The Pensions Ombudsman

Ombudsman's Determination

Applicant	Mr N
Scheme	Port of Felixstowe Pension Plan (**the Plan**)
Respondent	Port of Felixstowe Pension Trustee Limited (**the Trustee**)

Outcome

1. I do not uphold Mr N's complaint and no further action is required by the Trustee.

Complaint summary

2. Mr N's complains that the Trustee:-

   - Has awarded him the Lower Tier of incapacity pension (**IP**). He believes he should have been awarded Upper Tier on the basis that he will never be able to work again.
   - Has misinterpreted the criteria under the Plan rules (**the Rules**).
   - Has applied an incorrect salary in the calculation of his IP.

Background information, including submissions from the parties

3. The Plan is administered by Quantum Advisory (**the Administrator**). Mr N worked as a Mechanical Engineer for 17 years for Port of Felixstowe (**the Employer**).

4. There are two tiers that can be awarded under the Rules. Relevant sections of the Rules can be found in Appendix 1. The tiers are as follows:-

   - The Upper Tier is payable if the Employer and the Trustee are satisfied that a member's incapacity is serious enough to prevent him/her from following his/her normal employment or his/her earning capacity is seriously and permanently impaired.
   - However, if a member's incapacity prevents him/her from carrying out his/her previous role but, in the Employer's and the Trustee's opinion, it is more likely than not that he/she could pursue alternative employment, the Trustee may award the Lower Tier.

5. Since 2012, Mr N has suffered from a hip and urological conditions. On 24 September 2016, Mr N's sickness absence commenced.

6. In March 2017, due to ongoing symptoms, the Employer referred Mr N for an assessment with an occupational health (**OH**) adviser, WorkFit, regarding his eligibility for an IP.

7. On 21 March 2017, the OH doctor, Dr Kelly, advised that Mr N remained unfit for any work but said that she would write to Mr N's GP for an opinion on any planned treatments and further investigation.

8. Following an absence review meeting on 20 March 2017, the Employer wrote to Mr N informing him that his employment would be terminated on 23 June 2017. This was because Mr N had been unable to return to work and there was no alternative role or reasonable adjustments that could be made for him.

9. Following receipt of the GP's opinion, on 9 May 2017, Dr Kelly issued another report. She noted that further treatments had been advised by the urology team and Mr N would require hip impingement surgery. Therefore, based on current evidence, Dr Kelly was unable to advise whether Mr N was permanently incapable of working in his role but said that he remained unfit for work at that time.

10. Mr N subsequently provided further evidence to Dr Kelly to confirm his recent diagnosis of a deformity of his hips. On 6 June 2017, Dr Kelly advised that Mr N remained unfit for any work due to his ongoing symptoms. However, she said it was unclear whether he would be able to return to performing his engineering role in the future as this would depend on "his response to further treatment including surgery".

11. In June 2017, Mr N applied for an IP. He was then aged 37. On 22 June 2017, the Administrator wrote to Mr N informing him that the Trustee had decided to defer making a decision regarding his eligibility for an IP. This was because it wanted to see how Mr N responded to the hip surgery.

12. On 25 August 2017, Mr N underwent right hip surgery. Following his surgery, he was recovering and undergoing physiotherapy until June 2018, when he was discharged by the physiotherapist. However, his condition declined, and his left hip remained highly symptomatic.

13. Dissatisfied with the Trustee's decision to defer making a decision, Mr N complained to The Pensions Ombudsman (**TPO**) in early 2018. An Adjudicator for the Pensions Ombudsman issued an opinion expressing the view that Mr N's complaint could not be upheld. This view was based on the fact the Trustee had agreed to consider Mr N's application for an IP at a later stage, on the basis of the updated medical evidence. The Adjudicator was of the opinion that this was not unreasonable and was permissible. Mr N did not contest the Adjudicator's Opinion and the investigation into his complaint was closed.

14. Throughout the rest of 2018 and 2019, Mr N was obtaining further medical evidence in support of his IP application. In May 2019, Mr N completed a new consent form for the OH adviser to obtain any further medical evidence.

15. On 11 November 2019, Mr N attended a face-to-face assessment for an IP with an independent registered medical practitioner (**IRMP**), Dr Sharp. In his submissions, Mr N provided medical reports from his treating specialists.

16. In her report dated 13 November 2019, Dr Sharp said that, even though Mr N's pain was of a chronic nature, there were further therapeutic options available to him, such as support from the pain psychologist and possible further surgical intervention. Relevant sections of the medical evidence and Dr Sharp's report are set out in Appendix 2. Dr Sharp concluded that:

    "I am not able to confirm that on the balance of probabilities the member is permanently incapable of discharging the duties of his former employment until his normal retirement age. This is because he is of a relatively young age, there are therapeutic options that have been discussed with him and are available to him that could well significantly improve the situation and he has not proceeded with these due to his view of the benefits of these therapies."

