PO-20371

Ombudsman's Determination

Applicant	Ms S
Scheme	Local Government Pension Scheme (the **Scheme**)
Respondent	Halton Borough Council (the **Council**)

Outcome

1. Ms S' complaint is upheld and to put matters right the Council shall consider again Ms S' 2015 application for ill health retirement and pay Ms S £500 for the significant distress and inconvenience caused.

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

Complaint summary

3. Ms S was awarded the early release of her deferred pension on grounds of ill health from 12 March 2018. She believes she should have been made the award when she first applied in April 2015.

Background information, including submissions from the parties

4. The Council is a participating employer in the Cheshire Pension Fund (the **Fund**) which is part of the Scheme. The Administering Authority for the Fund is Cheshire West and Chester Council (**CWaC**).

5. Ms S was employed by the Council as a Neighbourhood Travel Team Area Co-ordinator in Traffic and Road Safety. Her employment with the Council ended following redundancy in April 2006. In April 2015 Ms S applied for the early release of her deferred pension on grounds of ill health.

6. About the same time Ms S applied for ill health retirement from her then current employer Cheshire Police, with whom she was employed as a Community Support Officer (**PCSO**). With her letter to the Council Ms S enclosed a report, dated 2 March 2015, from People Asset Management (**PAM**) OH Solutions, occupational health advisers to Cheshire Police.

7. The Local Government Pension Scheme 1997 Regulations (the **1997 Regulations**) apply. Regulation 31, 'Other early leavers: deferred retirement benefits and elections for early payment' says:

   "…

   (6) If a member who has left a local government employment before he is entitled to the immediate payment of retirement benefits (apart from this regulation) becomes permanently incapable of discharging efficiently the duties of that employment because of ill-health or infirmity of mind or body-

   (a) he may elect to receive payment of the retirement benefits immediately, whatever his age…"

   "permanently incapable" means that the member will, more likely than not, be incapable, until, at the earliest, his 65th birthday.

8. Before making a decision as to a member's eligibility under regulation 31, the Scheme employer must obtain a certificate from an independent registered medical practitioner (**IRMP**) as to whether in his opinion the member is permanently incapable of discharging efficiently the duties of the relevant local government employment because of ill-health or infirmity of mind or body.

9. The Council requested Occupational Health Services (**OHS**) North West Boroughs Healthcare NHS Foundation Trust (then called 5 Boroughs Partnership NHS Foundation Trust), to assess and report on Ms S' eligibility for ill health retirement.

10. Dr Hadland (Occupational Physician with OHS) saw Ms S. He subsequently suggested that a report be obtained from her GP.

11. Dr Matthews (GP) replied on 18 June 2016. She said Ms S:-

    - Had been diagnosed with an acoustic neuroma (a benign tumour that grows on the hearing and balance nerve between the ear and the brain) in 2008 and remained under the care of an ENT specialist.
    - She had type 1 diabetes and remained under hospital follow-up.
    - She also suffered with low back pain.

12. Dr Matthews submitted reports from:-

    - Ms Bridges, Diabetes Specialist Nurse, dated 6 October 2014.
    - Miss Munir, Consultant ENT/Skull Base Surgeon, dictated and typed on 25 March 2015.
    - A Radiology report, on an MRI scan of Ms S' lower back, dated 12 April 2013.

13. A summary of the medical evidence is provided in the Appendix.

14. Ms S was seen by Dr Lister (IRMP) on 12 August 2015. At the time Ms S' job description at the Council had not been found.

15. The same day Dr Lister certified that Ms S was not permanently incapable of discharging efficiently the duties of her former employment with the Council. A copy of Dr Lister's report was sent to Ms S.

