Ombudsman's Determination

Applicant	Mr L
Scheme	Usdaw Staff Superannuation Fund (**the Fund**)
Respondent	The Trustees of the Usdaw Staff Superannuation Fund (**the Trustees**)

Complaint Summary

1. Mr L's complaint concerns the Trustees' decision to suspend the payment of his ill health early retirement pension (**IHER**).

Summary of the Ombudsman's Determination and reasons

2. The complaint should not be upheld against the Trustees because there is no evidence to suggest that there was any error, or omission of fact, when Mr L's IHER entitlement was reviewed in 2016.

Detailed Determination

Material facts

3. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

4. Mr L is a member of the Fund, a defined benefit occupational pension scheme, which is administered in accordance with the Definitive Trust Deed and Rules (**the Rules**).

5. As relevant, rule 7(1)(b) states:

> "7(1) Every Contributor shall become entitled to an immediate superannuation allowance from the Fund in the following circumstances:
>
> …
>
> b) if he shall have been a Contributor to the Fund for a period of not less than 5 years and shall retire from the service of the Union before attaining Normal Retirement Age by reason of his inability to perform his duties in consequence of total or permanent infirmity or ill health, such inability being

> determined by a certificate to that effect given by the Executive Council and acceptable to the Committee.
>
> If any Member of the Fund having been superannuated under the circumstances set out in this Sub-Rule recovers sufficiently to resume his duties he shall not be deemed eligible to continue receipt of any benefits under the Fund except at the discretion of the Committee who shall fully consider each case on its merits.
>
> If the Member, in the view of the Executive Council and the Committee, is capable of or becomes capable of undertaking other employment then the Committee shall reduce the superannuation allowance at their discretion."

6. From May 2009, Mr L was unable to continue in his role as an Area Organiser due to severe back pain. Consequently, Mr L applied for IHER in 2010. However, at the time his application was declined.

7. On 30 January 2012, the Trustees agreed to award Mr L an IHER pension. Based on the medical evidence, it was agreed that he was permanently incapable of carrying out the duties of his role as an Area Organiser.

8. On 1 February 2012, the Trustees wrote to Mr L and informed him that his IHER appeal was upheld and that he was eligible to receive an IHER pension backdated to 20 September 2010. The Trustees drew Mr L's attention to the second paragraph of rule 7(1)(b) and said: "the Trustees will from time-to-time require continued evidence of the state of your health as required under this Rule".

9. In 2014, Mr L's continued entitlement to his IHER was reviewed by the Trustees. Overall, it was agreed that Mr L's condition had not improved to allow him to return to his role. Mr L continued to receive his IHER pension and was informed that his next review would be in two years.

10. On 5 July 2016, the Trustees wrote to Mr L and said that it had been two years since his last IHER review. Consequently, it had made arrangements for him to attend an appointment with the Fund's appointed occupational health provider, Medigold. If it was established that he was able to undertake his role or alternative employment, it held the necessary discretion to reduce or suspend his IHER pension.

11. On the same day, the Trustees wrote to Medigold and asked it to contact Mr L to arrange an appointment. The Trustees provided Medigold with a copy of the relevant Rules and Mr L's former job description. Medigold was asked to give a clear view/response to the following questions:

> "1) To what extent is the individual capable of performing the duties required by his former job role with the union?
>
> 2) To what extent is the individual capable of undertaking other employment or is the individual currently engaged in another employment?

3) Can the individual's infirmity/ill health be classed as either 'total' or 'permanent'?

4) What are the prospects of the individual recovering sufficiently to be able to resume his former role within the Union and within what timescales?

5) On the balance or probabilities, is the individual likely to recover sufficiently to be able to undertake some other form of employment between now and normal retirement age (age 65 under the Fund's Rules) and within the timescales? Please note that Dr Roy's [Medigold Consultant Occupational Physician] report dated 9 July 2014 stated that 'given [Mr L's] young age and the extent of his symptoms… it would be difficult to predict that he is permanently incapable of carrying out any work until his retirement age of 65'.

6) To what extent can the individual's condition be expected to (or have been expected to) improve in response to the medication and treatments he has been prescribed so far?

7) Since his last review, would you reasonably expect the individual's condition to have improved sufficiently by now to enable him to undertake some form of employment?

8) How long would you recommend that the Trustees wait until they request a further review of the individuals medical condition and continued eligibility for ill-health retirement?"

12. On 21 July 2016, Mr L failed to attend his appointment with Medigold. Consequently, Mr L's appointment was rearranged to 15 September 2016.

13. On 15 September 2016, Mr L cancelled his rearranged appointment with Medigold as he was unwell.

14. On 12 October 2016, the Secretary to the Trustees (**the Secretary**) emailed Mr L and informed him that if he did not attend his next appointment with Medigold, the Trustees would need to reconsider his entitlement to his IHER pension.

15. On 10 November 2016, Mr L attended an appointment with Dr Hall, the medical adviser (**the MA**) appointed by Medigold to carry out the IHER review.