17. Consequently, Dr Sharp did not recommend that Mr N was eligible for an IP. Following a meeting on 30 January 2020 to discuss Mr N's case, the Trustee wrote to Mr N, on 7 February 2020, declining his application for an IP. It said that having considered all the medical evidence and Dr Sharp's opinion, it had concluded that "the requirement of 'permanence' has not been met and therefore [Mr N's] application cannot be approved".

18. Dissatisfied with the Trustee's decision, on 12 February 2020, Mr N appealed to the Trustee under the two-stage internal dispute resolution procedure (**IDRP**). He said in summary:-

    - He was unhappy that the Trustee had not contacted him for three months between November 2019 and January 2020.

    - He had only just received a copy of Dr Sharp's report. He had not consented to the release of the report to the Trustee. Therefore, he had raised a complaint about this to the relevant regulative body.

    - He raised issues with factual inaccuracies in Dr Sharp's report, such as the inconsistent use of medication, which was wrong. He was taking medication until he was advised to stop by his psychiatrist.

    - There were no further treatments left for him to undertake in order to get better. He had also been discharged from counselling therapy. These treatments had not improved any of his symptoms.

    - He had been offered a procedure under anaesthetic with steroid injection. Unfortunately, his previous injection did not help and in fact made his pain

significantly worse. Therefore, he would not be undergoing a procedure that would cause him more pain and suffering.

19. On 14 February 2020, the Trustee acknowledged Mr N's appeal. It informed him that this would be expedited to stage two. It said:

> "In order to consider your appeal under Stage 2 in the most effective way…the Trustee wishes to review the GP and specialist reports that [OH] obtained in order to write their report dated 13 November 2019. If we do not see these reports we have to rely heavily on [OH]'s own report for the latest medical assessment.
>
> …
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> The Trustee has also asked [OH] to carry out a review of your file principally in relation to any medical evidence relevant to your meeting the definition of permanency…I understand that [OH] have emailed you...and asked you to contact your GP and orthopaedic specialist in order that certain medical reports issued in July/August 2019 can be released to them and can be considered as part of this review."

20. Between 10 March and May 2020, there were further exchanges between the Trustee and Mr N regarding him providing the requested reports and obtaining most recent specialists and GP's reports. However, the Trustee was still waiting for Mr N's consent form.

21. On 26 May 2020, the Trustee told Mr N that it would hold a meeting to discuss his case on 9 July 2020. It, therefore, urged Mr N to provide the consent form. Mr N subsequently provided the consent form to the Trustee.

22. Following the Trustee's meeting, it sought further clarification from Dr Sharp regarding Mr N's eligibility for an IP. It asked the following questions:-

    - Whether it would be reasonable for Mr N to undergo further surgery that was proposed, taking everything into account including his previous experience of the surgery in 2017 and his other physical and mental health conditions, as well as the nature of the surgery and the prospects of a successful outcome.

    - If Mr N did undergo the surgery, even with the successful outcome, was it more likely than not that his physical and mental health conditions would still prevent him from carrying out his former role up until his normal retirement date (**NRD**)? If so, was it more likely than not that he could still perform some other, less physical work?

23. On 4 August 2020, Dr Sharp provided her response and in summary said:-

    - It was understandable that Mr N had been reluctant to proceed with further surgical treatment in light of his previous experience. He was an adult with full

mental capacity and was entitled to make an autonomous decision. She [Dr Sharp] did not think it was unreasonable for Mr N to decline this treatment.

- Dr Sharp noted two specialists' reports dated May and August 2018 which confirmed Mr N's previous experience and that the further surgery may not improve his symptoms.
- Therefore, on the balance of probabilities, it seemed unlikely, despite Mr N's relatively young age of 37, that his symptoms would ever improve to a point where he would be able to undertake the heavy physical work of an engineer.
- However, with improved pain management, Dr Sharp saw no reason why he would not be fit for a sedentary/less physical role.

24. After further considering Dr Sharp's comments, the Trustee wrote to Mr N on 20 August 2020. It informed him that it was now satisfied that he met the criteria under the Rules and the requirements of the Finance Act 2004. It awarded Mr N an IP and backdated it to the day after his employment ended on 23 June 2017. It said that the Employer had also consented to this decision.

25. The Trustee also said the award was subject to a further medical review in three years. This review would require obtaining updated medical reports and would consider whether Mr N's condition continued to qualify for an IP at the same level, or whether an adjustment was required.

