CAS-40056-J1Q6

The Pensions Ombudsman

Ombudsman's Determination

Applicant	Mrs T
Scheme	The Principal Civil Service Pension Scheme (Northern Ireland) (**the Scheme**)
Respondent	The Department of Finance for Northern Ireland (**the DOF**)

Outcome

1. I do not uphold Mrs T's complaint and no further action is required by the DOF.

Complaint summary

2. Mrs T's complaint against the DOF concerns its decision not to award her early retirement on the grounds of ill health when she was dismissed from the Northern Ireland Civil Service's (**NICS**) employment on the grounds of inefficiency.

3. I am not considering the erroneous early payment of Mrs T's deferred benefits on the grounds of ill health. This was considered in a previous complaint, PO-21858, which I determined on 26 March 2019.

Background information, including submissions from the parties

4. Mrs T is represented in her complaint by her husband (**Mr T**).

5. Mrs T was employed as a staff officer in the Department of Culture, Arts and Leisure by the NICS. She was a member of the Scheme.

6. In May 2004, Mrs T transferred to the Classic Plus section of the Scheme. She had previously been in the Classic section.

7. On 14 May 2014, Mrs T started a period of sick leave. She was experiencing symptoms of dizziness and unsteadiness associated with nausea, fatigue and headaches.

8. On 16 May 2014, Mrs T attended a clinic with her Consultant Neurologist, Dr McMonagle. He recommended her for a brain MRI scan (see Appendix 1).

9. On 19 May 2014, Mrs T had a brain MRI scan. No significant abnormalities were identified in the scan.

10. On 28 May 2014, Mrs T attended a clinic with Dr McMonagle at which the results of her brain MRI scan were discussed. Extracts from his report dated 30 May 2014 together with his subsequent reports are set out in Appendix 1.

11. On 26 June 2014, Mrs T attended her first Occupational Health Service (**OHS**) appointment. Extracts from the OHS report and the reports from subsequent OHS appointments are contained in Appendix 1.

12. On 18 July 2014, Mrs T attended her first review meeting with Human Resources (**HR**). At this meeting, she was made aware of the Inefficiency Sickness Absence Policy. Mrs T said that Dr McMonagle had advised her that there had only been a minor improvement in her condition.

13. On 31 July 2014, Mrs T attended a clinic with Dr McMonagle. A dramatic improvement in her condition was noted. However, it was also noted that she was not fully back to normal.

14. On 14 August 2014, Mrs T attended her second OHS appointment. It was noted that, while some improvement had been made, her symptoms remained debilitating.

15. On 30 September 2014, Mrs T attended her third OHS appointment. It was noted that she was due to attend physiotherapy sessions.

16. On 14 October 2014, Mrs T attended her second review meeting with HR. She stated that she was still waiting for a neuro physiotherapy appointment.

17. On 8 December 2014, Mrs T attended her fourth OHS appointment. A slight improvement in her condition was noted together with the fact that she was awaiting further investigation by her Neurologist.

18. On 8 January 2015, Mrs T attended her third review meeting with HR. She advised that her condition had improved but it continued to be unpredictable. She stated that she was due to see her Consultant at the end of January or the start of February 2015 and felt hopeful of a return to work after that. She said that, while her Physiotherapist was concerned there was an underlying condition, her Consultant was happy there was nothing sinister.

19. On 12 February 2015, Mrs T attended her fifth OHS appointment. Some improvement in her symptoms was noted but she was still incapacitated.

20. On 26 February 2015, Mrs T attended her fourth review meeting with HR. She was advised that, if she did not meet the criteria for ill health retirement by the time of her next OHS appointment, dismissal would have to be considered.

21. On 2 March 2015, Dr McMonagle provided a report on her condition. In his report he stated that: “her prognosis for recovery is good but not guaranteed to be complete”.

22. On 11 March 2015, an OHS supplementary report acknowledged the information provided by Dr McMonagle. It said:

> "I have received the requested information from [Mrs T's] hospital specialist. This report indicates that [Mrs T's] prognosis for recovery is good."