16. On 5 December 2016, Dr Hall provided the Trustees with his opinion on Mr L's entitlement to an IHER pension, based on his current capacity for work (**the MA's Report**). In drafting the MA's Report, Dr Hall was provided with Mr L's IHER application, the report for Mr L's 2014 IHER review, and copies of medical evidence from 2009 to 2014.

17. In summary, Dr Hall said:-

    17.1. Mr L was 46 years of age at the time of the review. Based on his previous job description, Mr L was employed as a full-time Area Organiser. This involved

general office work, driving long distances, attending meetings, dealing with tribunals and employees in their workspace.

17.2. He had reviewed specialist reports from between September 2009 and March 2011 and the report by Dr O'Malley (Consultant Orthopaedic Spinal Surgeon) which resulted in Mr L being awarded his IHER pension. Mr L had a L5/S1 disc replacement in 2007; however, when lifting heavy furniture in 2009, he experienced pain in both his legs down to his ankles. His symptoms thereafter did not improve, and he was referred back to Dr O'Malley, the surgeon responsible for his disc replacement.

17.3. After an MRI scan in 2009, Mr L did not respond to an epidural injection with Dr O'Malley commenting "there does not appear to be any abnormality of the position of the disc replacement or loosening on the x-rays thus far". Mr L was subsequently diagnosed with mechanical lower back pain (**MLBP**) and prescribed with strong analgesics and referred to a chronic pain management team.

17.4. During his July 2014 IHER review, Mr L commented that the pain from his MLBP was now felt in his hips, groin, down through to his thighs and that it was getting worse. He no longer attended the pain management clinic and claimed to do physiotherapy exercises at home. On good days he needed to rest frequently, and on bad days he spent most of the day in bed. He said that he took 40mg of Tramadol a day, 600mg of Pregabalin, 150mg of Diclofenac, 20mg of Amitriptyline and oral morphine.

17.5. Mr L appeared to walk without difficulty, but he did have to sit and stand periodically. He was noted to have mild limitation of his lower back, but he was able to sit upright on the couch while extending his legs without discomfort. Mr L "grimaced frequently" however he was able to sit forward and converse without difficulty.

17.6. Mr L's hands showed "general grime, calluses at the base of his ring and little finger of his right dominant hand only. The general texture of both palms of his hands was rough, suggestive of manual work." This however could not be confirmed.

17.7. Mr L's MLBP and symptoms were disproportionate to the underlying medical condition. Guidance prepared by NICE, the faculty of medicine, and the Royal College of General Practitioners said that permanence could not be attributable to the condition and graded exercise, and activities were encouraged. Mr L was able to sit, stand and walk while still being able to undertake activities at home. His return to work was encouraged.

18. Dr Hall provided the following answers to the questions originally asked of him by the Trustees (see above paragraph 11):

> "I believe there is no medical reason preventing [Mr L] from duties of his former role.
>
> I believe [Mr L] is medically capable of undertaking other forms of employment. He claims not to be employed at present.
>
> In my opinion, he does not have any permanent or total infirmity/ill health.
>
> Yes, in my opinion, he is medically capable of undertaking such roles at present.
>
> [Mr L], in my opinion, is medically capable of undertaking the duties of his former role although there is no reasonable prospect of him doing so.
>
> Since his last review, would you reasonably expect [Mr L's] condition to have improved sufficiently by now to enable him to undertake some form of employment?
>
> Yes."

19. On receipt of the MA's Report, Mr L asked the Trustees to postpone making any decision regarding the continued payment of his IHER pension until he was able to provide a report from his GP. The Trustees agreed to postpone any decision.

20. On 30 January 2017, Dr Kearney, Mr L's GP, provided a report which said that he was not in a position to question the MA's Report as it was a specialist report based on answering questions that required a specialist assessment.

21. On 3 February 2017, Mr L wrote to the Secretary and raised a number of concerns and queries about the MA's Report. Mr L said:-

    21.1. His assessment with Dr Hall only lasted 40 minutes as opposed to the hour-long session that it should have been. He claimed that Dr Hall started the appointment by inferring: "he would not have granted my pension due to my age". In his view, it was clear that Dr Hall's view was "misconceived and was pre-judged based against [his] age which [he] challenged as discriminatory".

    21.2. In response to the comments Dr Hall made about his hands, he said that before his appointment he put air into his car tyres. He said that he had callouses on his hands for years and that his hands were generally dry. Further, he was right-handed and still had to clean his house amongst other chores all of which made his hands rough.

    21.3. Dr Hall said that he had arthritis in his hand, however this was absent from his report. The MA's Report said that the pain he felt in his legs after moving furniture was in 2009. This was incorrect as it occurred in 2007. This was the cause of his need for surgery on his L5/S1 disc. Further, the MA's Report did not mention a previous report by Dr O'Malley which said he was unfit for work. He also took 400mg of Tramadol a day, not 40mg. This was the highest dose his GP could prescribe.

