CAS-30338-Y0S9

Ombudsman's Determination

Applicant	Mr S
Scheme	Local Government Pension Scheme (the **Scheme**)
Respondent	Corby Borough Council (**CBC**)

Outcome

1. I do not uphold Mr S' complaint and no further action is required by CBC.

Complaint summary

2. Mr S' complaint is that he has not been awarded ill health retirement from active status membership of the Scheme.

Background information, including submissions from the parties

3. CBC is the Employing Authority and Northampton County Council is the Administering Authority for the Northamptonshire Pension Fund (the **Fund**), which is part of the Scheme.

4. Mr S was employed by CBC as a Health Protection Officer (**HPO**). Mr S commenced sickness absence in April 2016.

5. In a report dated 9 January 2017, Mr Harrison (Consultant Vascular Surgeon) said:-

   - Mr S had undergone a series of investigations, including an arterial duplex scan, venous duplex scan and a CT angiogram of the aorta and lower limbs.
   - Mr S' primary complaint was pain in his right hamstring and calf after taking a few steps. His symptoms were relieved by resting and elevation.
   - On examination of Mr S' right leg there was evidence of both arterial and venous disease and his calf was swollen and slightly tender. The investigations revealed narrowing in the arteries and damage to the veins. It was determined that angioplasty of the arteries on the right leg would be technically possible.
   - He next reviewed Mr S in November 2016 and explained the results:

> "I explained that I was still not entirely clear what the predominant aetiological factor in his ongoing pain was and that it may well be a mix of arterial and venous disease. His venous scan revealed deep venous reflux that would not be amenable to surgical intervention but his arterial narrowings would be. I explained to him that I was not entirely sure that treatment of his arterial lesions would improve his symptoms considerably and did come with a risk of complication. I also explained that arterial symptoms do tend to improve with exercise. Given that he had no signs of critical limb ischaemia, there was no indication for mandatory treatment. On review of the information I provided him, he decided that he did not want to have an angioplasty of his arteria tree. In my opinion that was reasonable. It is likely that his post-thrombotic syndrome will be a chronic problem without any obvious intervention. It may be that an angioplasty would help his symptoms somewhat but again this is not by any means mandatory and does come with some risk. He has been placed on best medical management for his peripheral arterial disease. His peripheral arterial disease may improve with exercise and in November he reported that his symptoms were somewhat better than when I first met him. I have arranged to see him in six months' time."

6. Mr S' employment was terminated on the grounds of ill health on 31 March 2017.

7. At that time Mr S was considered for ill health retirement. The relevant regulations are The Local Government Pension Scheme Regulations 2013 (SI2013/2356) (as amended) (the **2013 Regulations**). Regulation 35 provided:

> "(1) An active member who has qualifying service for a period of two years and whose employment is terminated by a Scheme employer on the grounds of ill-health or infirmity of mind or body before that member reaches normal pension age, is entitled to, and must take, early payment of a retirement pension if that member satisfies the conditions in paragraphs (3) and (4) of this regulation.
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> (2) The amount of the retirement pension that a member who satisfies the conditions mentioned in paragraph (1) receives, is determined by which of the benefit tiers specified in paragraphs (5) to (7) that member qualifies for, calculated in accordance with regulation 39 (calculation of ill-health pension amounts).
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> (3) The first condition is that the member is, as a result of ill-health or infirmity of mind or body, permanently incapable of discharging efficiently the duties of the employment the member was engaged in.
>
> (4) The second condition is that the member, as a result of ill-health or infirmity of mind or body, is not immediately capable of undertaking any gainful employment.
>
> (5) A member is entitled to Tier 1 benefits if that member is unlikely to be capable of undertaking gainful employment before normal pension age.

(6) A member is entitled to Tier 2 benefits if that member -

(a) is not entitled to Tier 1 benefits; and

(b) is unlikely to be capable of undertaking any gainful employment within three years of leaving the employment; but

(c) is likely to be able to undertake gainful employment before reaching normal pension age.

(7) Subject to regulation 37 (special provision in respect of members receiving Tier 3 benefits), if the member is likely to be capable of undertaking gainful employment within three years of leaving the employment, or before normal pension age if earlier, that member is entitled to Tier 3 benefits for so long as the member is not in gainful employment, up to a maximum of three years from the date the member left the employment."

8. "Gainful employment" was defined as "paid employment for not less than 30 hours in each week for a period of not less than 12 months". "Permanently incapable" was defined as "more likely than not, be incapable until at the earliest, the member's normal pension age". Mr S' normal pension age (**NPA**) is 66.