23. On 1 April 2015, Mrs T moved from the Classic Plus section of the Scheme to the Alpha section.

24. On 2 April 2015, Mrs T attended her sixth OHS appointment. As intimated during her meeting with HR on 26 February 2015, this was the appointment at which her eligibility for early retirement on the grounds of ill health was assessed. As a result of this appointment, Dr Graham, the OHS medical adviser, stated that Mrs T did not meet the criteria for ill health retirement.

25. On 29 May 2015, Mrs T appealed the OHS' decision of 2 April 2015, concerning her ineligibility for ill health retirement. She included a letter from her GP dated 21 May 2015. See Appendix 1 regarding a summary of the medical evidence provided by her GP.

26. On 22 July 2015, the DOF sent Mrs T to be assessed by an independent specialist, as required as part of the appeals process. The specialist who undertook the assessment was Dr Craig, a Consultant Neurologist. See Appendix 1 for extracts of his report.

27. In August 2015, OHS attempted to gain access to a neuropsychologist to undertake a further assessment of Mrs T, as suggested by Dr Craig. However, it was unable to secure the services of one.

28. On 26 August 2015, Mrs T was notified that her appeal against the decision not to award her ill health retirement had not been upheld.

29. On 1 October 2015, Mrs T attended a consideration of dismissal interview with HR.

30. On 21 October 2015, DOF sent Mrs T a letter notifying her of its decision to dismiss her on the grounds of inefficiency.

31. On 22 October 2015, Mrs T was sent a dismissal letter and, with effect from 21 January 2016, Mrs T was dismissed from the NICS. She was aged 50 and had 31 years of service.

32. On 6 March 2016, Mrs T had a review with Dr McMonagle. This review had been rescheduled from October 2015 due to his clinics running several months behind schedule. Dr McMonagle noted that there had been no improvement since he had last seen Mrs T. He stated that he had needed two years to be sure if her condition was permanent or not.

33. On 7 April 2016, Dr McMonagle wrote a letter in which he said that:

> "… she has been left with a significant disability …. Her disability appears to be fixed and may be permanent. Hence, I would support her application for retirement on medical grounds."

34. On 12 August 2016, Dr McMonagle wrote that he was now convinced there was an underlying cause for Mrs T's symptoms. He suggested post viral vestibular dysfunction.

35. On 9 May 2019, Mr T appealed Mrs T's dismissal to the DOF's Head of HR. Mr T stated that, if the latest medical evidence from Dr McMonagle had been available before her dismissal, she would have been awarded a pension on medical grounds.

36. On 14 August 2019, the DOF responded to Mr T's claim of unfair dismissal. It stated that it was unfortunate that Mrs T's diagnosis was confirmed two months after her dismissal. It also said that Mrs T's absence from work could not be sustained indefinitely. It said that, as three and a half years had passed since Mrs T's dismissal, an appeal of that decision was not possible.

37. On 27 September 2019, Mr T responded to the DOF's letter of 14 August 2019 asking it to reconsider its decision.

38. On 29 October 2019, the DOF responded to Mr T's letter of 27 September 2019. It stated that it was unable to reconsider its decision.

39. On 5 and 7 May 2020, Mr T emailed the DOF. He asked why Mrs T was not allowed to go down the internal appeal route. He also questioned why her benefits were not released before her employment was terminated.

40. On 14 May 2020, the DOF wrote to Mr T in response to his emails of 5 and 7 May 2020. It said that, when the dismissal decision was made, there was no confirmed medical diagnosis and therefore the criteria for early retirement on medical grounds was not met. It stated that the minutes of the consideration of dismissal interview on 1 October 2015 made no mention of an appointment with her Consultant Neurologist. It noted, however, that a letter from Mrs T's GP dated 21 May 2015 did mention that she was awaiting review by her Consultant Neurologist. This letter said that his clinics were running several months behind schedule.

41. In its letter of 14 May 2020, the DOF also said that the dismissal decision was made based on the evidence available at the time. It stated that the dismissal letter of 22 October 2015 highlighted that Mrs T had a right to appeal within ten working days of the decision.

42. Mr T provided some additional comments on Mrs T's complaint. He said that:-

    - Dr McMonagle had examined Mrs T numerous times over a two-year period. His report was not available until after her dismissal. His opinion was the most important.

    - Dr Craig only spoke to Mrs T for approximately 20 minutes and only examined her eyes.