21.4. He grimaced during the assessment because he was in pain. It was also incorrect for Dr Hall to say that he extended his legs without any discomfort as he was in pain. Dr Hall's conclusions seemed to be based on the fact he could sit forward and talk with him during the assessment. He could sit, stand, talk and carry out household chores, but this did not mean that he was fit for work. He was following the recommendations in the pain management toolkit he received from the Halton pain management team.

21.5. A specialist report should have been requested from a spinal surgeon/specialist on his condition, as Dr Hall was not a specialist. The section of the NICE guidelines that Dr Hall had referred to only covered general mechanical back pain. It did not refer to the section on sacroiliac joint pain/chronic pain.

22. On 3 March 2017, the Secretary wrote to Mr L and explained that his comments on the MA's Report were referred onto Dr Hall to respond to. Dr Hall's response was as follows:-

22.1. He was an accredited occupational health specialist with over 30 years' worth of experience in the field relating to pensions and IHER.

22.2. His report was in line with previous Medigold reports that said Mr L's MLBP was not a permanent condition. His advice on returning to work was in line with "various governing bodies, including local authority pension doctors".

22.3. He did say that it was unusual for someone of his age to be granted an IHER pension. However, this did not prejudice his assessment. He also made no such comment about Mr L having arthritis in his hands.

22.4. He only commented on Mr L's hands at the end of the assessment, which at the time Mr L did not inform him that he had bent down to put air into his car tyres before the assessment. Nor did Mr L given any explanation for the callouses at the of his little ring fingers of his right hand.

22.5. Mr L's own surgeon diagnosed him with MLBP and said that it was not sacroiliitis. This was an initial consideration when Mr L did not respond to treatment.

23. On 20 March 2017, Mr L wrote to the Secretary and said:-

23.1. The questions asked of the MA were the same questions that were asked during his initial IHER application. In his view, these were irrelevant questions meaning the Trustees misdirected themselves. They should have sought an opinion as to whether his condition had improved, and if so, to what extent. The questions asked were more akin to an assessment for IHER as opposed to a review for continued entitlement.

23.2. He should have been sent to an independent medical specialist, not to an occupational health specialist, before a decision was made on whether his condition had improved and to what extent.

23.3. Dr O'Malley's report, which was emailed to the Trustees on 2 February 2011, stated: "It is my belief that he has pain emanating from the lower joints in his spine sacroiliac and facet joints."

24. On 21 March 2017, the Trustees convened for their monthly meeting and discussed Mr L's IHER review. The minutes from the meeting evidenced that the following was discussed:-

24.1. Consideration was given to the MA's Report, the additional comments provided by Mr L on the MA's Report, and Dr Hall's response. The question that Dr Hall was asked whether Mr L's condition was either "partial" or "permanent", was irrelevant in regard to the review of Mr L's continued entitlement to an IHER pension.

24.2. Dr Hall's opinion was that Mr L's ability to perform the duties required of his former role was a relevant consideration. Overall, the Trustees' view was that Mr L had recovered sufficiently to resume the duties of his previous role. In accordance with the provisions of rule 7(1)(b), Mr L was no longer eligible to receive an IHER pension.

24.3. The Trustees decided not to exercise discretion to continue the payment of Mr L's IHER pension in light of the evidence provided. Mr L's pension would cease as of 31 March 2017. The Fund Actuary would be instructed to calculate Mr L's deferred pension based on his pensionable service and the amount he had received from his IHER pension between its effective date and date of cessation.

25. On 23 March 2017, the Secretary wrote to Mr L and informed him that his IHER pension was to be suspended from 31 March 2017 and he could appeal the decision through the Fund's Internal Dispute Resolution Procedure (**IDRP**) if he wished to.

26. On 15 September 2017, Mr L informed the Secretary that he wished to appeal the decision under stage one of the Fund's IDRP.

27. On 2 April 2018, Mr L said in his appeal:-

27.1. He believed the intention of paragraph two of rule 7(1)(b) was to establish if there was a sufficient improvement in his condition to:

27.1.1. enable him to carry out the duties of his former role as an Area Organiser; and

27.1.2. undertake other forms of employment, which would allow the Trustees to reduce his pension.

27.2. Dr Hall seemed to focus mainly on his age and the fact he was not working during the assessment. The MA's Report also included factual inaccuracies about the medication he took.

27.3. Despite having access to his medical records, the Trustees did not attempt to obtain a report from his GP who had treated him over the years. The GP's report that was obtained indicated that a specialist report was required to answer the questions posed to Dr Hall by the Trustees.

27.4. The Trustees disregarded the suggestion to obtain a specialist report and preferred the opinion of Dr Hall, which was at odds with the outcome of his IHER assessment and the review in 2014.

27.5. He submitted that the recent Determination (PO-11695[1]) by the Pensions Ombudsman (**the PO**) was similar to his own circumstance. He also highlighted an older Determination (LOO761[2]) by the PO which he said was relevant to his situation.

28. Mr L noted the following points from PO-11695 (Mr N):-

28.1. The Finance Act 2004 made a specific exception to allow for the reduction of an IHER pension. This reflected the general expectation that once a pension was granted, it should as far as possible be for life. It was recognised that an IHER should not be payable if there was an improvement in the recipient's condition.