26. On 7 September 2020, the Administrator sent Mr N a benefits statement setting out his IP. It incorrectly stated his NRD as 28 February 2025. It quoted a tax-free lump sum up to £29,063.08 based on Mr N's final pensionable salary (**FPS**) of £26,259.90 for the service of 13 years and three days.

27. On 14 September 2020, Mr N emailed the Administrator regarding the benefits statement. He believed the FPS and NRD quoted in it were incorrect.

28. On 18 September 2020, the Trustee wrote to Mr N addressing his concerns raised with the Administrator. It said in summary:-

- The level of IP Mr N was awarded was the Lower Tier. The basis of the calculation of such pension was Mr N's accrued benefits on ceasing pensionable service without any reduction being applied for early payment.
- It provided a calculation basis which also quoted the final FPS as £26,259.90.
- It apologised for the Administrator's error with the NRD in the benefits statement. However, the error did not have any bearing on the calculation of his pension.
- An Upper Tier award was calculated on the basis of assumed pensionable service up to age 63. To qualify for an Upper Tier award, Mr N would have to be unfit to carry out any type of work. In the Trustee's opinion, Mr N was unfit to carry out his role, but he could carry out work in a different role with a different employer.

- This was based on Mr N's medical evidence, specifically a report dated 28 May 2018 from his specialist in which he had said Mr N could undertake a more sedentary job that did not involve manual labour.

29. On 6 October 2020, Mr N wrote to the Trustee to challenge its decision. He said the specialist's report dated 20 August 2018 was the most recent one, not the 28 May 2018 one. This report did not mention him being able to undertake a sedentary job. He asked that the Trustee review its decision and he added:

> "It has already been established that I cannot carry out my role as an engineer when my job was terminated because of this very reason due to ill health. If I could carry out a role then why was I not offered any reasonable adjustments or alternative job roles before I was sacked? You cannot have it both ways, I can either work or I cannot and this statement that you refer to is supposed to be a like for like role as an engineer."

30. On 15 October 2020, the Trustee wrote to Mr N saying it would respond to his points under stage two IDRP. The next scheduled meeting to discuss his case was on 29 October 2020.

31. On 2 November 2020, the Trustee sent Mr N a stage two decision that said in summary:-

    - FPS was defined as the higher of; (i) Mr N's pensionable salary in his last 12 months of pensionable service; or (ii) the highest average of any three consecutive years of pensionable salary in his last 13 years of pensionable service.

    - His FPS was calculated in (i) as £26,259.90 and in (ii) as £25,899.65. As the amount of £26,259.90 was the highest out of the two figures, this was used as his FPS.

    - It provided the definition of Pensionable Salary and salary under the Rules. These definitions can be found in Appendix 1.

    - In determining pensionable salary, a deduction was made with reference to the 'Lower Earnings Limit', and this was reflected in the contributions paid. The Lower Earnings Limit was the minimum amount of earnings an individual must have in order to qualify for any state benefits and statutory payments. It was reviewed each year by the Government and the figure in force at 1 January each year was used in the calculations of Mr N's pensionable salary. Increases in pensionable salary were also capped with reference to the rate of inflation.

    - The report of 20 August 2018 from Mr N's specialist, Mr Haggis, summarised his previous report to the OH. He had said that "we can only offer limited information as to your ability to work…it would be for [OH] to discuss with you as to whether any other occupation is possible with your current symptoms".

- The reference to a different role with a different employer, was not to a different role with the same employer, nor to a like for like role with a different employer.
- It was unable to comment on the actions of the Employer before the termination of Mr N's employment. This was the matter between Mr N and the Employer to discuss.
- It reiterated the fact that, if the updated medical evidence provided at the three-year review point demonstrated that his situation had changed, the impact of the change on the benefits that had been awarded would be considered by the Trustee.

32. Dissatisfied with the Trustee's stage two decision, Mr N raised issues for clarification on two occasions in which he repeated his arguments. On 17 November and 17 December 2020, the Trustee provided more clarification in answer to the issues he had raised and said in summary:-

- A 'different role' under the Rules was defined as, "…an employment with another employer".
- The reference to 'employment' meant any employment. This could be the member's existing role or a different role but was most likely to be a different role, since it had already been decided that Mr N could not carry out his existing role with the existing employer.
- It was satisfied that Mr N's IP had been calculated correctly, and it had adhered to the requirements under the Rules and relevant legislation when making a decision regarding Mr N's eligibility to a Lower Tier award.
- It had provided Mr N with a schedule of the calculations of his pensionable salary. It was based on his FPS.