16. Ms S disagreed with Dr Lister's findings and requested a review of the medical certificate. Ms S said:-

- The main side effects from the acoustic neuroma surgery had not been properly considered.
- Loss of hearing, poor balance and chronic fatigue, combined with her back problem and diabetes meant she could no longer work.
- She had seen two OHS doctors (Dr Hadland and Dr Lister) but neither had asked her whether she felt she could do her previous role with the Council.
- While she left her role with the Council prior to the diagnosis of the medical conditions she now faced, she was obviously showing symptoms during the last few years in that job.
- Due to an administration error, that no one seemed to want to own up to, her pension with the Council had been closed/deferred and a new one started with Cheshire Police, despite her qualifying for continuous service. As a consequence, she had had to make separate applications to the Council and Cheshire Police for ill health retirement.
- Dr Lister's opinion was based solely on her back pain. The other issues she suffered with had not been explored fully in relation to carrying out her role at the Council.
- The back pain meant she was unable to wear body armour for her current role. She was unable to walk any significant distance or carry anything heavy. Her previous role involved taking boxes of information to locations where she was working. Whilst she had a car, there was still the issue of lifting and carrying them into the venue from the car park some distance away. This she could not do now.
- Following the 2013 MRI scan she was advised that she had a progressive degenerative disc disease. It was best managed with pain killers as required. Therefore, she had not requested any further referral and it had not been suggested to her. On 14 August 2015 she had seen Mr Gardener (Osteomyologist), who confirmed that the condition could not be remedied. He also found her hips out of alignment for which she was now having treatment.
- She was completely deaf in her right ear from the acoustic neuroma surgery in 2008 and had constant loud tinnitus in her right ear and pulsatile tinnitus in both

ears. This was extremely tiring and she could not concentrate on tasks for long periods of time. A hearing aid did not help her hearing problems.

- Part of her Council role involved working in busy places such as supermarkets, job centres, children's nurseries, college open days and employer recruitment evenings. Due to her loss of hearing she would not be able to do this now.

- While she was office based for part of her role a high percentage of her time was spent on the telephone. Currently she was doing some office duties with Cheshire Police. But she had difficulty with noise from other people which echoed in a large office and tried to limit her use of the telephone. She would not now be able to do this part of her former Council role.

- She was not able to work in noisy environments as it triggered her tinnitus. There was also the safety issue of not hearing moving traffic while working outdoors or at bus depots.

- At the Council she would attend meetings. She could not now cope in noisy environments or follow conversations in a group setting.

- Her hearing loss had affected her balance. She found using escalators and lifts, slip and trip hazards from pavements and uneven ground difficult. Her role at the Council involved doing surveys in public places, including on buses. She could not now stand on public transport. She could not hear traffic and there was the risk of falling.

- While she was currently employed by Cheshire Police she was not fulfilling her role as a PCSO. She was on restricted duties following a risk assessment of her safety. The risk implications for her previous Council role were similar.

17. On 1 September 2015, Ms S wrote to: a Specialist Nurse (at the Diabetic Clinic); a Consultant (at the Acoustic Neuroma Clinic); the Department of Clinical Audiology; and her GP's practice, asking that they provide her with supporting evidence of her conditions. The letter advised that OHS and Chester Police's respective occupational health advisers had her authority to request documents from them.

18. On 9 September 2015, OHS wrote to Ms S informing her that her comments on Dr Lister's report and her letter of 1 September 2015 had not altered Dr Lister's opinion. OHS similarly notified the Council.

19. The Council duly accepted Dr Lister's certified opinion and turned down Ms S' application.

20. On 23 September 2015 Ms S complained to OHS about Dr Lister's report. Ms S said:-

- Earlier in the year PAM had suggested ill health retirement as she would find it difficult to find other suitable employment due to ongoing disabilities. She had an

appointment at Cheshire Police and the OH doctor had now asked her treating doctors for more information and evidence of her conditions.

- She was unhappy with Dr Lister's report and did not believe the process had been carried out correctly. The report lacked information on her illnesses and despite providing her consultants' details they had not been contacted.

- Her duties at Cheshire Police were irrelevant to her application to the Council and there was little reference to an assessment of her duties at the Council.

- Dr Lister should have had a job description of her duties at the Council and assessed how her disabilities would affect her in that role and whether she could do it.

- She had said what had been missed, but Dr Lister had not changed his mind.

- Dr Lister's report made no reference to her being totally deaf in her right ear as a result of the 2008 surgery. She had no directional hearing capability. While she had a hearing aid it did not help much and increased her tinnitus. She had constant loud tinnitus, pulsative tinnitus in both ears, chronic fatigue, headaches, poor balance, facial pain and tingling.

- Dr Lister appeared to have based his decision solely on her diabetes and lower back pain. Two days after seeing Dr Lister a Chiropractor had found her hips out of alignment. Dr Lister had reported no issues with her spine and movement even though she did have difficulty moving in the examination and stated she had pain in her right hip and back. Her balance was poor on uneven ground. Dr Lister had tested her in a safe environment holding onto her.

21. Ms S reiterated her duties at the Council and the reasons why she could no longer carry out that role.

22. OHS replied to Ms S on 7 October 2015:-

- Dr Lister had requested and viewed reports from her GP, Diabetes Specialist, ENT Consultant and a Radiologist's report detailing the results of an MRI scan on her lower back.