9. Mr S was referred to an independent registered medical practitioner (**IRMP**), Dr Mullick. Dr Mullick certified that Mr S was permanently incapable of discharging efficiently the duties of his employment but was immediately capable of undertaking gainful employment:

"[Mr S] suffers from hypertension, venous and arterial disease. His leg pain limits the distance he can walk and the amount of time he can stand for. He has post thrombotic syndrome as a result of his venous disease and this is a chronic condition that is not amenable to surgery. His arterial disease symptoms may improve with exercise and angioplasty, though there are risks from this procedure. Due to the chronic nature of his leg pain it would be very difficult for him to undertake the role of a Health Protection Officer due to the amount of walking and prolonged standing required. He would however be capable of working in a sedentary role."

10. Dr Poolchund reviewed Dr Mullick's opinion:

"I agree with Dr Mullick that this gentleman is likely to be capable of a sedentary office based role with some adjustments re: access to the place of work (e.g. parking near his office). The issue of permanence is also not established as his surgeon has advised him that his symptoms may improve with exercise. There is also the issue that he decided not to have interventional treatment (angioplasty of his arterial tree) which would possibly lead to an improvement in his condition."

11. CBC accepted Dr Mullick's opinion and informed Mr S that he was not entitled to an ill health pension award.

12. Mr S appealed the decision invoking the Fund's Internal Dispute Resolution Procedure (**IDRP**).

13. In October 2017 the appointed person at IDRP stage 2 upheld Mr S' appeal on the grounds that:-

    (i) It was not clear that Dr Mullick or Dr Poolchund had considered:-

    - The effects of the medical issues raised on Mr S' ability to undertake any gainful employment as defined in the 2013 Regulations.
    - The prognosis of those issues including treatment options tried and outstanding.
    - The likely efficacy and timescales of those treatment options.

    (ii) CBC appeared to have accepted the opinion expressed on the certification without questioning whether it was supported in clear terms by the accompanying report.

14. CBC was directed to obtain the opinion of another IRMP and make a fresh decision.

15. CBC asked Dr Williams (IRMP) whether Mr S met the criteria for ill health criteria from active status; and, if not, whether Mr S met the criteria for ill health retirement from deferred status.

16. Mr S saw Dr Williams. Subsequently Dr Williams wrote to Mr Harrison. Mr Harrison replied on 6 June 2018:-

    - Angioplasty was booked following his meeting with Mr S in July 2016.
    - In November 2016 Mr S informed him that he was trying an exercise programme and his symptoms had improved considerably. Following a long discussion with Mr S about the different options for his condition, Mr S decided he wanted to continue with the conservative management with exercise. Generally, exercise therapy was safer than early intervention in symptomatic peripheral arterial disease without a threatened limb and there was some data that the long-term results were better. He was happy with Mr S' decision.
    - He next saw Mr S in January 2018. Mr S was static in regard of his leg symptoms and still had pain when he walked, which was relieved by elevation. It was not particularly limiting at that time, but he had not documented the precise distance Mr S could walk without pain. He explained to Mr S that the relief of his pain by elevation suggested there was a venous component to the pain and that a common iliac angioplasty alone might not help his symptoms, albeit that was difficult to predict. As Mr S was doing well a further appointment was arranged for a year's time.

- Mr Harrison continued:

  "…In summary he has leg pain upon walking on the right side and I am not entirely clear on the aetiology of this as there is both peripheral arterial and peripheral venous disease. Assuming he does not progress to critical ischaemia…no further intervention is mandatory and on balance, if he continues to exercise, it is likely that his symptoms will either remain static or may even improve. Whilst treatment is possible, I have expressed a view that I am not entirely convinced it will help his symptoms and it does come with a small risk of a significant complication such as a limb-loss. Therefore any decision to proceed with intervention upon intermittent claudication is determined by the patient's own view of their limitation and is not mandatory for limb-salvage. In general we support a non-interventional route. You have asked about prognosis and to the best of my ability I have answered this. I expect that with continued exercise his symptoms will at least remain static and may well improve. Indicators of a deterioration are ischaemic rest pain and/or tissue loss.

  I do not have an opinion as to the disparity between [Mr S'] account and mine and I have not documented a claudication distance in his more recent letters. It is clear that he was happy with a non-interventional path and was managing his symptoms. I can only give you a factual account of his medical condition rather than speculate upon perceived disparities and accounts."