33. In his submissions to TPO, Mr N said in summary:-

- He is unhappy that the previous complaint with TPO was "withdrawn and closed" against his wishes. He would like the previous complaint to be considered as there had been, "a serious breach of medical information and the law".
- Dr Sharp's IRMP, report was released to the Trustee without his consent or knowledge at the time.
- He has had enough of, "being sent round in circles with deferred decisions and a so called lack of information or up to date information or the fact that [his] condition is not permanent or that [he] will not be able to perform [his] occupation permanently".
- He is about to lose everything, his home, belongings, partner as he is no longer able to support her, all because his incapacity pension has been refused by some

"extremely insensitive, ignorant and corrupt trustees along with [OH] who are clearly not independent or impartial".

- He is drowning in debt and being continually dragged through the courts as he cannot pay his bills.
- He refers to the issues he raised in the letter to the Trustee dated 12 February 2020 which explained he will not be able to perform his occupation for the foreseeable future as he has had all the available treatments which have not been successful.
- The favourable parts to him were ignored, overlooked and only the factual inaccuracies have been considered and no careful consideration given to his case.

Adjudicator's Opinion

34. Mr N's complaint was considered by one of our Adjudicators who concluded that no further action was required by the Trustee. The Adjudicator's findings are set out in paragraphs 35 to 53 below.

35. Mr N's previous complaint concerned the Trustee's decision to defer making a decision on his application for an IP. Mr N would like TPO to reconsider this now. Mr N received an opinion from an Adjudicator for TPO at the time. He did not contest it and his case was closed, in line with TPO procedures.

36. The complaint that had been accepted for investigation was as summarised in paragraph 4. So, the Adjudicator's investigation was restricted to this.

37. Mr N had raised a number of issues which the Adjudicator addressed in turn.

38. Member's entitlements to benefits when taking early retirement due to ill health were determined by the scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members were eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

39. Mr N's application for an IP was governed by Rule 4.2.1 and Rule 4.2.3 (see Appendix 1). Essentially, the Rules stated that a member may apply for the immediate payment of their pension at any time before their NRD on the grounds of incapacity. Incapacity was defined as:

> "… physical or mental deterioration which, in the opinion of the Employer and the Trustee … is serious enough to prevent the Member from following his normal employment or seriously and permanently impairs his earning capacity".

40. If the member satisfied the definition of Incapacity and with the consent of the Employer and the Trustee, Rule 4.2.3 provided for the payment of an enhanced

pension; an Upper Tier award. Rule 4.2.3 also provided for the payment of a Lower Tier award if, in the opinion of the Employer and the Trustee, the member was unable follow his normal employment with his Employer but he could nevertheless carry out an employment with another employer. The payment of a Lower Tier award was at the discretion of the Trustee.

41. Rule 4.2.3 would apply only if it had been established that Mr N was unable to perform his current role, that is he had met the definition of Incapacity under the Rules. Rule 4.2.3 was then concerned with the extent of the incapacity and the amount of IP to be awarded.

42. In addition to the Rules, the Trustee must comply with the Finance Act 2004. This provided that, in order to authorise a payment of IP to Mr N under the minimum pension age 55, the Trustee must determine that he met the ill-health condition set out under the Finance Act 2004. The ill-health condition required the Trustee to have received evidence from a registered medical practitioner that Mr N was (and would continue to be) incapable of carrying on his occupation because of his health and that he had ceased to carry on his occupation.

43. The Trustee was required to consider the likely prognosis for Mr N at the date of his application. However, as Mr N was undergoing hip surgery, the decision was deferred until he had responded to the surgery. Mr N was then invited to re-apply three months after his surgery. The Trustee's consideration required a forward-looking assessment on the balance of probabilities based on the updated evidence which was provided throughout 2018 and 2019 as this was the time Mr N was recovering from his surgery.

44. The Trustee sought the IRMP's report when Mr N had provided further evidence from his specialists. Dr Sharp, in her report dated 13 November 2019, concluded that Mr N was still young, and if he did feel able to consider further surgical interventions, there was a possibility over the long timescale to his normal retirement age that his physical capabilities could significantly improve with further surgery as well as specialist input. On that basis, the Trustee declined Mr N's application.

45. At the IDRP appeals, Mr N challenged the Trustee's decision on the basis that he would not undergo further treatments due to the pain and suffering the previous treatments had caused him. The Trustee then sought further clarification from Dr Sharp as to whether it was reasonable for Mr N to have declined further treatments. In Dr Sharp's opinion, it was not unreasonable for Mr N to do so. Dr Sharp also said that Mr N would not be able to go back to the role of a Mechanical Engineer. The Trustee subsequently considered Dr Sharp's additional comments and decided to award Mr N a Lower Tier IP. This was also on the basis that Mr N's specialist supported the view that Mr N would be able to undertake a sedentary role before his NRD.