- Dr Lister had formed his opinion from his assessment with her and the information provided in the reports.

- It was not uncommon for differences in medical opinion. As she disagreed with Dr Lister's opinion she had the right of appeal directly with the Fund.

23. Ms S duly invoked the Fund's two-stage internal dispute resolution (**IDR**) procedure. In her stage 1 appeal Ms S reiterated what she had said in her complaint to OHS. With the appeal she enclosed: a copy of hearing tests demonstrating single sided deafness, an MRI report, Consultant appointment records from 30 May 2012 to 8 July

2015, Dr Lister's report of 12 August 2015, the Council's decision letter of 15 September 2015 and OHS' letter of 7 October 2015.

24. The Council requested Dr Lister to review Ms S' job description at the Council and asked if it changed his opinion. Dr Lister said it did not and gave no reason(s).

25. The Council duly turned down Ms S' stage one appeal. In its letter of 23 March 2016 to Ms S the Council said:

"In your complaint, you stated that you did not believe that the appointed physician had assessed the correct role, that of Neighbourhood Travel Team Area Co-ordinator. In view of that, I requested that the matter was reconsidered and I provided a job description and person specification for that post to the Consultant Occupational Physician and asked that the physician to review it, in relation to the opinion given in August 2015.

I have been advised that a review of that job description and person specification has taken place, however it does not alter the opinion of the physician.

…

Given that the opinion stated in the medical certificate issued in August 2015 remains unchanged, you are not considered to meet the requirements of this regulation."

26. Ms S invoked IDR stage 2 with the Fund in September 2016. Ms S said:-

- She had two local government pensions. Her appeal related to her Council pension.
- While at IDR stage 1 Dr Lister had reviewed her job description, the Council had not taken into account the severe and disabling side effects she had reported in her appeal letter and relate them to her work environment. OHS should have asked her Consultant for more information.
- The Council's stage 1 decision relied on Dr Lister's report. No reasoning or detail was given for its decision.
- The Council failed to ask the right questions. It did not ask how her conditions would affect her in the working environment in which she had been employed.
- Dr Lister and the Council failed to ask her Consultant about the full details of her acoustic neuroma with various side effects.
- Dr Lister and the Council had just considered the lesser issues of her diabetes and back problem. No detailed reference was made to her acoustic neuroma with side effects. There was no mention of her deafness, tinnitus and chronic fatigue. These were her most relevant illnesses and disabilities.

- Guidance for Occupational Health Physicians, from the LGPS, BMA and GMC, that they must contact specialists and consultants had not been followed. Her main consultant at ENT/Skull base surgery had not been contacted.

- There was a severe lack of medical evidence in the medical reports. Without full details it would be difficult for someone with no medical knowledge of acoustic neuroma to make a fair and balanced decision.

- She had advised Dr Lister of the duties of a Neighbourhood Travel Co-ordinator as he did not have a job description. Dr Lister referred to it as an office role. But it was very community engagement based. She visited jobcentres, attended meetings and carried out passenger surveys on moving buses. She held community workshops at schools, colleges, job fairs and employers' premises to give advice to students and job seekers on transport options. She could not hear in noisy environments and the role involved a substantial amount of verbal communication and listening skills. She often did presentations to large audiences, which she would now find impossible because of her hearing disability.

  In the office she did substantial work on the telephone providing bus timetable information. She could not use the telephone for long periods as she tired easily and became frustrated without the support of lip reading and facial expression to help her. ENT had advised her not to use the telephone excessively on increased volume to preserve her remaining hearing.

- The job description from the medical file was not descriptive enough to cover the role she did. The person specification clearly detailed the requirement for good communication.

- Single sided deafness meant she could only hear in mono and it had been estimated that she could only hear 30-40% of a conversation, the rest of the information was gathered by facial expression, body language and lip reading. She had no directional hearing so did not know the location of sounds such as a telephone ringing, a car horn, or the direction of travel of a vehicle. Even with the latest hearing aids it was hard to filter out background noise. She often became isolated, could not follow a conversation or missed important bits causing anxiety and embarrassment.

- Tinnitus affected her remaining hearing and was more debilitating in noisy environments. It was constantly with her and nothing relieved it.

- Together the conditions caused her extreme fatigue. She tired after around 4 hours and regularly had to sleep. At the Council she had worked a 30 hour week over five days. She could not do that now. Trying to communicate for more than an hour caused her stress, anxiety and was extremely exhausting. Her concentration was poor and she could not undertake tasks requiring more than a few hours input and effort.

