PO-14458

Ombudsman's Determination

Applicant	Mr S
Scheme	Anglian Water Group Pension Scheme – Mirror Image Section (**the Scheme**)
Respondents	Anglian Water Group (**AWG)** The Trustees of the Anglian Water Group Pension Scheme (**the Trustees**)

Outcome

1. I do not uphold Mr S's complaint and no further action is required by AWG and the Trustees.

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Mr S complains that AWG, his former employer, and the Trustees wrongly declined his application in May 2016 for payment of his pension on the grounds of ill health early retirement (**IHER**) from active service. He alleges that AWG prior to reaching its decision that he did not meet the incapacity criteria of the Scheme (as shown in the Appendix below):
    - did not ask the right questions or allow for all his medical conditions;
    - did not consider how his mental health problems triggered his primary condition, chronic epilepsy, or that previous medical treatments have been ineffective;
    - did not allow for the fact that he has met the criteria for long term incapacity relating to epilepsy and depression as defined in the Equality Act 2010; and
    - did not consider that following his recent successful court appeal during which the difficulties of prognosis and treatment of his connected neurological and psychological conditions were acknowledged, he was awarded Personal Independence Payments (**PIP**) for five years from 10 August 2016

Background information, including submissions from the parties

4. Mr S commenced working for AWG in September 1984. In 2001, he was diagnosed as suffering from chronic epilepsy. He was subsequently afflicted by several mental illnesses including stress, depression, anxiety, phobias, panic and obsessive-compulsive disorders.
5. Mr S applied for IHER benefits in the Scheme whilst still in active service and in March 2016, met with Dr Hardman, AWG's Company Medical Adviser (**CMA**), who wrote in his report that:

> "A full assessment was made today, during which it became apparent that Mr S's condition had deteriorated…
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> Mr S admitted that he had only recently been commenced on a treatment by a GP that would be considered to likely be of benefit to his symptoms. It was also noted that…further information would be required. This would take the form of formal diagnosis, prognosis and any advice in treatment from a consultant specialist in his second condition.
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> This report when obtained will potentially result in a further assessment by a CMA…Potentially it could result in a return to workplace functioning and a timescale in which this could be achieved.
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> With respect to his driving licence, this issue is complex and relates to both the main conditions and sets of symptoms that he is suffering from. It is my opinion that the recently commenced treatment by his GP is likely to yield beneficial symptom reduction but this would be enhanced by advice from the specialist. This improvement would include the issues relating to his driving and wider work role. It is not clear until he has been assessed whether these improvements will be sufficient for him to be able to resume his full previous role or what timescale this would be possible within…"

6. Dr Ray, Consultant Psychiatrist, wrote to AWG in April 2016 as follows:

> "…in August 2013, he (Mr S) started experiencing things that he would describe as déjà vu. It got him quite worried as he started thinking what would happen if it occurred while he was driving. Most of them would last only a split second…however there were some when he would end up collapsing in a heap…Those would last a few seconds and he would also feel sick at the same time...
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> These incidents trigger off extreme anxiety…Over the next couple of years these anxiety attacks…started getting more frequent and more intense. On average now he has about four panic attacks a week…
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> Regarding his ability to work and drive, I do not believe his current state would allow him to hold a driving licence. Normally from a DVLA perspective one needs three months of stability before one can get their

driving licence back, however at this point in time Mr S is quite far from being stable. There is also the issue that the hyperventilation might be a factor in making his déjà vu like symptoms worse thus I believe there is a long way to go before he will be able to drive again.

Also, his current presentation is such that I do not believe he will be able to deal with phone calls of customers…I understand reasonable adjustments have been made and he has still struggled to carry out…his role thus I believe that retirement through ill health is an option that ought to be seriously considered.

Regarding his prognosis, I would have thought that his recovery will need at least a year given that he has had a fair bit of psychological support and so far, if anything things have got worse however there is a part of me which is hopeful because he has not been treated aggressively with psychopharmacological approaches. I could make a more accurate prognosis after such treatment has taken place."

7. In May 2016, AWG informed Mr S that he did not meet the criteria for incapacity in the Scheme because it agreed with Dr Hardman's medical opinion that his incapacity was not permanent under the terms of the Scheme. In his report dated 17 May 2016, Dr Hardman said that:

   "…Mr S was assessed and further medical information was requested. This information was a specialist report to specifically seek information on diagnosis, treatment and prognosis to allow consideration of permanency (in terms of the Mirror Image Section (**MIS**) as a period of 5 years or the foreseeable future).