46. In the Adjudicator's view, Dr Sharp and the Trustee had applied the criteria under the Rules correctly and had considered Mr N's application properly. The Trustee was

entitled to rely on the advice it had received from its IRMP unless there was a good reason why it should not have done so or should not have done so without seeking clarification. The Adjudicator said the kind of things she had in mind were errors or omissions of fact or a misunderstanding of the relevant rules by the IRMP. The Trustee could only be expected to review the medical evidence from a lay perspective. It was not expected to challenge a medical opinion.

47. The Adjudicator did not agree with Mr N's interpretation of the Rules that a different employment meant the same type of employment with another employer. The definition of Incapacity referred to physical or mental deterioration which prevented the member from following his normal employment or seriously and permanently impaired his earning capacity. The Adjudicator agreed that the first half of the definition meant the role Mr N was engaged in. However, the second half of the definition was clearly much wider ranging and covered the member's capacity to earn in any employment. The Adjudicator was satisfied that the Trustee's interpretation of the Rules in that respect was correct.

48. Furthermore, the Rules allowed for a review of the original decision three years from the date of the original decision, which would be due in August 2023. The Trustee informed Mr N that it would then consider updated evidence and decide whether the Lower Tier IP remained appropriate or an Upper Tier IP should be awarded. So, it was open for Mr N to provide further evidence in support of the review when it was due to take place.

49. Mr N was also not happy with the amount of FPS that was used in the calculation of his IP. However, pensionable salary was not the same as salary. The definition of FPS under the Rules was: "the higher of the Member's Pensionable Salary in his last 12 months of Pensionable Service and the highest average of any 3 consecutive calculations (or such few calculations as have been made) of a Member's Pensionable Salary made in the last 13 years of Pensionable Service".

50. Mr N's FPS was calculated on both bases and the highest calculated amount of his pensionable service (£26,259.90) was used in the benefit calculations. The Adjudicator considered that the Trustee had correctly applied the definitions of pensionable salary and FPS in the calculation of Mr N's IP. She was also satisfied that the Trustee had provided sufficient explanation to Mr N regarding the meaning of FPS under the Rules, summarised in paragraph 31 above.

51. The Adjudicator also noted that Mr N was unhappy that the Administrator quoted an incorrect NRD in the benefits statement. However, this was a typographical error for which the Trustee had apologised, and it had not affected the calculation of Mr N's IP.

52. In the Adjudicator's view, the Trustee had given proper consideration to Mr N's application for an IP by assessing all the relevant medical evidence available and it had acted in accordance with the Rules. The Trustee could only be expected to make a decision at the time when Mr N provided updated evidence three months after surgery. The Trustee did the right thing by seeking clarification from Dr Sharp as Mr

N's condition was complex and he was still young. In the Adjudicator's view, the steps taken by the Trustee when making a decision regarding Mr N's eligibility for IP, were the ones I would want to see when it is making such a decision.

53. Consequently, it was the Adjudicator's view, there were no grounds on which to remit the matter back to the Trustee for reconsideration.

54. Mr N did not accept the Adjudicator's Opinion and said, in summary:-

- He disagreed with every aspect of the Adjudicator's findings.
- Still no calculation had been provided to him. His calculations submitted to my Office had not been considered.
- There was a legal requirement to show him exactly how FPS was calculated.
- He had shown from his payslips and tax documents that his pay was higher than the Trustee used in its calculations.
- His FPS should have been properly calculated and granted when he was "unceremoniously sacked with no reasonable adjustments, alternative jobs, medical severance or ill health pension".

Ombudsman's decision

55. My role is primarily to decide whether the Trustee has correctly applied the Rules, considered all of the relevant evidence (it is for the Trustee to decide what weight, if any, to attach to that evidence) and reached a decision in the proper manner.

56. In order to be eligible for the Upper Tier IP, the Employer and the Trustee must be satisfied that Mr N's incapacity is serious enough to prevent him from following his normal employment or his earning capacity is seriously and permanently impaired.

57. Initially, the Trustee declined Mr N's application on the basis that there were further surgical interventions available to him. At IDRP, Mr N said he would not undergo further treatments due to the pain and suffering the previous treatments had caused him. The Trustee subsequently sought further clarification from Dr Sharp who said that it was not unreasonable for Mr N to have declined the surgical interventions. Consequently, the Trustee decided to award Mr N a Lower Tier IP.

58. I understand that Mr N believes he should be awarded an Upper Tier IP due to the fact that he cannot work anymore. I note Dr Sharp considered Mr N's health condition and was of the view that although he was no longer able to return to his role as a mechanical engineer, there was a possibility for him to get better with treatments before his NRD. Dr Sharp said Mr N was still young and was able to undertake a sedentary type of job before his NRD (a view shared by Mr N's Specialist, Mr Haggis). So, Mr N did not meet the criteria for the Upper Tier IP as his incapacity was not permanent.