    - Mrs T had seen the OHS six times and it did not report her fit to return to work. Her GP shared this opinion.

Adjudicator's Opinion

43. Mrs T's complaint was considered by one of our Adjudicators who concluded that no further action was required by the DOF. The Adjudicator's findings are summarised below:-

- The Adjudicator said that the Scheme Regulations specify the criteria that must be met for a member to be able to take early retirement due to ill health. He noted that, in order for Mrs T to have been eligible to take ill health early retirement, she must have met the test of being permanently incapable, that is until reaching pension age, of undertaking her own, or a comparable job. Extracts from the Scheme Regulations can be found at Appendix 2 and 3.

- The Adjudicator noted that the granting of early retirement on the grounds of ill health was a matter of discretion for the DOF, provided that, in the opinion of the Scheme medical adviser, the member satisfied the test. The Scheme medical adviser was the OHS and, in the case of Mrs T, it did not consider that she met the test.

- The Adjudicator was satisfied that the original decision was considered by the correct decision-makers.

- Mr T said that the decision-maker did not fully consider all of the evidence. The Adjudicator was of the opinion that the strongest evidence in support of Mrs T's request was provided by Dr McMonagle in his reports of 7 April 2016 and 12 August 2016. The Adjudicator noted that these reports post-dated when Mrs T was notified that she was not eligible for ill health retirement. The Adjudicator took the view that, for this reason, OHS was not required to consider them.

- A letter from Mrs T's GP in May 2015 was less optimistic about the chances of her recovery than the evidence available from Dr McMonagle at that time. The Adjudicator noted this fact and said that, in his opinion, it would not have been unreasonable for the decision-makers to add greater weight to Dr McMonagle's evidence. The Adjudicator noted that Dr McMonagle was a consultant who would be likely to have greater experience than a GP in the relevant area of medicine.

- The Adjudicator said that it was not unusual for medical opinions to change over time as medical conditions develop and further examinations and treatments take place. In the case of Mrs T, Dr McMonagle acknowledged that he had needed two years to be able to fully assess her condition.

- The Adjudicator said that it was known that Mrs T was due to have another assessment with Dr McMonagle at the point when a decision on her ill health retirement was being made. However, the Adjudicator was of the view that there was no obligation on the DOF for it to wait until this delayed assessment had been completed.

- In the Adjudicator's opinion, there was some optimism when Mrs T's application for ill health retirement was being considered, that her condition would improve. Dr McMonagle's letter of 2 March 2015 stated that her prognosis for recovery was good but not guaranteed.

- The Adjudicator noted Mr T's concern that Mrs T's appointment with Dr Craig on 22 July 2015 was a quick, one-off consultation. However, the Adjudicator was satisfied that Dr Craig had access to Dr McMonagle's reports and the notes from Mrs T's OHS assessments. In the Adjudicator's opinion, this would have given him adequate information to make his recommendation.

- Mr T said that Mrs T had seen the OHS six times and it did not once report her fit to return to work. The Adjudicator was of the opinion that the assessments that the OHS made in relation to Mrs T's ability to return to work were based on the near future. Typically, it was looking eight weeks into the future. The Adjudicator said that, when considering eligibility for ill health retirement, it was the period to pension age that needed to be considered.

- In summary, the Adjudicator said that, in his opinion, there was nothing irrational in the decision not to grant Mrs T early retirement on the grounds of ill health. He was of the view that the correct process was followed, the correct parties were involved, the correct evidence was considered, and the decision was not perverse based on the evidence available.

44. Mrs T did not accept the Adjudicator's Opinion and Mr T made further submissions on her behalf. He said:-

- The DOF knew that Mrs T was waiting on an appointment with Dr McMonagle. It proceeded to dismiss her before this appointment. Ill health retirement would have been awarded if Dr McMonagle's report from this appointment had been available for consideration by the DOF.

- Appointment delays were common at the time and there was nothing that Mrs T could have done to get an earlier appointment. The DOF's decision not to allow additional time for Dr McMonagle's assessment before it made its decision to dismiss Mrs T was irrational and perverse.

- The facts back up Dr McMonagle's opinion that it had taken two years to properly diagnose Mrs T's condition and that her condition was permanent.