   …From this report and the previous assessment, it is concluded that the treatment will likely lead to sufficient improvement on the balance of probabilities to allow a return to his role within 12 months and before 5 years..."

8. AWG terminated Mr S's employment on incapacity grounds on 7 August 2016.
9. Mr S appealed AWG's decision not to award him an IHER pension in the Scheme from active service and AWG responded as follows in its letter dated 10 August 2016:

   "With regards to the Scheme rules and the question of permanent incapacity, whilst it is accepted that your epilepsy may be considered permanent, the reason for your sickness absence is given as anxiety and depression…

   Dr Ray was of the opinion that you satisfied the criterion for severe panic disorder and felt that there is a strong case for treating the panic disorder fairly aggressively using psychotropic medication. He suggested a course of treatment with Pregabalin, which is also anti-epileptic and said that given

that you suffer from epilepsy your treatment might best be done under a consultant psychiatrist. He did say that he thought your recovery will need at least a year and he could make a more accurate prognosis after the suggested treatment had taken place.

Dr Hardman's opinion is based on specialist reports, commonly available information as well as his own face to face meeting (22 March 2016) and telephone discussion (17 May 2016) with you…Dr Hardman, concluded that, on the balance of probabilities …you would – after treatment – be able to "return to his role within 12 months and before 5 years".

…he refers to the availability of treatment, the likely length of the course of treatment and the expected effectiveness of such a treatment. Applying the ordinary meaning of the phrase, it seems reasonable for Dr Hardman to determine that your condition will not prevent you from returning to work in the foreseeable future, applying a 12 month to 5 years parameter and so is not permanent.

You imply that as you have been suffering from ill health for some time, that this period should be taken into account when applying a 5 years parameter. However, the CMA has been asked to certify whether the condition will continue for a period of at least 5 years. This is looking forward for a period of at least 5 years and is from the date of his assessment and signing the certificate…

To satisfy the first limb of the incapacity test under the Scheme rules, a MIS Member must suffer physical or mental ill health or infirmity which is (in the Employer's opinion) permanent…the CMA…is routinely provided with a form/certificate which provides further guidance on the meaning of "permanent" which is along the lines that "in your opinion the condition will continue for a period of at least 5 years or for the foreseeable future" and that this is the test which the Company applies to incapacity cases.

You have questioned whether Dr Hardman has applied this guidance correctly and suggested that he interpreted it as "5 years and for the foreseeable future" rather than "or" the foreseeable future.

The implications of reading the test with "and" rather than "or" is that a condition could never be permanent unless, in the opinion of the CMA, it will continue for a period of at least 5 years. However, it is recognised that there are circumstances where it could be less than 5 years for example if the Normal Retirement Date (**NRD**) fell within the 5 years minimum period.

We do not agree with your interpretation of the second limb of the test in the guidance given…to the CMA that a medical condition will necessarily continue for the "foreseeable future" (and therefore be permanent for the purposes of the incapacity definition) if the effects are likely to continue for

at least 12 months. The legislation which is cited in your appeal (Equality Act 2010, Disability Act and the guidance given by the Office for Disability Issues…) is not likely to be considered relevant…Whether a condition will continue for the foreseeable future is fact specific and partly dependent on the availability and likely effectiveness of treatment (amongst other factors). In addition, if your interpretation was to be accepted, it could make the first part of the guidance to the CMA…redundant which is not a logical outcome.

Your appeal refers to a report from Occupational Health dated 5 July 2016 in which reference was made to "foreseeable future" meaning at least 6 -12 months but this was a note…to the Line Manager and Human Resources (**HR**) giving an opinion on the likely timescale that you would remain unfit for work (minimum 6 -12 months) based on the psychiatrist's opinion. It did not relate to the criteria or guidance we use for incapacity (ill health) retirement.

Dr Hardman's decision was based on the opinion that if you undertook the suggested treatment, on the balance of probabilities, you would be medically fit to return to your job between 12 months and 5 years' time. It was not solely limited to your ability to drive although a valid driving licence is a qualification required for the job.

Neither your Consultant Neurologist nor the Consultant Psychiatrist is familiar with our Scheme rules and whilst they may support ill health retirement that does not mean that you meet the criteria.

It is accepted that epilepsy is a permanent illness…However, you have been able to perform your job with this medical condition. It is only since you have suffered anxiety and depression, now diagnosed as severe panic disorder that you have not been able to…On the balance of probabilities, this condition is treatable in eight or nine cases out of ten but the treatment is expected to take at least 12 months in your case.