59. It is open for Mr N to provide further evidence when his review will take place in August 2023. The Trustee will then consider his eligibility for an Upper Tier IP.

60. Turning to Mr N's point regarding the FPS that was used in the calculation of his Lower Tier IP. I appreciate that Mr N's own calculations and payslips show a higher amount of salary than his FPS. However, the Trustee must apply the Rules correctly. Pensionable salary is not the same as salary, as explained in paragraph 49. I find that the Trustee calculated Mr N's FPS correctly as it used the highest calculated amount of his pensionable service, as required by the Rules.

61. I consider that the Trustee gave proper consideration to Mr N's application for an IP by assessing all the relevant medical evidence available and that it acted in accordance with the Rules. It also applied the Rules correctly when calculating Mr N's FPS in the calculation of his Lower Tier benefits.

62. I do not uphold Mr N's complaint.

Anthony Arter

Pensions Ombudsman
16 November 2022

Appendix 1

The Plan Rules

1. Rule 4.2.1 states:

   "If a Member wishes to apply to commence his pension under the Plan he shall notify the Trustee and his Employer in writing. If a Member in Pensionable Service wishes to commence his pension before Normal Retirement Date…with the consent of the Employer and the Trustee at any time because of Incapacity, he shall be entitled to elect for an immediate annual pension payable during his lifetime as alternative to any benefit payable under Rule 8 (Termination of Service)."

2. Rule 4.2.3 states:

   "The amount of any immediate annual pension payable to a Member who commences benefits under the Plan at any time before Normal Retirement Date, as a result of Incapacity and with the consent of the Employer and the Trustee, shall be the annual amount of the pension to which the Member would have been entitled had the date on which he ceased to be in Pensionable Service been his Normal Retirement Date but calculated on the basis of his Final Pensionable Salary at the actual date of commencing benefits under the Plan and his Potential Service.

   However if, in the opinion of the Employer and the Trustee, the Member is Incapacitated to the extent that he cannot follow his normal employment with his Employer but he can nevertheless carry out an employment with another employer the Trustee may determine that the Member's pension shall be calculated instead by reference to the Member's Pensionable Service and Final Pensionable Salary at the date of his actual retirement."

3. "Incapacity" is defined as:

   "…physical or mental deterioration which, in the opinion of the Employer and the Trustee, after having taken such medical advice as they may reasonably require is serious enough to prevent the Member from following his normal employment or seriously and permanently impairs his earning capacity."

4. "Salary" is defined as:

   "… the Member's hourly rate of basic salary or wages (calculated at each Salary Review Date) before any Salary Sacrifice including normal shift payments for regularly scheduled shifts and other supplements or payments including flexible shift allowances, if any, as determined from time to time by the Principal Company but excluding any bonuses or profit share…"

5. "Pensionable Salary" is defined as:

"… in relation to a Member shall be calculated on the day he becomes a Member and at each Salary Review Date thereafter (subject to the provision of (3) below) and means the Member's Salary less an amount equal to 1.5 times the Lower Earnings Limit in force at the date of the calculation. With effect from 1 April 2009 [or in certain circumstances 28 May 2020] a Member's Pensionable Salary shall only increase at a subsequent Salary Review Date by the lower of: the actual increase in Pensionable Salary (as calculated under the previous sentence) or the amount of Pensionable Salary as at the previous Salary Review Date multiplied by the increase in the Retail Price Index published the previous December.

(1) For the purpose of calculating a Member's benefits under Rules 4 and 5 (but not for the purpose of calculating Member's contributions under Rule 2) the reduction in respect of the Lower Earnings Limit shall not be greater than 25% of the Member's Salary.

(2) Subject to the provisions of paragraph (3) below, Pensionable Salary shall then be deemed to remain fixed until the next Salary Review Date.

(3) No further calculations of Pensionable Salary shall be made after the earliest to occur of Normal Retirement Date, the date of termination of Pensionable Service and the date of the Member's death."

Finance Act 2004

6. Paragraph 1, Schedule 28 states:

"For the purposes of this Part the ill-health condition is met if-

The scheme administrator has received evidence from a registered medical practitioner that the member is (and will continue to be) incapable of carrying on the member's occupation because of physical or mental impairment, and

The member has in fact ceased to carry on the member's occupation."

Appendix 2

Medical evidence

1. In his report dated 1 December 2017, Specialist Registrar, Mr Haggis said:

> "I discussed his case with Mr Pollard who also came to see the patient. We believe that this gentleman's symptoms may well be caused by the Cam deformity. We have recommended hip arthroscopy surgery, starting with the right to try and improve his symptoms. We have given him leaflets detailing what the operation involves including the risks. The patient is keen to proceed. We have added him to the waiting list."