- Her application for ill health retirement with Cheshire Police had been agreed by an IRMP.

27. With her appeal Ms S submitted:-

- A letter from her former Manager at the Council, who created the Neighbourhood Travel Team. Mr Y said:-
    - Ms S was mainly field based and required to engage with job seekers, employers, job centres, colleges, students, community groups and members of the public. Much of the engagement was through travel fairs. The role also involved travelling on buses, conducting interviews with passengers and liaison with bus companies and other transport providers.
    - The office element of the work involved analysis and interpretation of the engagement and surveys, follow-up telephone calls with residents, and feedback to job centres, colleges and community groups.
    - The main essence of the role was face to face communication. With Ms S' hearing difficulties it would be extremely difficult for her to carry-out the role.
- A factsheet on AN/help sheet for employers produced by the British Acoustic Neuroma Association (**BANA**).
- A BANA help sheet for fatigue.
- A letter from Miss Munir dated 13 June 2016.
- Her medical file from OHS.
- A 2 September 2016 report from her GP.

28. On 13 October 2016 Mr Riley, the nominated person appointed by CWaC, queried with the OH Manager whether Dr Lister had seen Miss Munir's ENT report. Dr Lister replied stating that he had seen Miss Munir's report dated 25 March 2015.

29. In January 2017 Mr Riley turned down Ms S' stage two appeal:-

- The application was separate from her application to Cheshire Police. The 1997 Regulations only applied to this application and the occupation was of a different nature. The two applications were also at different IDR stages.
- Ms S' pensions with the Council and Cheshire Police had not been combined. Ms S made no election to do so when she was offered the option by the Fund after she started accruing pension benefits with Cheshire Police.

- Regulations 27 and 97 of the 1997 Regulations applied. Under regulation 27 the Council was required to obtain a certificate from an IRMP setting out their opinion on Ms S' eligibility under regulation 27. While the Council was not bound by the IRMP's opinion it ought to give clear reasons if its decision departed from the IRMP's opinion. The Council's original decision considered the reports and comments by Dr Lister. Whilst the Council was required to show how it reached its decision it did not have to supply voluminous exhaustive detail. It did not consider that there was compelling reason to go against the IRMP's view and it provided a reasoned response in reaching its decision.

- The Council's IDR stage 1 decision was unfortunately delayed, but it was not fatal to the decision made. In respect of Ms S' assertion that additional medical reports should have been obtained the function of IDR was to enable consideration of the Council's original decision. A copy of Ms S' job description was made available to Dr Lister, who said it did not change his opinion. The Council concluded that there was no new evidence to support a change to its original decision. While Ms S was of the opinion that the Council had failed to consider the disabling side effects she had reported it was entitled to consider the opinion of the IRMP and the evidence before him in reaching his conclusion at that juncture,

- It was not reasonable to expect the Council to specifically compose detailed medical questions for an IRMP or doctor to answer. The Regulations required the IRMP to assess an employee and determine whether they were incapable of carrying out their employment duties. The employer then interpreted that assessment and reached a decision. Dr Lister examined Ms S and discussed with Ms S all of her medical conditions, albeit Ms S asserted she was not asked sufficient details about those conditions,

- Dr Lister had access to the relevant medical evidence available at the time of the original decision in August 2015. He subsequently considered Dr Lewins' report of 23 October 2015, prior to the Council's stage 1 decision.

- The reports that Dr Lister had access to were sufficient and he adequately considered these before reaching his conclusion. His report detailed all of Ms S' conditions and he gave relevant reasons for his opinion.

- While Ms S' former manager was of the opinion that Ms S could not carry out her former job role, he acknowledged that he did not have medical knowledge which inevitably impacted on the weight of his view. Additionally, his letter was written a year after Dr Lister's report. The IRMP must reach his opinion based on the medical evidence available at the time of the appeal.

- Chapter 9 of the BMA's guidance supplied by Ms S states: "The occupational physician must ensure that they have sufficient objective medical evidence from occupational health clinical records and/or factual and objective reports of the individual's health condition from the patient's GP and/or consultant". There was no evidence that relevant reports had been omitted, altered or were not objective

or that BMA or Department for Local Government guidance for IRMPs had been breached.

- On Ms S' comment that Dr Lister did not have any experience of acoustic neuroma or its effects. Dr Lister was an accredited and experienced IRMP, qualified to apply information from specialist reports and apply them in an occupational context. Dr Lister's conclusion was not flawed and the evidence obtained was not misleading or incomplete such that a reasonable decision could not be made.