After carefully considering the circumstances, the Pension Review Panel did not uphold your appeal. The Panel urges you to undertake the suggested course of treatment suggested by Dr Ray and hopes that with that treatment you will make a recovery from the anxiety, depression and panic attacks you have been experiencing.

If after taking the appropriate treatment, your condition does not improve you could re-apply for an incapacity pension."

10. Mr S's complaint was not upheld at both stages of the Scheme's Internal Dispute Resolution Procedure (**IDRP**) in November 2016 and June 2017 respectively.
11. At Stage One IDRP, the Trustees said that:

"The IDRP review must focus on the provisions of the rules and the wording of the definition of incapacity. In your case, the questions the Employer must ask itself in deciding whether you meet the definition of

incapacity are "is the member's condition permanent" and "does the member's condition prevent him from carrying out the normal duties of his employment."

It is entirely up to the Employer to decide how it goes about answering these questions…it is not for the IDRP review to question or judge the instructions the Employer gave to the CMA to assist it to decide on the "permanence" of your condition, the weight given to each CMA's opinion or to any other piece of evidence, and the conclusion it came to on the question of whether your condition is permanent.

The only time IDRP review might intervene would be if the evidence used by the Employer was obviously wrong or if material points had been overlooked. Even in this case, the most that could be done would be to ask the Employer to reconsider its decision…the IDRP review could not unilaterally overturn or go against the Employer's decision.

…I reviewed and considered all the information which was provided…and did not identify anything obviously wrong with the Employer's investigations based on the requirements of IDRP…"

12. In their Stage Two IDRP letter to Mr S, the Trustees wrote that:

"You raised four specific points relating to the Employer's application of the incapacity definition…under the Scheme rules relating to the facts of your case. The Trustees made the Employer aware of your letter and sought its observations on those points.

You stated that you believed the Employer had reached its views with no consideration of the relationship and effect of your epilepsy on your secondary condition. The Employer has responded that, on the basis of medical evidence and your condition at the time of making the decision, it considered the suitability of the proposed treatment in respect of your primary and secondary conditions. The Employer stated that in its view the medical advice provided on 30 June 2016 showed that the proposed medication for your secondary condition would be suitable despite changes in medication for your epilepsy. The Employer therefore confirmed that its decision was based on consideration of appropriate treatment taking into account both conditions.

You stated that you believed the Employer based its opinion on your driving limitations as a result of your secondary condition without considering limitations as a result of your primary condition and whether they could ever be overcome. The Employer has responded that it did consider that with appropriate treatment…both your driving phobia could be overcome and also that should your anxiety/depression be successfully

> treated, on the balance of probabilities, the likelihood of further epileptic seizures would be reduced allowing a normal return to employment…
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> The Trustees understand from the Employer that it considered the fact that you had one condition which was permanent but it concluded that the condition did not prevent you from carrying out the normal duties of your employment; and that you had another condition which did prevent you from carrying out the normal duties of your employment but which was not permanent. The Employer has stated that it considered on the balance of probabilities that your overall ill health would not…be permanent and prevent you from carrying out the normal duties of your employment.
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> You stated that you believed the Employer did not take into account the degree of driving involved in your commute. The Employer has confirmed that it understood that the majority of your daily driving was in commuting between home and work. However, it did not consider your commute to be relevant to its determination of whether your ill health prevented you from carrying out normal duties of employment.
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> You stated that you believed the Employer based its opinion only on the driving impact of your employment role rather than any wider factors…The Employer has confirmed that it considered that your anxiety/depression affected your ability to perform the role adequately as well as your ability to drive. The Employer also confirmed that it considered that were your secondary condition to be controlled…your stress levels could be reduced and the likelihood of further seizures reduced…"
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> In light of the confirmation provided by the Employer, as summarised above, the Trustees decided that they had received evidence from the Employer that it had considered the correct Scheme rules and asked itself the correct questions."