2. In his report dated 29 March 2018, GP, Dr Driscoll said:

> "I increased his medication for Pregabalin to 150mgs twice daily. He has become depressed and was diagnosed with depression on 6th December 2017, commenced on antidepressants and referred to the Suffolk Well being Service. He has also been drinking alcohol heavily, as he finds it is a way of combatting the pain. He was advised to start Sertraline but has had side effects with antidepressants and prefers to take the psychological route.
>
> He was also seen by the Mental Health Team having been referred due to concerns with depression, insomnia and anxiety. He was seen by them on 13th April 2018. His medication of Mirtazapine was increased from 15mgs to 30mgs.
>
> He was referred to an anxiety management course which he was due to start in May. He was given information about Turning Point and a CBT website. He was discharged from outpatient follow-up."

3. In his report dated 28 May 2018, Mr Haggis said:

> "He underwent a right hip arthroscopy on 25th August 2017…We have seen him three times since surgery, initially six weeks postoperatively. His clinic letter says that at this stage he was making a good recovery considering how much pain he was in preoperatively. His wounds had healed fully. His hip was stiff but preoperatively he was hardly able to move it at all. We then reviewed him again on 24th November 2017. The patient informed us that his hip continued to get better but his rate of recovery was slow. He was just about to start some hydrotherapy and physiotherapy was ongoing.
>
> At that stage we gave him the option of undergoing a manipulation under anaesthetic plus steroid injection or to persevere with physiotherapy. The patient has elected to pursue more physio which was entirely reasonable.
>
> At review on the 22nd of June 2018, Mr N had now been discharged by the Physios, and continued to complain of severe pain, although he does state that his hip is better than it was preoperatively. He has again been offered a

manipulation under anaesthetic with steroid injection…However, due to a previous experience of worse pain following an injection to his hip performed at Ipswich, he continued to decline this Intervention as he is highly concerned that the injection may make his pain worse as the previous injection did.

With regard to prognosis, it is usual that most patients have responded to surgery at this stage. A small proportion of patients do continue to have some pain afterwards. We may not be able to improve his current symptoms further as he declines our recommended treatment at the moment.

Meanwhile, his left hip remains highly symptomatic. We would not embark on surgery for his left hip until his right hip has improved.

It is most likely that he will be unable to perform a very physical job; for example one involving heavy lifting. However, we would expect that despite his pain he would be able to perform a more sedentary job that does not include manual labour."

4. In his report dated 20 August 2018, Mr Haggis said:

"To address the point raised in your email the company work fit asked us to provide a report on your musculoskeletal problems. We therefore provided your medical history relating to this, in particular describing the severity of your symptoms and how long they have been going on for. The report describes the considerable efforts that have been made to resolve your symptoms. The report also details your recovery from your most recent surgery and the fact that, unfortunately, you continue to experience severe pain.

I can confirm that no further procedures or surgery are planned for you.

…

With regards to your ability to work, as we are not specialists in occupational health we can only offer limited information as to your ability to work. However, the report does say that it is most likely that you will be unable to perform a very physical job, specifically one involving heavy lifting. It would be for work fit to discuss with you as to whether any other occupation is possible with your current symptoms.

It is likely that work fit will need to assess you themselves before making any decision regarding your ill health pension. However, I do believe that the report does detail the significant pain that you have from your hips, the fact that multiple interventions including surgery have not improved your symptoms. Once again I am happy to confirm that there are no further procedures or surgery planned for you."