28.2. The decision to vary or suspend an IHER pension under rule D3.(b) was discretionary. However, this was not the same as the discretion available when deciding if a member was initially eligible for an IHER benefit. This would be contrary to the principle that the payment of a pension should be final.

28.3. The decision to review Mr N's pension should only be to consider if his condition had improved. This would be the result of an improvement in his underlying condition due to a new treatment that could help him return to remunerated employment. The fact that the discretion allowed the Trustees to vary Mr N's pension indicated that the employment did not need to be his normal employment or similar.

28.4. In 2012, under review, Mr N's GP was asked if there had been any changes in Mr N's condition, or if he had undertaken any work. This was in keeping with the approach envisioned by the scheme rule and the courts. In 2015/16 the Trustees asked whether Mr N met the definition of incapacitated instead of asking if there was an improvement in his condition. The evidence available did not indicate that that there had been any improvement in Mr N's condition. On the contrary the medical advisers agreed that Mr N was unfit for work.

[1] John Lewis Partnership Pension Scheme (PO-11695) | The Pensions Ombudsman

[2] Royal Bank of Scotland Staff Pension Scheme (L00761) | The Pensions Ombudsman

28.5. Overall, the Trustees failed to ask themselves the correct questions and did not construct a correct interpretation of the scheme rules. This amounted to maladministration.

29. Mr L noted the following points from L00761 (Mrs Y): -

29.1. A specialist in his condition should have been asked the question of whether or not there was an improvement in his condition.

29.2. The Trustees failed to adequately provide a proper explanation of its reasons for suspending his IHER pension.

29.3. The Trustees did not obtain any up-to-date medical evidence other than the MA's Report when it made the decision to suspend his pension.

29.4. The situation should be remedied by reinstating his pension as quickly as possible.

30. On 13 June 2018, the Secretary provided the stage one IDRP response to Mr L's appeal, on behalf of the Trustees, and did not uphold the complaint. The Secretary explained that:-

30.1. The Trustees were required to ask themselves two questions: if he had sufficiently recovered to allow a return to his role; and if he was capable of undertaking other gainful employment. The Trustees found that he was capable of returning to his role, so the second question was not relevant.

30.2. There were differences in Mr L's circumstances compared to those of PO-11695. In the case of PO-11695, the Trustees essentially revisited the initial decision to grant the applicant an IHER pension and changed their mind. In Mr L's case the Trustees considered if there had been an improvement in his condition to allow a return to work, which there had been. Consequently, his pension was suspended.

30.3. In conducting the two-yearly review, it had: obtained evidence; allowed Mr L to review and challenge the evidence; considered the evidence and any points of challenge; and the Trustees convened to discuss his continued entitlement to an ill health pension. All of which occurred during the review period.

30.4. The Trustees did not revisit their initial decision to grant him an IHER pension. The process followed correctly involved consideration of the first question about his ability to undertake his role. The Trustees decision was based on the appropriate evidence available.

30.5. In the case of Determination L00761, the scheme rules specifically required an appropriately appointed or approved MA to provide a certificate on the members health. The findings in that case were that the Trustees failed: "to request certification from an appropriately appointed or approved medical practitioner in the right terms at the right time".

30.6. The Trustees had previously considered specialists' reports in regard to his condition. Dr Hall's additional comments of 3 March 2017 agreed with this specialist diagnosis. Dr Hall was also asked "what are the prospects of [Mr L] recovering sufficiently to be able to resume his former role and with what timescales" and "to what extent is [Mr L] capable of performing the duties required by his former job role with the union".

30.7. Mr L's diagnosed condition was not disputed. Dr Hall was tasked with considering if Mr L's condition had improved, which he believed that it had. So, it was not unreasonable for the Trustees to have relied on the MA's Report when arriving at the decision to suspend Mr L's pension.

30.8. The MA's Report, in conjunction with the letter of 23 March 2017, provided sufficient reasoning as to why Mr L's IHER pension was suspended.

31. On 2 September 2018, Mr L asked for his complaint to be considered under stage two of the IDRP and submitted that:-

31.1. To reasonably suspend his IHER pension, new evidence needed to be obtained that supported a suspension. This would include information on a recent operation or any new treatments that had a marked improvement in his condition.

31.2. The Trustees had not said how his condition had improved, and the MA's Report was not based on any new information other than medical reports that were previously considered during the initial assessment and subsequent review.

31.3. The questions that Dr Hall was asked to answer were the same questions asked during his IHER application assessment. He noted that the Trustees had agreed that some of these questions were irrelevant for his review. This then called into question why they were asked.

31.4. The MA's Report referred to a report by Dr O'Malley which inferred that he was at a loss as to what was causing his pain. Dr Hall claimed that his pain was not related to his sacroiliac joints but due to MLBP. However, a further report by Dr O'Malley that was provided to the Trustees during his IHER assessment said that his pain was emanating from his sacroiliac joints and that he was not fit for sedentary work.