13. Mr S contends that:

- the CMA formed his medical opinion based upon one psychiatrist's report which "was based upon a generalised group of individuals suffering from mental disorders" and only sought advice on his secondary condition, i.e. his mental health problems;
- the CMA had therefore "paid little or no regard" to the effect of his mental health illnesses on his chronic epilepsy and particularly the possible adverse effects of taking/coming of medication for anxiety and stress on his epilepsy;
- previous treatments for his epilepsy and mental health issues have proved ineffective;
- AWG has failed to "recognise the effect of the relationship between the psychological conditions and neurological condition, or the effect of his employment on both…when the decision was reached";

- AWG and the Trustees had to take advice on the "definition of foreseeable in the permanency test…upon their own scheme rules" after rejecting his IHER application;
- the CMA based his decision upon his own interpretation of the permanency test, albeit, thereafter, accepting that there was no definition of foreseeable; and
- AWG's decision did not take into consideration the timescale for actual availability of treatments, albeit the psychiatrist had specifically recommended that any treatment should be undertaken by a consultant psychiatrist due his epilepsy

14. AWG says that:

> "Contrary to the claim "that the Company/Trustees had to take advice, after the event, upon their own scheme rules, the Company had been using the advice from the Scheme Lawyer dating back to 1999/2000…and had provided that advice to successive CMAs. That advice includes "the requirement for the member's condition to be permanent has to be interpreted as meaning that at the time of consideration it is reasonably foreseeable that it will be permanent." Checking with the Scheme Lawyer that the previous advice was still valid, in advance of the appeal hearing, was just a precaution.
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> The wording on the MIS certificate regarding permanent incapacity has the scheme rule in bold i.e. **is permanent** and guidance in italics and in parenthesis asking the CMA whether, at the time of consideration in (*your opinion the condition will continue for a period of at least 5 years of for the foreseeable future*).
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> With regards to the differences between the HR referral to Occupational Health (**OH**) and the OH referral to Dr Ray…
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> The referral from OH to Dr Ray…requested a psychiatric assessment and a report answering a number of questions…Dr Ray was not asked to provide an opinion on all the points in the HR referral to OH. This was for Dr Hardman to do after receiving the medical advice which he received from Dr Ray.
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> The treatment with antipsychotics (Pregabalin), augmenting antidepressants, suggested by Dr Ray was specifically mentioned as being suitable for people suffering from epilepsy…A psychiatrist can be seen on the NHS and usually needs a referral…A psychiatrist can also be seen privately…
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> At the time the decision was made in May 2016 it was "concluded that the treatment will likely lead to sufficient improvement on balance of probabilities to allow a return to his role within 12 months and before 5 years". The fact that Mr S has not followed the treatment recommended by Dr Ray does not alter the fact that the untried treatment is available. Dr Hardman said in his letter dated 2

August 2016 that "Based on the commonly available information on the prognosis of his mental health condition, appropriate treatment would be expected to achieve remission in the majority of individuals though 10-20% will continue to be severely affected." These confirm the availability and likely effectiveness of the treatment.

There has been no evidence that the treatment recommended by Dr Ray is not available to Mr S."

Adjudicator's Opinion

15. Mr S's complaint was considered by one of our Adjudicators who concluded that no further action was required by AWG and the Trustees. The Adjudicator's findings are summarised briefly below:
    - In March 2016, faced with inconclusive medical opinion, AWG accepted the advice given by Dr Hardman to seek further information before deciding whether to grant Mr S's request for IHER in the Scheme. That was its prerogative; AWG, rather than the CMA was the decision maker.
    - Its decision made in May 2016 to refuse Mr S's IHER application was therefore taken only after obtaining the view of Dr Hardman who, in turn, had deferred forming his medical opinion until after receiving the medical advice which he sought from Dr Ray. That Dr Hardman did not also seek further advice about Mr S's chronic epilepsy from a specialist does not mean, as Mr S alleges, that he did not consider all Mr S's illnesses when subsequently forming his medical opinion. Dr Hardman might already have gathered sufficient information on Mr S's chronic epilepsy to do so. In any case, the available evidence did not support his allegation because Dr Hardman in his March 2016 report clearly said that, in his view, the driving licence issue related to both of Mr S's main conditions and sets of symptoms which he was suffering from. There was also no concrete evidence to corroborate the other allegations made by Mr S against Dr Hardman.
    - AWG had therefore taken some time to consider Mr S's case and based on the medical evidence that was before it at that time, it cannot be said that it was improper for AWG to have decided, after allowing for both Mr S's primary and secondary conditions, that his overall health did not permanently prevent him from carrying out the normal duties of his employment and the definition of incapacity in the Scheme rules had not been met.
    - A difference of opinion between medical advisers would not be sufficient to warrant AWG setting aside the advice it received from its CMA. There is a difference between ignoring an opinion and not accepting it after due consideration. AWG have not ignored the medical opinions provided by the experts supporting Mr S's application, rather it has decided to accept the advice of its own medical adviser.
    - AWG had weighed the evidence before it and considered, on the balance of probabilities, that Mr S's incapacity was not permanent because there was a

strong possibility that his health might improve in the future from better managed treatments of both his conditions so that he would be capable of employment again.