30. Following a further MRI scan in August 2017 Ms S was diagnosed as having a benign cyst (cholesterol granuloma).

31. After taking advice from the Pensions Advisory Service (TPAS), in January 2018, Ms S applied to the TPO and in March 2018 she submitted a fresh application to the Council for ill health retirement.

32. The Council requested the opinion of another IRMP. Dr Sarangi, concluded given the nature of Ms S' former employment and that her ongoing symptoms were unlikely to resolve she was permanently incapable of efficiently discharging the duties of that employment.

33. The Council accepted the IRMP's certified opinion and awarded Ms S ill health retirement from 20 March 2018.

34. The Council's position on Ms S' complaint is unchanged from the IDR stage 2 decision.

35. Commenting on the Council's formal response to TPO Ms S says:-

- It was standard practice for OHS to write to an applicant's treating consultants. Her GP did not have all the information or expertise in the field of acoustic neuroma.

- Dr Lister and the Council did not have sufficient information to make a fair decision and information she submitted was not used and ignored.

- The Council at IDR stage 1 should have obtained consultant reports as her main complaint was that there was a lot more to her symptoms and disabilities that required explanation by a consultant and consideration in the proper manner. Even with the job description there was no consideration of how she would cope with that role with her disabilities.

- She was unsure of the stage 2 decision-maker's reason for referencing comparable or gainful employment as the certificate signed by Dr Lister did not ask the question.

- Dr Lister did not give a clear explanation of her symptoms and she does not believe that he was fully knowledgeable about acoustic neuroma or the issues caused by the tumour.

- Limited resources and cost implications should not be a deciding factor of whether the IRMP should be provided with consultant reports. Without confirmed future prognosis from consultants her capability was not properly considered.

- Dr Mathews notified OHS that she was still under the care of consultants. She would have expected OHS to write to them as common practice. The report that Dr Mathews submitted from Miss Munir stated that an MRI scan was due in June 2015. But the results of this were not requested by OHS or Dr Lister. Dr Lister signed his certificate without knowing what the scan revealed.

- She was in a position where consultants would not supply her with reports as they wanted OHS to write to them. She submitted information to help her appeals but it was ignored.

Adjudicator's Opinion

36. Ms S' complaint was considered by one of our Adjudicators who concluded that further action was required by the Council. The Adjudicator's findings are summarised below:-

    - The Council's decision to refuse Ms S' original application was based on Dr Lister's certified opinion and report of 12 August 2015.

    - In his report Dr Lister noted that Ms S' main symptoms were diabetes, low back pain and acoustic neuroma. Concerning the latter his attention appeared to have been focused on the residual tumour, of which he said there was no evidence of any significant growth. While he mentioned that Ms S complained of tinnitus, facial pain and balance issues (symptoms of acoustic neuroma) he did not comment on what affect he considered they had on her capability to efficiently discharge her former Council duties.

    - Dr Lister made no reference to Ms S' other hearing problems: deafness in her right ear, struggling with the localisation of sound in crowed or noisy environments and sensitivity to sound. What appeared to be Dr Lister's notes of his consultation with Ms S was written "deaf on (R)". The reports of PAM OH Solutions and Dr Hadland referred to Ms S having hearing problems. Dr Lister confirmed he considered both reports prior to certifying his opinion. Nevertheless, the Council could not be sure from Dr Lister's report that he had taken into account all of Ms S' hearing problems and it did not subsequently ask him.

    - At the time of his report Dr Lister did not have a copy of Ms S' job description, albeit he appeared to have discussed with Ms S what her role was when he saw

her. Dr Lister appeared to have focused on the office based element of Ms S' job when it appeared her role was mainly field based.

- Dr Lister's examination of Ms S appeared to focus on her cervical lumbar movement and balance. On the latter he commented that Ms S appeared good in terms of normal day to day activities, but he did not clarify what he meant by that. Again, the Council did not ask.

- While Dr Lister had a copy of Miss Munir's 25 March 2015 report, due to the specialist nature of the condition and the fact that Ms S remained under the Specialist's care, it was surprising that neither Dr Lister nor the Council asked Miss Munir for further comment on how post-surgery Ms S' single sided hearing, tinnitus and balance issues affected her. Particularly given that Miss Munir's report was simply an update letter to Ms S' GP on a same day appointment and made no mention of Ms S' balance and hearing issues.