31.5. The MA's Report omitted this information and instead relied on information that was superseded by Dr O'Malley's further medical report. Dr Hall also suggested that his MLBP was a "bad back" and that it would improve/get better. This was incorrect as MLBP was attributed when the exact cause of pain was not completely known. The pain emanated from his joints, but its exact origin was unknown, so it was mechanical. 10% of MLBP sufferers did not see any improvement and suffered from chronic pain.

31.6. He was in receipt of universal credit from the Department for Work and Pensions as he was still unable to work.

31.7. The Trustees should reinstate his pension, backdated to the date it was suspended. The Trustees should also pay him an additional amount to cover the tax that he would likely be subject to in receiving three-years' worth of backdated payments.

32. Between June and December 2020, Mr L corresponded with the Secretary. Mr L said that he had not received a response to his stage two IDRP appeal. The Secretary explained that Mr L's complaint was now out of time, however he would refer the matter to the Trustees to consider whether they wanted to accept his appeal.

33. On 2 December 2020, the Trustees agreed to accept Mr L's stage two appeal and said they would review it during their next meeting on 17 March 2021.

34. On 17 March 2021, the Trustees convened for their quarterly meeting and discussed Mr L's appeal. The Trustees decided not to uphold it. This was supported by advice from the Fund's legal counsel. The Trustees said Mr L was misguided in saying that the decision to suspend his pension was made without any new evidence. Dr Hall was appointed to conduct the two-year review and provided the MA's Report which represented new evidence. This evidence was appropriate for the Trustees to rely on when making their decision. Dr Hall was expressly asked about the prospects of Mr L recovering sufficiency to return to his role. Dr Hall's opinion was that he had recovered sufficiently. No previous medical reports were omitted by Dr Hall in arriving at his opinion. Further, Dr Hall was a qualified occupation health physician with 30 years' experience.

35. On 12 April 2021, the Secretary provided Mr L with the Trustees stage two response and said that:-

35.1. The Trustees reviewed the process undertaken in 2017 when the review of Mr L's entitlement to IHER was undertaken and subsequently suspended his pension. Overall, the Trustees were satisfied that the applicable Rules were followed and acted on.

35.2. The key point to consider was whether Mr L's condition had improved to the extent that he could sufficiently resume the duties of his former role.

35.3. In considering this question, the Trustees relied on the opinion of Dr Hall, whose report was prepared based on an in-person assessment in November 2016. The MA's Report represented new evidence for the Trustees to review and make a decision on. Overall, Dr Hall said: "I believe there is no medical reason preventing [Mr L] from [performing the] duties of his former role".

35.4. Mr L's comment that Dr Hall did not refer to an earlier report by Dr O'Malley was noted. However, all the medical reports made available to the Trustees were passed to Dr Hall prior to his assessment. The Trustees noted Mr L's

contention over the outcome of the MA's Report. However, they concluded that it was reasonable for them to rely on the MA's Report when considering the question of his recovery.

35.5. The fact that the Trustees agreed his condition was permanent did not preclude them from posing the question of whether he had recovered enough to sufficiently undertake his former role. It was the effects of the condition, not the condition itself, that needed to be reviewed.

35.6. The Trustees did not uphold his complaint and his IHER pension remained suspended.

Summary of L's position

36. Dr Hall's theory was that "rest and graded" exercise would help alleviate his symptoms to allow a return to work. This contradicted the view expressed by any specialist/doctor within any medical reports from 2010 onwards. Dr Hall appeared to base this assumption on the basis of the permanence of his condition and that the NICE guidance which said that MLBP was not permanent but variable. The permanence of his condition was supported by multiple specialists more qualified than Dr Hall.

37. Rest, graded exercise and medication were encouraged in the first 6-12 weeks of his diagnosis in 2009. However, in spite of this his pain remained and so was therefore classed as chronic pain. The NICE guidance does not override the diagnosis and prognosis of consultants Dr Hall's comment that his "symptoms are disproportionate to [his] diagnosis" and that rest and exercise were required and that he should have recovered within 12 weeks of his diagnosis was counter intuitive. If he recovered sufficiently within six months he would have been back in his role as opposed to be dismissed after 14 months on sick leave.

38. He believed the Trustees only accepted the MA's Report, and his own letter, when it made the decision to suspend his pension. He did not believe that any previously provided medical evidence was considered, as much of its contents contradicted Dr Hall's view. It was clear that the Trustees blindly accepted Dr Hall's opinion as neither Dr Hall, nor the Trustees, pointed to any treatments that he had undertaken between 2014 and 2016 that resulted in a recovery of his symptoms.

Summary of the Trustee's position

39. The key question that the Trustees needed to consider and answer when reviewing Mr L's continued entitlement to an IHER pension was if he had recovered sufficiently enough to return to his former role. Alternatively, they could consider if he was capable of any other work. If he was, they could reduce, instead of suspending, his pension. The Trustees concluded that Mr L had recovered sufficiently to return to his role, so they did not need to consider the second question.