- There was no compelling evidence that AWG took any irrelevant matters into account when making its decision or that anything of relevance was overlooked. There was also nothing to suggest that the Scheme rules have not been interpreted correctly or that AWG had failed to ask the right questions when assessing Mr S's eligibility.
- Mr S's eligibility for PIP and his illnesses meeting the criteria for long term incapacity in the Equality Act 2010 does not necessarily mean that he would automatically qualify for an IHER pension from the Scheme. The criteria used by DWP to assess Mr S's entitlement to PIP and those used to determine whether he met the definition of long term incapacity are very different to those used by AWG to assess whether he should be awarded an IHER pension from the Scheme.
- The fact that Mr S has subsequently provided further medical evidence showing that he is still suffering from the same conditions does not impact upon the validity of the original decision in May 2016. AWG could only be expected to make its decision on the basis of the condition as it was understood at the time. But there is nothing improper in taking account of later medical evidence when reviewing a decision in so far as it bears on what Mr S's condition was at the time when the original decision was made. Caution needs to be taken however in revisiting earlier decisions based upon contemporary material at the time of reconsideration but this is exactly what AWG and the Trustees did at Stage Two IDRP when allowing for the medical evidence provided on 30 June 2016.
- AWG say that if Mr S undertakes the course of treatment suggested by Dr Ray and his condition does not subsequently improve, he may reapply for an IHER pension from deferred status. This is a reasonable and pragmatic option that Mr S may wish to take up in the future.

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

Ombudsman's decision

17. When considering how discretion has been exercised by AWG, I will generally look at whether:
    - the correct questions have been asked;
    - the applicable scheme rules or regulations have been correctly interpreted;
    - all relevant but no irrelevant factors have been taken into account; and
    - the decision arrived at must not be perverse

18. In this context, a perverse decision is one which no other decision maker, properly directing itself, would come to in the same circumstances.
19. However, the weight which is attached to any of the evidence is for AWG to decide including giving some of it little or no weight.
20. I will not generally interfere in the exercise of a discretion unless I consider the decision process was in some way flawed or the decision reached was one that no reasonable body faced with the same evidence would have taken.
21. If the decision-making process is found to be flawed, the appropriate course of action is for the decision to be remitted for AWG to reconsider. I cannot overturn the decision made by AWG just because I might have acted differently.
22. I have considered all of the points made on Mr S's behalf, and in this case, I am satisfied that AWG have acted in accordance with the above principles and within the powers given to it by the Scheme Rules. I consider that AWG have properly considered all the relevant information available at the time and the decision made was within the bounds of reasonableness.
23. Whilst I fully appreciate the points which Mr S has raised and sympathise with his circumstances, the available evidence does not support a finding of maladministration by AWG in coming to the decision it did.
24. I am also satisfied that the Trustees have properly investigated the issues in Mr S's complaint against AWG under IDRP and agree with the conclusions they reached.
25. I do not therefore uphold Mr S's complaint against AWG or the Trustees.

Karen Johnston

Deputy Pensions Ombudsman
18 July 2018

Appendix

Relevant Paragraphs taken from the Scheme Trust Deed and Rules dated 29 March 2012

"Incapacity" means

(b) in relation to an MIS member, physical or mental ill-health or infirmity which in the Employer's opinion:

(i) is permanent*; and

(ii) prevents the individual from carrying out the normal duties of his employment"

*There is no explicit definition of "permanency" in the Scheme rules.

Schedule 4 – Rules applicable to MIS members

12. Ill-Health Retirement Benefits

12.1 Incapacity Pension

(a) Where a Member retires on the grounds of Incapacity the amount of Reckonable Service for the purpose of calculating both standard retirement benefits under Rule 11…shall be increased as follows:

(iii) where Reckonable Service exceeds 13 1/3 years, by an additional 6 2/3 years

(b) The Member's Reckonable Service shall not in an event exceed the period of Reckonable Service which he could have completed at age 65 or the period of 40 years. whichever is the shorter

24, Cessation of Active Membership

24.3 Preservation of benefits within the Scheme

(b) Early payment of pension

(i) Without reduction

A Member may elect to have his preserved retirement benefits paid before NRD without any reduction:

(A) if he suffers Incapacity in relation to the employment in which he was engaged at the date when his Active Membership ceased;

(B) at or after age 50* if the Employer consents on compassionate grounds

*Following recent legislative changes to the minimum pension age, the Employer will now not give consent below the age of 55 as it would be an unauthorised payment.