- Following Ms S invoking IDR stage 1 the Council provided Dr Lister with Ms S' job description and asked him whether it changed his opinion. Dr Lister simply said it did not. He did not explain why he considered that Ms S was capable of efficiently discharging her previous role with the Council.

- These shortcomings were not resolved at either stage of the IDR procedure.

- At IDR stage 2 the decision-maker incorrectly stated that regulation 27 (of the 1997 Regulations) applied to Ms S' application. Regulation 27 applies to active members who apply for ill health retirement. Regulation 31(6) applies to deferred members.

37. Mr Riley, the stage 2 decision-maker, responding on behalf of the Council, did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr Riley 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 Riley for completeness.

Ombudsman's decision

38. Mr Riley says that as Miss Munir is not an IRMP, it was not realistic to request from her a view as to the link between Ms S' ongoing condition and her capacity for employment whilst at the Council.

39. But Miss Munir was in a good position to say how Ms S' single sided deafness affected her. Dr Lister did not mention Ms S' deafness in his report. Whilst Ms S' relationship with Miss Munir may have broken down she was still under the care of a specialist. The Council needed more information about her deafness to make a decision: either from Dr Lister or the specialist.

40. Mr Riley says following his correspondence with Dr Lister he was comfortable that, in terms of Ms S' Acoustic Neuroma and related deafness, Dr Lister had considered from the available ENT report that Ms S' condition was stable. Mr Riley says this was supported by Ms S' own evidence that she continued to work in employment as a PCSO and subsequently in a supermarket, which were environments that are arguably as challenging as her post was with the Council and potentially more so.

41. But that ignores the fact that when Ms S made her application to the Council she was on restricted duties as a PCSO and ultimately was retired on grounds of her ill health.

42. Mr Riley says it is possible that Ms S' Council duties were later altered to be more office based as a reasonable adjustment, but there is no evidence to show that Dr Lister had misinterpreted what was said to him by Ms S at the time of the assessment.

43. Nevertheless, it is not sufficient to rely on what Ms S might have said when she saw Dr Lister. Ms S made it clear in her stage 1 and 2 submissions that she did not agree that her Council role had been primarily office based. Ms S said the job description was not descriptive enough and to support her position Ms S submitted a letter from her former manager, who set up the Neighbourhood Travel Team, who said Ms S' role was mainly field based and the main essence of the role was face to face communication. Whilst the letter was written after Dr Lister had given his opinion, as it was clarifying Ms S' job role at the time she worked for the Council, the Council should have asked Dr Lister whether it changed his opinion and if not why.

44. It was not sufficient for Dr Lister to just say that the job description did not change his recommendation. He needed to explain why.

45. Mr Riley says Dr Lister discussed Ms S' lower back pain in some detail in his report, both in relation to her former Council employment and, at the time, the then PCSO employment; he also discussed Ms S' balance. But that fails to address the Adjudicator's point that Dr Lister did not clarify what he meant by saying that Ms S' balance appeared good in terms of normal day to day activities.

46. Mr Riley suggests that Ms S considered that her mobility was not so serious as to take up the PCSO role. But the relevant question is how did Ms S' condition affect her at the time of her application for ill health retirement, not when she took up the post of PCSO.

47. Therefore, I uphold Ms S' complaint.

48. In coming to this conclusion, I am not expressing a view as to whether Ms S should receive ill health retirement benefits from 2015. That decision is for the Council to make. But its decision must be supported by appropriate evidence.

Directions

49. To put matters right the Council shall:-

- Consider afresh whether Ms S qualified for ill health retirement from the date of her original application in 2015. Prior to making its decision the Council should obtain the certified opinion of another IRMP who has not been previously involved in this matter.
- Pay Ms S £500 for the significant distress and inconvenience which she has suffered.

Anthony Arter

Pensions Ombudsman
27 September 2018

Appendix

Summary of the Medical Evidence

Radiological report on MRI scan of Ms S' lumbar spine, typed 12 April 2013

50. The report noted:

    "Mild degenerative changes. Otherwise unremarkable. No stenosis, no disc protrusion and no nerve root impingement."

Diabetes Specialist Nurse, report dated 6 October 2014

51. The report detailed results of continuous glucose monitor and commented on Ms S' use of insulin.

PAM OH Solutions report, dated 23 March 2015 – pertaining to Ms S' separate application for ill health retirement with Cheshire Police.

52. Current Issues: Back pain ongoing, more severe when wearing her body armour. Diabetes managed on medication. Acoustic neuroma, treated in 2008, requires ongoing monitoring. Caused partial deafness and balance issues.