40. Dr Hall's assessment in 2016 was unequivocal in that he believed Mr L had recovered sufficiently to return to his former role. Specifically, Dr Hall was asked if, in his opinion, Mr L "had sufficiently improved in order to enable him to undertake some form of employment and he answered "yes"".

41. An improvement in Mr L's condition was anticipated by Dr Coles and Dr Roy. In particular, Dr Coles' report from December 2011 said that Mr L had not had the benefit of attending a pain management programme, so he was unable to conclude that Mr L was permanently unfit for employment and that a future review was required. In July 2014, Dr Roy commented that he hoped Mr L would recover sufficiently to undertake some form of employment before his normal retirement age. This was on the basis of his continued involvement with the pain management clinic. Dr Roy said that he could not realistically see Mr L returning to his former role within the next three to six months, therefore implying he could undertake that role in the future.

42. Dr Hall accepted the specialist diagnosis of Mr L's condition, but his view was that the symptoms of that condition no longer prevented Mr L from working. It should be noted that improvement and recovery are not restricted to the underlying condition. Dr Hall's opinion was clear, so the Trustees did not accept that there were differing medical opinions or that additional medical evidence should have been sought.

43. The Trustees refuted Mr L's assertions regarding their reliance on the MA's Report as opposed to the opinion of a specialist spinal consultant. Dr Hall had over 30 years of experience in the field and was in the best place to provide a view on a condition/symptoms and how they affect an individual's ability to undertake their role based on its requirements. Dr Hall also considered and responded to the comments and additional questions raised by Mr L in response to the MA's Report.

44. As recorded in the Trustee minutes from March 2017, the question of whether Mr L's condition was permanent was not a relevant consideration nor did it have any bearing on the decision to suspend Mr L's pension. However, this did not mean that it was not appropriate to pose the question to Dr Hall as it might have been that Dr Hall concluded that Mr L remained incapable of resuming his former role and so a further review might be required. If Dr Roy indicated, in 2014, under the first review that there was no possibility of improvement in Mr L's symptoms, the Trustees' might not have asked for a further review in two years-time. These questions would also be relevant in deciding to reduce Mr L's pension if it was found that he was unable to return to his former role, but that he was able to undertake some work.

45. The Trustees did not blindly accept Dr Hall's opinion. They asked themselves the correct questions and, based on Dr Hall's unequivocal report, and response to follow up questions, it was reasonable for the Trustees to conclude that Mr L had recovered sufficiently to return to his former role. Mr L provided no contemporaneous evidence to suggest otherwise. The MA's Report was so conclusive that a significant amount of weight was attached to it.

46. When the decision to suspend Mr L's pension was reached, the Trustees could have decided that Mr L was not due any further benefits from the Scheme. The Scheme Actuary had advised that the sum of IHER pension payments Mr L received exceeded his benefit entitlement under the Scheme. As such, the Trustees were presented with a choice of deciding if Mr L's entitlement was now extinguished, or award him a deferred pension which took into account the benefits already received by Mr L with a new deferment date of 31 March 2017. The Trustees elected to undertake the latter option to allow Mr L a deferred pension, but with no lump sum entitlement. Mr L was now over the age of 55 and eligible to claim his pension.

Mr L's response to my Preliminary Decision

47. On its true interpretation, rule 7(1)(b) provides that once an IHER pension is in payment, it can only be suspended if the recipient has "enjoyed a recovery of health to such an extent that he or she would in principle be fit once again to perform the duties of the position from which he retired on IHER grounds". Alternatively, the award can be reduced if the recipient is unable to undertake their role, but they have recovered sufficiently enough to undertake other employment.

48. The discretion available to the Trustees under rule 7(1)(b) to reduce or suspend an IHER award is contingent on there having been a change in the individual's health. Essentially, there has to have been a recovery in their health to undertake the duties or their role, or other employment. Paragraphs two and three or rule 7(1)(b) do not allow the Trustees to reduce or suspend a pension if they believe that the criteria in paragraph one of rule 7(1)(b) is no longer met at the date of the review. The review is not an opportunity to "second guess the initial decision".

49. The MA's Report should not have been taken into consideration when reviewing his IHER entitlement. The report included irrelevant considerations such as Dr Hall commenting that he was not suffering from a permanent incapacitating condition. This was not the right question to ask under rule 7(1)(b) for the purpose of a review. During the face-to-face assessment Dr Hall told him that he would not have recommended that he receive the original IHER award.

50. Dr Hall said that MLBP was a variable condition and permanence could not be established. He also referenced NICE guidance when arriving at this view. Regardless of whether this was correct, it was accepted in 2012 that he was suffering from a permanent condition that gave rise to incapacity. So, the permanence of his condition was irrelevant. Consequently, Dr Hall's comment that "there was no medical reason preventing [Mr L] from duties of his former role" appeared to be made on the assumption that he was never incapacitated. There was no mention of any improvement in his health that allowed his return to work.