5. In her report dated 13 November 2019, Dr Sharp said:

> "Mr N explained that his mood has been low for around four years and as an adjustment reaction to his employment and health situation. The community mental health team wrote a report dated March 2018 linking his mental health to developing hip pain and the physical limitations associated with this. The assessment noted that he was using alcohol as a maladaptive coping strategy and was also not tolerating medications with reported side-effects. The management plan at that stage was to try alternative medication, a referral to an anxiety management course and he was given information about further support services including CBT.
>
> A more recent report from the community mental health team dated May 2019 has been written to the occupational health department. This provides a diagnosis of mixed anxiety and depression with comorbid harmful use of alcohol. A list of various medications have been prescribed and it was noted that there hasn't been a consistent use of a particular anti-depressant or anxiety medication due to reported side-effects to various medications prescribed. His mental health was noted to be secondary to both physical health issues and other associated problems.
>
> Mr N currently tells me that he sees a psychiatrist every three months and is currently accessing talking therapy through MIND. He explained he has not seen the pain clinic for around 3 to 4 years and I discussed with him that in my opinion he would benefit from CBT and a referral to a pain psychologist. He is currently taking antidepressant medication but despite this, reported a high level of symptoms on a mood questionnaire that I asked him to complete. I do feel that if he was able to effectively engage with a robust psychological support service there is likelihood of improvement in the level of his mental health symptoms allowing him to cope better with both chronic pain and the physical and social limitations that he is reporting as a consequence of his hip complaint. There is therefore likelihood of improvement and in relation to his mental health, I would not see this specifically as a barrier to employment in the future.
>
> Mr N has a known bilateral hip condition. His GP wrote to the occupational health department in March 2018 explaining that he was being prescribed painkilling medication and was being advised to take antidepressants but due to the side-effects, was preferring to try psychological support. He has reported to his general practitioner that his mobility was significantly limited. He reported being uncomfortable sitting 10 minutes and walking 20 yards and was also not driving at that stage. In May 2018, his orthopaedic specialist wrote to the occupational health department explaining that he had right hip keyhole surgery in August 2017 and the findings were at the severest level, grade 4 and also a large right hip impingement was noted which was surgically decompressed. On a post-operative review he was still in considerable pain and was having physiotherapy and hydrotherapy. He was

reviewed in June 2018 and at that stage he had been discharged by the physiotherapists but was still complaining of severe pain. He was offered a manipulation under anaesthetic with steroid injection, which his specialist has indicated that around one in five patients require post-operatively and his specialist noted that most find significant improvement afterwards.

Mr N however, due to a previous experience of worsening pain after a similar injection, declined this intervention and as he was highly concerned that it would make the situation worse. His specialist noted that a small proportion of patients do continue to have some pain afterwards but they were unable to improve his current symptoms further and as he had declined their recommended treatment. They also felt unable to embark on a similar surgery on the left-hand side until the right hip had improved. His specialist summarised that it will be unlikely that he would be able to perform a very physical job. For example, one involving heavy lifting but he would be able to perform a more sedentary job that does not include manual labour and as an opinion regarding the situation at the point the report was written.

Mr N provided me with a further report dated August 2018 written to him by his specialist explaining that as they were not specialists in occupational health, and as such they were only able to offer limited information as to his ability to work. The advice that a sedentary role would be most suitable was reiterated and in relation to his current symptoms. His specialist notes that his original report in May 2018 did detail the significant pain that he was having from his hips despite multiple interventions including surgery which hadn't improved his symptoms. There were no further procedures or surgery planned.

Occupational health has re-written to his specialist to obtain a more up-to-date report in order to advise regarding the current situation in 2019 but have been unable to obtain this further report. Mr N has advised me that he has not re-seen his specialist since these reports were written in 2018 and as such, it is unlikely that his specialist will be able to provide any further information. In my opinion, there is a possibility of further intervention in the form of this manipulation under anaesthetic with steroid injection that his specialist refers to as well as similar surgery on the left-hand side and this may well improve the situation, if Mr N did feel able to proceed. Psychological support will also have a positive impact on his coping strategies in relation to chronic pain. Despite this, he has reported significant pain over a prolonged period of time and it is likely that Mr N will not be fit for heavy lifting or physically demanding tasks for the foreseeable future.

Mr N has had some support in relation to his alcohol consumption which was a maladaptive coping strategy in relation to his health situation. He informed me that he has had no alcohol since May 2019 and his alcohol consumption does not appear to be a factor impacting on his fitness to resume work.

In summary, Mr N has chronic hip pain associated with secondary mental health symptoms. Occupational health has not been able to obtain an up-to-date report from either his general practitioner or his specialist. There are further therapeutic options available to Mr N such as support from the pain psychologist to help him cope with his health situation and possible further surgical intervention. Mr N explained that his role as a mechanical engineer involved repairing, servicing and maintaining the machinery on-site including cranes arid forklift trucks. He advised me that he could work at height and carried loads such as his tools. In view of the severity of the hip condition noted at surgery and the failure of surgical intervention in the past to improve the situation, there is likelihood that his hip condition will have an impact on his mobility for the foreseeable future which will have an impact on his fitness to return to the role as a mechanical engineer. He is however of a young age, and if he did feel able to consider further surgical interventions, there is possibility over the long timescale to his natural retirement age that his physical capabilities could significantly improve with further surgery as well as specialist input. I do not see any reason why Mr N would not be fit for alternative duties such as the sedentary role that does not include manual labour as advised by his specialist and once his mental health situation improves with the input of psychological support.

I was able to obtain Mr N's consent and he has opted to receive a copy of this report at the same time as it is released to the Port of Felixstowe and via email. This would be with a view to correct any factual inaccuracies rather than asking me to alter my opinion or reword the report."