- The improvements in Mrs T's condition noted in the medical evidence were from a very low starting point. While her condition did improve, it never reached the point where she could ever return to work.

- The medical notes that Dr Craig had access to were inconclusive and not a full diagnosis.

- The point about the OHS looking eight weeks ahead was confusing. It never said that Mrs T was fit to return to work.

45. Mrs T's complaint was passed to me to consider. Mr T's comments do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Mr T.

Ombudsman's decision

46. Mrs T's complaint relates to the DOF's decision not to approve her request for early retirement on the grounds of ill health.

47. When considering how the decision has been made by the DOF and the OHS, I will generally look at whether:

    - the correct questions have been asked;
    - the applicable Scheme Regulations have been correctly interpreted;
    - all relevant but no irrelevant factors have been taken into account; and
    - the decision arrived at was one that a reasonable body would make.

48. Providing the DOF and the OHS have acted in accordance with the above principles and within the powers given to it by the Scheme Regulations, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Mrs T's eligibility for payment of ill health early retirement benefits under the Scheme Regulations. I am primarily concerned with the decision-making process.

49. The weight which is attached to any of the medical evidence is for the DOF and the OHS to decide, including giving some of it little or no weight. It is also open to the DOF and the OHS to prefer evidence from its own advisers unless there is a cogent reason why it should or should not, without seeking clarification first. For example, when an error or omission of fact or a misunderstanding of the relevant regulations has been made by the medical adviser.

50. If I find that the decision-making process was in some way flawed or the decision reached by the DOF or the OHS was perverse, that is, one that no reasonable body would have taken, the appropriate course of action is for the decision to be remitted for the DOF and the OHS to reconsider.

51. The decision made by the DOF and the OHS, in April 2015, to decline Mrs T's application for ill health early retirement benefits from the Scheme was taken only after they had carefully considered all the available relevant evidence at the time. They had weighed the evidence before them and considered that Mrs T was, on the balance of probabilities, not permanently incapable, that is until reaching pension age, of undertaking her own, or a comparable job.

52. I am satisfied that the DOF and the OHS gave proper consideration to Mrs T's application at the time by assessing all the relevant medical evidence available and that they acted in accordance with the Scheme Regulations and the above principles. In my view, their decision not to award Mrs T early retirement on the grounds of ill health was therefore not one that no reasonable body would make, and it was within the bounds of reasonableness.

53. I note the comment made by Mr T in relation to the fact that the DOF was aware that Mrs T was waiting on a delayed assessment by Dr McMonagle at the time that she was dismissed. The timing of Mrs T's dismissal was an employer decision and, as such, is not something that I am able to comment on.

54. Mr T said that the medical notes that Dr Craig had access to were inconclusive and not a full diagnosis. Dr Craig had access to all the relevant medical evidence including Dr McMonagle's reports and the notes from Mrs T's OHS assessments. He also undertook a one-off consultation with Mrs T. Dr Craig had adequate information available to make his recommendation.

55. Mr T has said that the OHS never said that Mrs T was fit to return to work. On 2 April 2015, Mrs T attended her sixth OHS appointment. Following this appointment, Dr Graham made his assessment on behalf of the OHS that Mrs T did not meet the criteria for ill health early retirement. He was of the opinion that Mrs T would, on the balance of probabilities, be capable of undertaking her own, or a comparable job, before reaching pension age.

56. I do not uphold Mrs T's complaint.

Anthony Arter

Pensions Ombudsman
21 May 2021

Appendix 1 – Medical evidence

57. A report from Dr McMonagle (consultant neurologist) dated 16 May 2014 said:

> "One would have to wonder about midline cerebellar or brainstem pathology, perhaps vascular or inflammatory in nature. The possibility of functional neurological disease exists as well given the context and the apparent disparity between bed-side findings and gait. She needs an MRI of brain to look at things further …"

58. A report following an MRI brain scan on 19 May 2014 concluded:

> "There is no significant abnormality identified within the brain parenchyma on this study."

59. A report from Dr McMonagle dated 30 May 2014 said:

> "… I went over the results of her recent MRI of brain and cervical spine with her and reassured her that it showed no significant abnormality… I reassured her that in general people recover on their own, spontaneously though this can take a few months."