51. During the assessment Dr Hall noted that he could sit, stand and walk, albeit while "grimacing frequently". There was no consideration as to whether he could make the movement necessary to undertake his former role without an intolerable level of pain. Dr Hall also demonstrated a level of bias against him. This was demonstrated when

Dr Hall commented on the texture and roughness of his hands suggesting manual work. This indicated that Dr Hall did not trust or believe that he was not working, and so this hindered Dr Hall's ability to offer an impartial opinion for the purpose of the review.

52. He submits that the Trustees' meeting of 21 March 2017, when the review of his entitlement was undertaken, was flawed. During this meeting the Trustees agreed that he was capable of undertaking the duties of his former role. So, the review was undertaken against the second paragraph of rule 7(1)(b), and not the third paragraph. The MA's Report, which the Trustees based their decision on, said that he was able to undertake his former role, not that he had recovered to a sufficient extent to do so. However, the report was not supported by any relevant medical evidence that supported a decision to be made under paragraph two or rule 7(1)(b).

53. When answering a question of whether he was suffering from "total" or "permanent" incapacity, Dr Hall said that he was not permanently incapacitated. This was an irrelevant consideration for the purpose of a review under paragraph two of rule 7(1)(b). Consequently, as the Trustees accepted and relied on the MA's Report when it made the decision to suspend his pension, they had relied on an irrelevant consideration. On this basis, the decision was flawed. Given the bias in Dr Hall's report, the Trustees should have requested a fresh report from a new MA.

Conclusions

54. Mr L's complaint concerns the Trustees' decision to suspend his IHER pension.

55. It is important to highlight my role in this process. My role is not to review the medical evidence and decide whether Mr L's IHER award should have remained in payment following the 2016 review. I am primarily concerned with the decision-making process followed by the Trustees.

56. When considering how a decision has been made, I will look at whether:

    56.1. the applicable scheme rules or regulations have been correctly applied;

    56.2. appropriate evidence has been obtained and considered; and

    56.3. the decision is explained and supported by the available relevant evidence.

57. Provided the Trustees have acted in accordance with the above principles, and within its powers under the Rules, I have no grounds to submit the matter back to the Trustees to consider again.

58. Mr L was granted IHER in 2012, backdated to September 2010, on the basis that the Trustees had concluded on the medical evidence at the time that Mr L's condition was permanent. The provision of an IHER pension was however subject to periodic review. The relevant provision under rule 7(1)(b) paragraphs two and three are as follows:

> "If any Member of the Fund having been superannuated under the circumstances set out in this Sub-Rule [i.e. in receipt of an IHER pension] recovers sufficiently to resume his duties he shall not be deemed eligible to continue receipt of any benefits under the Fund except at the discretion of the [Trustees] who shall fully consider each case on its merits.
>
> If the Member, in the view of the Executive Council and the Committee, is capable of or becomes capable of undertaking other employment then the Committee shall reduce the superannuation allowance at their discretion."

59. Essentially, there are two limbs to the review provision:

    59.1. If Mr L recovers sufficiently to carry out the duties of his former role i.e. to work as an Area Organiser, the IHER pension is suspended unless the Trustees exercised their discretion not to suspend it.

    59.2. If, in the view of the Trustees, Mr L is or becomes capable of undertaking some other form of remunerated employment, then the IHER can be reduced at the Trustees' discretion.

60. The second limb is not in issue as the Trustees proceeded under the first limb. The second limb would only become a necessary consideration if, under the first limb, it was agreed that there had not been a recovery in Mr L's health to allow him to return to his role as an Area Organiser. For the purpose of the 2016 review, the second limb was an irrelevant consideration.

61. The first limb does not specify who is to determine whether the member has sufficiently recovered. I find that, in the context of the Rules, it is a determination to be made by the Trustees objectively. It is not a matter of discretion although if the provision applies, they have discretion to maintain the pension. I agree with the Trustees that the key question that they needed to consider and answer when reviewing Mr L's continued entitlement to an IHER pension was whether he had recovered sufficiently to return to his former role. In making that determination, it was for the Trustees to determine what evidence they required, including medical evidence. My role is not to determine what evidence they should have considered but to consider whether the evidence the Trustees obtained and considered was appropriate and whether it reasonably supported the conclusion they reached. Essentially, I need to consider whether their decision was a rational decision based on relevant evidence but no more.

62. I should add that I find that the words "recovers sufficiently to resume his duties" requires the Trustees to determine whether the member is in sufficient health that he would be able to carry out his former role. On the assumption that he was not able to carry out his role at the time the pension was originally granted, the provision assumes there must have been some recovery. However, the matter to be determined is not the extent of or the reasons for any change or improvement but to determine, at the review date, whether or not the member is in sufficient health that he could resume the duties of his previous role. The reasons for the original decision

are not key except as part of the medical background that may inform the current medical assessment at the review date.