53. OH Opinion: Concerns about Ms S' fitness to perform her PCSO role effectively due to her various medical conditions. Specific concern about her hearing and her balance (especially in the dark) and the possibility of pain levels increasing. If redeployed due to auditory irritation would require somewhere away from telephones and multiple noises and somewhere where she was not required to lift move handle.

54. Management Advice: For safety reasons voluntary redundancy or ill health should apply.

Miss Munir, Consultant ENT/Skull Base Surgeon, report dictated and typed 25 March 2015

55. Current symptoms: Ms S complained of increased tinnitus and intermittent right sided facial pain.

56. Examination: Ms S' left tympanic membrane appeared healthy and on the right side she had a blind sac closure. Lower cranial nerves and vocal cord function normal.

57. Management Plan: To arrange surveillance scan in June 2015 and follow-up. Ms S not keen on tinnitus management therapy and felt facial pain bearable.

Dr Hadland, Occupational Health Physician with OHS, 22 May 2015 report

58. Dr Hadland said he had discussed with Ms S her current medical situation. He noted that Ms S required surgery for a brain tumour in 2008, that she currently was under the care of two hospital specialists and also attended the audiology clinic due to hearing problems affecting her right ear in particular. He also noted that Ms S had a history of diabetes and back pain,

59. Dr Hadland said at present Ms S was experiencing balance issues and increased tiredness in addition to daily tinnitus symptoms and hearing problems. She was also experiencing back pain most days.

60. To progress Ms S' ill health application, Dr Hadland suggested to the Council that a report be obtained from her GP prior to her being assessed by an IRMP.

Dr Matthews, GP, report dated 18 June 2015

61. Dr Matthews said:-

- Ms S had been diagnosed with a vestibular schwannoma in 2008, remained under the care of an ENT specialist and enclosed Miss Munir's most recent clinic letter.
- Ms S had also been diagnosed with type 1 diabetes and remained under hospital follow-up. She received insulin treatment via an insulin pump and was started on this treatment in November 2011 as her diabetes was poorly controlled.
- Ms S also suffered with low back pain

Extract from Dr Lister's hand-written notes dated 12 August 2015

62. "Travel Coordinator – full time then 30 hrs for last 12/12 for home life – office based day time. Occ evening to go to outreach functions. Computer/telephone/sitting most of time/ 3 x 1/2 say wk bus passenger surveys. travel on buses doing surveys. currently PCSO – Cheshire Police in work – restricted duties since April – office based…

Main problems – diabetes
acoustic neuroma
low back pain"

"Acoustic Neuroma on (R) surgery gets (R) facial pain. Residual tumour around facial nerves near brain stem annual MRI – no significant change. Deaf on (R), tinnitus in (R) occ in (L)balance can fall – problem in dark, trip on kerbs (uneven ground / heights / ladders – day to day OK has been back front line PCSO since …

Tinnitus worse – getting fatigue - worse…stress/noisy environment. Gen health otherwise OK"

Dr Lister, IRMP, 12 August 2015 report

63. Dr Lister noted:-

- Ms S' age.
- Her former job role at the Council.
- Her current employment as a PCSO with Cheshire Police and that she was on adjusted duties, doing office based work, since April 2015 due to back pain.

64. Dr Lister said Ms S saw her main problems as being her diabetes, her previous acoustic neuroma and low back pain.

65. Dr Lister said Ms S' diabetes was diagnosed in 2006 and she had commenced insulin in 2008. He understood from Ms S that she had quite good control and that her diabetes was stable. She was not experiencing any problems with neuropathy or vision and said she could have occasional hypo episodes, but she was very aware of these.

66. Ms S' low back pain had developed after surgery in 2008 for her acoustic neuroma. An MRI scan showed mild degenerative changes, but was otherwise unremarkable. Nevertheless, she complained of continued low back pain and some altered sensation in her right lateral thigh. Dr Lister noted that Ms S had not been referred to secondary services, such as an orthopaedic surgeon or to a pain clinic, but had had some physiotherapy and managed her pain with anti-inflammatories and occasional paracetamol. She had limited her physical activities to avoid provoking pain. She was able to sit in an office type environment, but had to get up from time to time to move around. She was mobile and able to go out and about.

67. Following the 2008 surgery, there was still some residual tumour around the facial nerve and near the brain stem, but there was no evidence of any significant growth. Ms S complained of some right sided facial pain and tinnitus and some balance problems. Her general health was otherwise good and did not require any particular pain management for her acoustic neuroma.