60. An OHS report dated 26 June 2014 said:

> "… She had been feeling unwell with flu like symptoms for some months when she suddenly developed a sharp in her head and became unsteady with nausea and vomiting. Her condition worsened leaving her unfit for work.
>
> [Mrs T] was seen by a Consultant Neurologist and is under review. Her symptoms have eased … A phased return to work could be expected in four weeks if her condition continues to improve."

61. A report from Dr McMonagle dated 31 July 2014 said:

> "She has improved dramatically since I saw her last but still is a bit disappointed that she is not back to fully normal. She still has spells were (sic) she feels unsteady and light in the head and needed the aid of her partner …"

62. An OHS report dated 14 August 2014 said:

> "She has been investigated by a specialist and the diagnosis remains uncertain. Although there has been some improvement her symptoms remain debilitating and her mobility is impaired…
>
> A gradual recovery is expected but I am unable to predict how quick her recovery will be, or when a return to work may be possible."

63. An OHS report dated 30 September 2014 said:

"Her symptoms of imbalance have settled to some extent but she remains quite unsteady at times and I do not think she would manage a return at present.

She is due to engage with physiotherapy which will hopefully help to improve her walking and balance."

64. An OHS report dated 8 December 2014 said:

"Her balance when walking and standing remains a problem and she still has regular episodes of increased symptoms each day. I would think a return would not be managed at this stage due to her symptoms. There is perhaps a slight improvement …

She awaits a review by her neurologist to see if further investigation is required. She is engaged in physiotherapy at present on a weekly basis …"

65. An OHS report dated 12 February 2015 said:

"She notes some improvement in her symptoms … but continues to experience balance difficulties which affect her walking.

[Mrs T] is incapacitated as a result of her health complaint. She reports some improvement but this is not sustained. In my opinion she is unfit for work."

66. A letter from Dr McMonagle to the OHS dated 2 March 2015 said:

"1) Her diagnosis is of functional neurological symptoms – i.e. no structural neurological disease.
2) No further investigations are planned and
3) Her prognosis for recovery is good but not guaranteed to be complete."

67. An OHS report from Dr Graham dated 2 April 2015 said:

"While there has been some improvement in her symptoms she still suffers from symptoms which have a significant impact on her daily activities and would prevent a return to work at present. She hopes to be reviewed by her neurologist again soon. She is unfit to return to work and given the slow progress is unlikely to be fit to return for at least a further 8 weeks…

She does not satisfy the ill health retirement criteria…

[Mrs T] is still in the early stages of treatment. The response to treatment has yet to be determined, and the prognosis is not clear at this time."

68. A letter from Mrs T's GP dated 21 May 2015 said:

"The patient started her neurophysiotherapy with Siobhan McAuley October 2014 at BCH with some further slight improvement. She however remained debilitated with her symptoms.

[Mrs T] continues to struggle with balance and dizziness associated with profound fatigue and intermittent nausea and headaches. This limits her ability to walk and function normally…

At present there is no further planned recognised treatment and she is awaiting review from Dr McMonagle at RVH whose clinics are running several months behind.

In summary [Mrs T] has been diagnosed with functional gait disturbance and is awaiting further follow up. The prognosis of this condition is very variable and hard to predict especially now with her long duration of symptoms. As stated earlier her neurologist was disappointed that she had not recovered. I feel that now, over one year later from the onset of her symptoms that her prognosis for complete recovery is poor and at present I feel she is permanently unfit for her duties at work."

69. A report from Dr Craig (consultant neurologist) dated 22 July 2015 said:

"… In preparing this report I have had access to previous occupational health service clinical notes and records and medical records from Dr P McMonagle, Consultant Neurologist.

… I have no reason to counter the working diagnosis that this woman's symptoms are non-structural or functional in origin. While she has persistent symptoms which undoubtedly are debilitating with a working diagnosis of a functional neurological problem, she should at this stage be assessed by a clinical neuropsychologist. … it is probably also worthwhile her being seen by a consultant psychiatrist. Certainly until both of these assessments have taken place, I think it would be inappropriate to state that she is likely to be permanently incapacitated until the age of 65 years due to medical condition."