17. In a report dated 18 July 2018 Dr Williams noted Mr Harrison's comments. In conclusion Dr Williams said:

    "…whilst Mr Harrison is of the opinion that there appears to be a mixed cause for [Mr S'] presentation and that currently no further intervention is planned, I do note that Mr Harrison has stated that [Mr S'] symptoms are not 'particularly limiting him at the moment'. This is not the presentation that Mr S gave me when I reviewed him. It is my personal opinion that there is a reasonable chance of further intervention being of benefit to [Mr S] and as such permanency has not been established and therefore [Mr S] would not meet the criteria for Early Ill Health Retirement under the Local Government Pension Scheme."

18. CBC asked Dr Williams to further explain why he had certified that Mr S was not permanently incapable of discharging efficiently the duties of his employment from active and deferred status. In a supplementary report dated 10 September 2018 Dr Williams answered:

    "Firstly, I can confirm that it is my view that my decisions were based on [Mr S'] normal pension age of 66. I note that he is currently aged 60 and therefore has six more years to go before his normal pension benefit age.

    I reviewed [Mr S'] case, noting that he has been under the care of a Vascular Surgeon. While at present there are no plans for any further intervention, as [Mr S] had stated that his condition was not specifically limiting his ability. [Mr S], however, describes considerable limitation as far as his mobility is concerned which currently

prevents him from being able to resume the substantive duties of the post for which he was employed by the Local Authority. It is my opinion and view that if [Mr S] was to undergo vascular surgery, then it is likely that this would be beneficial to him and result in him being able to return to his substantive role as a Senior Environmental Health Officer at [CBC]. There is certainly sufficient time over the next six years for such surgical intervention and the benefit accruing from it to be achieved, hence my view that permanency has not been established. I note specifically that [Mr S] has a further review with the Vascular Surgeon arranged for twelve months following his last review in January 2018."

19. CBC accepted Dr Williams' opinion and turned down Mr S for ill health retirement from both active status and deferred status. CBC informed Mr S that as he had taken payment of his deferred benefits with an early payment reduction it would not be possible to again consider whether he met the criteria for the early payment of deferred benefits on ill health grounds.

Mr S' position

20. Mr S says:-

- Dr Williams failed to provide any medical evidence to justify his opinion that he would benefit from vascular surgery.
- In his reports of 9 January 2017 and 6 June 2018, Mr Harrison provided several medical reasons why he did not recommend vascular surgery:
    - He recommended exercise as an early intervention rather than surgery.
    - He also advocated exercise as a longer-term intervention rather than surgery.
    - Assuming Mr S did not progress to critical ischaemia, no further intervention was mandatory.
    - There are serious risks associated with vascular surgery, including heart attack, strokes, loss of limb and death.
- The pain he experiences in his right leg when walking may not be due to peripheral arterial disease, but rather deep venous insufficiency for which no surgery is currently available, or complex regional pain following a leg fracture in 2014.
- Referring to Mr Harrison's June 2018 report, Dr Williams said Mr Harrison believed "undertaking angioplasty on the common iliac artery may not alleviate the symptoms completely". But the word "completely" was not used by Mr Harrison.
- CBC accepted Dr Williams' opinion without questioning why it was contrary to Mr Harrison's view and why he had provided no medical evidence to support his opinion.

- Mr Harrison is an expert in his field who he has seen on several occasions. He was asked whether he recommended surgery. He made no such recommendation. Dr Williams, who saw him for 45 minutes without viewing his angiogram or ultrasound results concluded that he should have surgery.

- He fails to see how the situation fundamentally differs from when his appeal at IDRP stage two was upheld.

- He was diagnosed with chronic obstructive pulmonary disease (**COPD**) in 2013, and during the last 12 months it has deteriorated, and he requires inhalers to breathe[1]

- He saw Mr Harrison in March 2019. Mr Harrison advised him that his condition was static and did not recommend surgery. He advised that COPD increased the risks of surgery.

- His health condition/disability was reassessed on 30 January 2019 for Personal Independence Payment (**PIP**). It was concluded that his needs had not changed in that he has severe difficulty walking more than 20 metres (due to his leg and breathing difficulties) and needs assistance to prepare a meal and with washing, bathing, toilet needs and dressing and undressing. He has a blue badge for disabled parking.

- He has been advised to undertake walking exercises. He can manage the pain he experiences in his right leg by taking pain killers in advance of walking with a stick, resting after around 18 metres to reduce the pain and breathe more easily. After repeating the process 5 to 10 times he returns home and elevates his leg to chest height. It takes around 20 minutes to reduce the pain. Being retired he can do the walking exercises and leg elevation at a time he chooses. He always has some residual discomfort in his leg which he has learned to live with. He does not let his limited mobility restrict him from doing other things when his leg is elevated and at other times. The residual discomfort does not usually affect his sleep.