63. The Trustees' decision was primarily based on the MA's Report. I find reliance on the MA's Report was reasonable in all the circumstances. Dr Hall MFOM, Chief Medical Adviser at Medigold, was the medical adviser appointed by Medigold, an occupational health provider, and had over 30 years of experience in the field. It was reasonable for the Trustees to consider that Dr Hall was qualified to provide an expert opinion on an individual's condition or symptoms and how they might affect their ability to undertake their role based on its requirements. Dr Hall

64. I appreciate Mr L's comments that Dr Hall's opinion, that he (Mr L) has recovered sufficiently to undertake his former role, was not in his view, supported by any newly obtained medical evidence. The relevant rule does not provide that such a determination is based on any particular level of medical evidence but in any event Dr Hall's opinion itself constituted medical evidence.

65. In preparing the MA's Report, Dr Hall had access to Mr L's IHER application, the report for Mr L's 2014 IHER review, and copies of medical evidence from 2009 to 2014 which he referenced. He carried out a physical examination in person and an interview with Mr L. He also considered and responded to the comments and additional questions raised by Mr L in response to the MA's Report.

66. Dr Hall's report stated clearly that in his opinion:

    66.1. there was no medical reason preventing [Mr L] from carrying out the duties of his former role;

    66.2. Mr L did not have any permanent or total infirmity or ill health;

    66.3. Mr L was medically capable of undertaking other roles at present.

67. Additional questions were asked and answered which may have been directed to the need to carry out future reviews, as explained by the Trustees, or to issues relevant to their discretions, rather than to the immediate issue of determining whether Mr L had recovered sufficiently to return to his previous role or undertake other roles. I do not consider that inclusion of such questions and Dr Hall's answers and other comments make it unreasonable for the Trustees to have relied on the relevant parts of his evidence.

68. Dr Hall was required to give his opinion on whether the symptoms of Mr L's condition meant he was now capable of his former duties (or other employment) and provide sufficient explanation to enable the Trustees to reach their own conclusion.

69. Dr Hall commented that he did not believe that Mr L's condition was permanent and said: "Mechanical Back Pain is a variable condition, and permanence cannot be established" and referred to guidance prepared by NICE, the Faculty of Occupational Medicine and the Royal College of General Practitioners.

70. Dr Hall noted the condition of Mr L's hands and said it was suggestive of manual work, albeit not confirmed. Later in the report, Dr Hall said: "There may be some suspicion that he is undertaking manual work, but this cannot be confirmed", and "he claims not to be in employment". Dr Hall commented that Mr L was able to sit, stand and walk and undertake activities at home and said he would "encourage Mr L to return to the work environment".

71. I do not find that there is anything in these comments that should have led the Trustees to disregard his evidence or made it unsafe for them to reach their determination on the basis of the MA's Report. I agree that the question of whether Mr L was, at the time of the review in 2016 suffering from permanent incapacity, was an irrelevant question and consideration. It was accepted in 2012 that Mr L did suffer from a permanent condition giving rise to an IHER award entitlement. However, this was noted during the Trustees meeting of 21 March 2017 where it was agreed that the permanency of Mr L's condition did not need to be taken into consideration. Irrespective of Dr Hall's comments, the Trustees noted, and did not take an irrelevant consideration into account for the purpose of the review.

72. Dr Hall's opinion was that Mr L could undertake his former role. To the specific question "to what extent is Mr L capable of performing the duties required by his former job role with the union?", Dr Hall responded "I believe there is no medical reason preventing Mr L from [performing the] duties of his former role". The report did provide some explanation including the comments mentioned above, and I do not consider it unreasonable for the Trustees to have relied on Dr Hall's clear conclusion given that it was based on an examination and interview with Mr L and a review of the earlier medical reports. The Trustees' were entitled to place significant reliance on Dr Hall's expertise as a specialist in the field of occupational health.

73. For these reasons, by placing significant weight on Dr Hall's opinion and responses to follow up questions, directing themselves to the correct questions, I find it was reasonable for the Trustees to conclude that Mr L had recovered sufficiently to return to his former role and therefore I find that the Trustees' decision to suspend Mr L's pension was properly made. I also confirm that there was no need to consider what had changed on the basis that the medical opinion of Dr Hall was clear that he was now sufficiently able and that it also explained, consistently with some of the previous medical reports, that his symptoms might vary over time.

74. Finally, Mr L has expressed concern that Dr Hall held a biased view towards him and that the Trustees should have sought to obtain a fresh opinion from a new MA. The basis for Mr L's comments centre on Dr Hall allegedly saying that he would not have agreed that Mr L was eligible for an IHER award in 2012, and that he believed he may have undertaken manual work due to the roughness of Mr L's hands.

75. The Trustees sought further clarification regarding these comments from Dr Hall, for which answers were provided. While I understand Mr L's comments, there is no evidence of any bias towards Mr L from Dr Hall. In any event, the comments regarding the permanence of his condition and the condition of his hands was not

taken into consideration by the Trustees, and so it did not prejudice the Trustees' decision to suspend his IHER pension.

76. I do not agree that the Trustees should consider again the 2016 review of the continuation of Mr L's pension.

77. I do not uphold Mr L's complaint.

Camilla Barry
Deputy Pensions Ombudsman
16 January 2026