outweigh the benefits".

Mr X was referred to a pain management programme by his consultant in pain management in 2011. Ms Penman (a specialist occupational therapist) reported, on 18 October 2011, that he had presented with chronic mechanical low back pain. She said Mr X was cautious with movements and had developed compensatory patterns to manage his pain. Ms Penman reported that Mr X had given up sport and going to the gym and struggled with bending, kneeling and getting on and off the floor. She went on to say that, from the physiotherapy assessment, there were no physical barriers to him attending and participating in a pain management programme. Ms Penman then described the impact Mr X's pain was having on his everyday functioning. She noted that he had continued to work and was managing his pain by taking annual leave and working from home. Ms Penman said that Mr X's consultant, Dr K, had recommended he attend a pain management course. She went on to say,

> "[Mr X] understands that by coming onto the programme he will have to come to terms with the fact that there is no cure possible for his chronic pain and no further medical interventions are deemed suitable or appropriate for his condition.
>
> Chronic Pain syndrome is a permanent, medically-recognised condition that causes a great deal of suffering. There are recognised neuro-physiological changes in the central nervous system, although these are not detectable on scans or X-rays, and there may appear to be no visible damage or deformity. Many people with Chronic Pain find that it impacts significantly on their lives. Patients who are referred to the INPUT Pain Management Unit, like Mr X, have usually experienced a wide range of medical interventions, with little or no relief from their pain, and, as a sensitised/dysfunctional nervous system is the generating 'source' of the pain, further anatomical-based interventions would not offer a cure for or relief from his pain. However, the Pain Management programme does aim to improve a patient's quality of life despite the pain and seeks to improve their physical function, mood, and ability to cope with the tasks of everyday living, such as work. It does not offer a cure for the pain or involve an interventional treatments or procedures for patients whilst they attend the programme.

Mr X is motivated for a pain management approach and the goals he would to work on include: learning techniques to help him deal with the pain from a physical and emotional point of view, learning exercises and movements, and practical ways to keep a positive outlook and maintain his momentum. Understandably, he would like to reduce his pain, but unfortunately this cannot be a goal of the programme."