CBC's position

21. CBC has twice been asked for its formal response to Mr S' complaint, but to date it has not responded. CBC's position has therefore been taken as unchanged from the decision it made after obtaining Dr Williams' certified opinion.

Adjudicator's Opinion

22. Mr S' complaint was considered by one of our Adjudicators who concluded that no further action was required by CBC. The Adjudicator's findings are noted as follows:-

- The relevant regulations were the 2013 Regulations. Regulation 35 provided for the early payment of benefits on the grounds of ill health. Briefly, in order to receive his benefits under Regulation 35, Mr S had to be:

    - permanently incapable of discharging efficiently the duties of the employment that he was engaged in; and

    - immediately incapable of undertaking gainful employment.

    Permanently incapable meant that Mr S was likely to be incapable at least until his NPA of 66 – when Mr S' employment with CBC ended he had more than 8 years to his NPA. Gainful employment meant paid employment for at least 30 hours a week for a period of not less than 12 months.

- The decision as to whether Mr S met the eligibility requirements of Regulation 35 was for CBC to make. This was a finding of fact; Mr S either met the conditions set out in Regulation 35 or he did not. Had CBC determined that Mr S met the requirements for early payment of his benefits, it would then have been required to decide which tier of benefits was appropriate depending upon the level of his incapacity for employment.

- In order to do so, CBC was expected to consider all relevant information which was available to it and ignore any irrelevant information. The weight which it attached to any of the available relevant information was for CBC to decide, including giving some of it little or no weight. It was open to CBC to prefer the advice it received from the IRMP unless there was a cogent reason why it should not have done or should not have done without seeking clarification. The kind of reasons the Adjudicator had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations on the part of the IRMP.

- Before making any decision under Regulation 35, CBC was required to obtain a certified opinion from an IRMP.

- When reviewing an IRMP's advice, CBC would not be expected to challenge matters of medical opinion. While it could be expected to review all the available medical evidence, it could only be expected to do so from a lay perspective. This was the approach that the Ombudsman would take.

- So far as their medical opinions are concerned, IRMPs were not within the Ombudsman's jurisdiction. They were answerable to their own professional bodies and the GMC. However, if there had been an error or omission of fact on the part of the IRMP, CBC, as the decision-maker, would be expected to seek clarification before basing a decision on it. Additionally, if an IRMP's opinion was very different

to the member's treating physicians, the Ombudsman would expect CBC to be able to give reasons for preferring it.

- Dr Williams certified that Mr S was not permanently incapable as surgery was likely to sufficiently improve his symptoms to mean that he would be capable of efficiently discharging his former HPO duties before his NPA. But in his two reports:-
    - Dr Williams did not explain why he considered that Mr S' symptoms were likely to be amenable to vascular surgery (angioplasty) when Mr Harrison was not convinced surgery would improve Mr S' symptoms, and had said the surgery was not without risk and that he favoured non-intervention when there was no current risk of limb loss.
    - Dr Williams did not comment on Mr S' COPD, which would be another significant factor in deciding whether to undergo surgery.
    - While he noted Mr Harrison's view that Mr S' ongoing pain may be a mix of arterial disease and venous disease, Dr Williams did not comment on Mr Harrison's view that Mr S' post-thrombotic syndrome was likely to be a chronic problem with no obvious intervention.
- As Dr Williams was recommending treatment that had not been recommended by Mr Harrison; and, unlike Mr Harrison, he was not a specialist in this particular field of medicine, CBC should have gone back to Dr Williams and asked him:-
    - To explain why he believed surgery would improve Mr S' symptoms to the extent that he would be capable of his former HPO duties before his NPA when Mr Harrison was not sure that surgery would help Mr S' symptoms
    - Had he considered the risk associated with the surgery, particularly as Mr S has COPD?
- But these questions only went to the merits of deciding whether Mr S met the first condition for ill health retirement from active status. To qualify for ill health retirement the second condition also required satisfying.
- However, it appeared that Mr S was immediately capable of gainful employment when his employment with CBC ended:-
    - In his January 2017 report Mr Harrison commented that Mr S' primary complaint was pain in his right leg after walking a few steps which was relieved by resting and elevation.
    - Dr Mullick (IRMP) considered that Mr S was immediately capable of gainful employment in a sedentary role.
    - In his June 2018 report Mr Harrison commented that Mr S' symptoms were not particularly limiting, he expected with continued exercise Mr S' symptoms

would at least remain static and may improve and that Mr S was doing well and managing his symptoms.