70. A letter from Dr McMonagle dated 7 April 2016 said:

"This lady has been attending my Neurology Clinic for the last 2 years with significant balance problems. After an initial improvement her level has reached a plateau, and she has been left with a significant disability. Whether her symptoms are due to a functional cause, or vestibular dysfunction, which may be a post viral phenomenon is unclear but, after this duration, her disability appears to be fixed and maybe permanent. Hence, I would support her application for retirement on medical grounds."

71. A report from Dr McMonagle dated 12 August 2016 said:

"… she remains significantly disabled, feels constantly off balance and describes a sensation of continuing to move after she has stopped walking. There were quite a lot of inconsistent findings when she was first seen … However with time I have become more convinced of an underlying

neurological cause (post viral vestibular dysfunction) revealed as the functional component to her presentation has settled.

… Now over two years on from her initial presentation I feel her disability is likely to remain permanent with ongoing symptoms the likeliest outcome …"

Appendix 2 – The Public Service (Civil Servants and Others) Pensions Regulations (Northern Ireland) 2014

This Appendix covers the Alpha Section of the Scheme

72. Part 6 Chapter 4 covers "Ill Health Benefits". It states:

"**Meaning of "permanent breakdown in health"**

70. For the purpose of these Regulations, a member's breakdown in health is "permanent" if the scheme medical adviser is of the opinion that the breakdown will continue until the member reaches prospective normal pension age.

Meaning of "incapacity for employment" and "total incapacity for employment"

71. For the purpose of these Regulations -

(a) a member's breakdown in health involves "incapacity for employment" if the scheme medical adviser is of the opinion that, as a result of the breakdown, the member is incapable of doing the member's own or comparable job; and

(b) a member's breakdown in health involves "total incapacity for employment" if the scheme medical adviser is of the opinion that, as a result of the breakdown -

(i) the member is incapable of doing the member's own or comparable job; and

(ii) the member is incapable of gainful employment. …

Entitlement to ill-health pension

74.(1) An active member of this scheme who has not reached normal pension age under this scheme is entitled to the immediate payment of an ill-health pension under this scheme, in accordance with the provisions of this Chapter, if the conditions in paragraph (2) are met.

(2) The conditions are –

(a) the member or the member's employer has claimed payment of an ill-health pension;

(b) the scheme medical adviser –

(i) is of the opinion that the member has suffered a permanent breakdown in health involving incapacity for employment or total incapacity for employment; and

(ii) gives the scheme manager and the employer a certificate stating that opinion ("ill-health retirement certificate");

(c) the member has at least 2 years' qualifying service; and

(d) the employer agrees that the member is entitled to retire on ill health grounds."

73. Part 1 states that:

"scheme medical adviser" means the medical adviser appointed by the scheme manager for the time being to provide a consulting service on medical matters relevant to this scheme;

Appendix 3 – Section I of the Principal Civil Service Pension Scheme (Northern Ireland) 2019

This Appendix covers the Classic Plus Section of the Scheme

74. Section D.4 covers "Early payment of pensions: Ill-health". D.4(1) – (3) states:

"(1) An active member is entitled to immediate payment of a pension before reaching pension age if -

(a) in the opinion of the Scheme medical adviser the member has suffered a permanent breakdown in health involving incapacity for employment, and

(b) the member has at least two years' qualifying service, and

(c) the DOF has agreed to the member becoming so entitled.

(2) For the purpose of these rules a member's breakdown in health is "permanent" if, in the opinion of the Scheme medical adviser, it will continue until the member reaches pension age.

(3) For the purpose of these rules a member's breakdown in health involves incapacity for employment if, in the opinion of the Scheme medical adviser, as a result of the breakdown the member –

(a) is incapable of gainful employment, or

(b) is incapable of doing his own or a comparable job.

A member within sub-paragraph (b) will be entitled to a lower tier pension and a member within sub-paragraph (a) will be entitled to a lower tier pension and an upper tier top up pension.

This is subject to paragraph (3A)."

75. Section A.1(4) states that "the DOF means the Department of Finance and Personnel". It also states that:

"the Scheme medical adviser means -

(a) the medical adviser appointed by the DOF for the time being to provide a consulting service on medical matters relevant to this Section of the Scheme, or

(b) in a case where a function normally exercisable by that adviser is being exercised by another person on an appeal from that adviser's decision in accordance with procedures that are acceptable to the DOF, that other person;"