- Mr S said he had learned to live with the discomfort and did not let his limited mobility restrict him from doing other things when his leg was elevated and at other times.

- Mr S commented that he was in receipt of PIP and was a blue badge holder. While PIP was an indicator of Mr S' current health the criteria under Regulation 35 were more stringent and CBC's decision was not bound by the State's decision to pay Mr S PIP.

- So, while there were procedural failings by CBC the impact of those failings did not appear to have undermined the outcome, as the overall evidence did not suggest that Mr S satisfied the second condition.

23. Mr S did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr S has provided his further comments which do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the main points made by Mr S for completeness.

Ombudsman's decision

24. Mr S says:-

- The facts and reasons he has provided apply equally to his health condition in 2017 as now.

- When he submitted his complaint to us, he did not refer to the second condition for ill health retirement as the Fund's appointed person at IDRP stage two upheld that he was not immediately capable of undertaking gainful employment after disregarding Dr Mullick's opinion.

- His mobility in 2017 (as currently) was less than required for even the most sedentary role of gainful employment.

- He has been prescribed the maximum dosage of painkillers to reduce the pain from his limited mobility at home. The increased mobility required for getting to and from and being at work would worsen the pain.

- He can only reduce the pain by taking painkillers and elevating his leg to at least chest level, which in practice requires lying down. A workplace would be extremely unlikely to accommodate this. Due to his COPD, he would also experience more severe shortages of breath and need to increase his dosage of steroid inhalers.

- Whilst lying down, he watches television, reads a book, does a crossword, etc. This is what he told his surgeon and is what he meant by not letting his limited mobility restrict him from doing other things when his leg is elevated and how he manages his symptoms.

- His GP and surgeon have told him that he must not use a wheelchair as sitting for prolonged periods will worsen his condition.

- In 2016 his GP additionally diagnosed that he had depression, initially caused by his physical condition, and prescribed him anti-depressants. Prior to his consultation with Dr Williams, he submitted to CBC for referral to Dr Williams, a letter from his GP dated 9 March 2017, stating that he was unfit for employment due to his physical condition and depression and a 'Statement of Fitness for Work'. He is not sure whether both documents were passed onto Dr Williams, but at the consultation Dr Williams did ask him about his depression.

- Due to his health conditions, he is at risk of severe illness if he catches Coronavirus. He has had to stay at home and avoid face-to-face contact with other people.

25. With his comments Mr S has submitted:-

- A 'Statement of Fitness for Work' prepared by his GP for the period 6 March 2017 to 21 April 2017, on which a cross is marked in the box next to 'you are not fit for work'.

- His GP's letter of 9 March 2017, stating that Mr S is unfit for any employment "due to his peripheral vascular disease, enchondroma left femur and having depression".

- The results of an angiogram on his lower limbs issued in September 2016.

26. CBC originally refused Mr S ill health retirement based on Dr Mullick's opinion that Mr S was immediately capable of gainful employment. At IDRP Stage Two, the Fund's appointed person remitted the matter back to CBC on the grounds that its decision had not been properly made. The appointed person did not decide that Mr S had met the second condition. The direction required CBC to make a wholly fresh decision on whether Mr S satisfied both conditions for ill health retirement.

27. Dr Williams' reports focused on Mr S' vascular disease, Mr S' primary condition. Nevertheless, Mr S has confirmed that Dr Williams did ask him about his depression during the consultation. It is evident, from this, that Dr Williams was aware that Mr S had been diagnosed with depression.

28. On its own, Mr S' depression does not appear to have been considered notable by Dr Williams, as it is not mentioned in his reports of 18 July 2018 and 10 September 2018.

29. In March 2017 Mr S' GP said Mr S was not capable of any work. Clearly Dr Williams (and before him Drs Mullick and Poolchund) disagreed. Nevertheless, a difference of medical opinion between Mr S' GP and Dr Williams, who is an expert in occupational health, is not sufficient for me to say that by accepting Dr Williams' opinion CBC's decision was not properly made.

30. Before certifying his Opinion, Dr Williams received Mr Harrison's 6 June 2018 report. Mr Harrison said when he saw Mr S in January 2018 his leg symptoms were not particularly limiting and that he was doing well. Mr Harrison's prognosis was that with continued exercise it was likely that Mr S' symptoms would "at least remain static and may well improve".

31. I agree with the Adjudicator that while there were procedural failings by CBC the impact of those failings do not appear to have undermined the outcome, as the overall evidence does not suggest that Mr S satisfied the second condition for ill health retirement when he left CBC's employment.

32. I do not uphold Mr S' complaint.

Anthony Arter

Pensions Ombudsman
26 June 2020