68. On physical examination, there was no evidence of any nerve root impingement in her spine. Her balance appeared good in terms of normal day to day activities.

69. Dr Lister concluded by saying:

> "My overall impression was that she is now aged 49 years and she is currently in work as a PCSO doing adjusted duties, principally because she feels she can't wear body armour due to low back pain.
>
> Her diabetes is stable, is not causing any significant problems and is well controlled.
>
> She has low back pain and there is no evidence of any significant serious pathology and she has not required any significant secondary referral other than for physiotherapy. I do not feel that her back pain would functionally affect her role in her previous employment.
>
> In my opinion, she is not permanently disabled from her previous role and I have completed the certificate accordingly."

Mr Ewins, Consultant Physician in Diabetes/Endocrinology, 23 October 2015 letter to Dr Roy at PAM OH Solutions – pertaining to Ms S' separate application for ill health retirement with Cheshire Police.

70. Mr Ewins said:-

- Ms S had been attending the clinic for several years for management of her insulin dependent diabetes.
- She had a long history of very difficult and poor control of her condition with frequent episodes of hypoglycaemia.
- Various measures had been tried to optimise her control. Currently she used an insulin pump, but there had been problems because her body armour easily dislodged the insulin cannula and she had difficulty replacing it for the same reason.
- As a complication of her diabetes she had some diabetic retinopathy but there was currently no evidence of any nephropathy.
- In addition to the diabetes he was aware that Ms S had been diagnosed with an acoustic neuroma for which she had surgery in 2008. While not directly involved in its management he was well aware of the problems this had led to, that further impeded Ms S' ability to carry out her PCSO role. Following surgery, she had been left completely deaf in her right ear, which meant she had no directional hearing. Additionally, she had constant tinnitus which impaired her concentration and seriously limited her sleep leaving her constantly fatigued. She also had very poor balance and often tripped and fell particularly when walking alone in the dark. She also had been left with a facial weakness and facial nerve pain. She found the loss of hearing and balance very debilitating.
- Additionally, as a consequence of the surgery, she also had severe back pain following an epidural anaesthetic. She still got recurrent back pain, particularly after walking on long shifts. Investigations had found just wear and tear and muscle spasm.
- In his opinion, Ms S was permanently incapable of carrying out her previous PCSO role. In particular she was unable to do long shifts, patrol on foot especially at night, respond to emergency calls, work alone, follow conversations in busy noisy rooms and had difficulty using an ordinary phone and was unable to wear an ear piece with a police phone.

Miss Munir letter dictated 9 June 2016 to Ms S

71. "From the point of view of chronic fatigue, being distressed and emotional and not being able to cope as well as having a reduced concentration and having problems remembering things or words and struggling to undertake simple tasks as you mention in your email. I feel you would benefit from a consultation with a psychologist. I would be grateful if you would liaise with your GP to have these symptoms investigated further and to seek further in-put and help that may be potentially available locally to help you along with these problems that you are experiencing…

From the point of view of your single sided deafness you are being seen at Chester already for consideration for a bone anchored hearing aid and for pulsatile tinnitus we would recommend tinnitus management therapy and I believe that this has already been suggested to you. We can look at options of various neuropathic pain killers for the facial pain that you are experiencing and you can discuss these further at your next out-patient appointment…We will organise for you to undergo a speech and language therapy assessment from the point of view of the difficulty that you are having swallowing and we will perform upper airway endoscopy when you attend clinic next to ensure that your voice box is working normally."

GP's open letter dated 2 September 2016

72. The GP said Ms S' right sided acoustic neuroma had almost completely been excised in 2008. Post operation she had become profoundly deaf on the right side and had been troubled with tinnitus and had a lot of problems with fatigue. As a consequence, she had found it very difficult to work in an active role and had been moved to an office role in April 2015.

73. Unfortunately, she found it very difficult to sustain an office role. Her problems were not ones for which there was significant medical treatment and it was unlikely that they would improve in the future.

Skull-base Specialist Nurse, open letter dictated 11 August 2017

74. The letter explains what an acoustic neuroma is and that its removal renders the patient totally deaf and removes any balance function on the affected side, in Ms S' case the right side. The hearing loss is permanent. This makes it difficult to localise sound and background noise cannot be filtered, which makes it difficult in noisy and crowded environments. In some cases, as with Ms S, the person becomes sensitive to sound. Ms S also described tinnitus which was constant and invasive.

75. The letter goes on to say that:

- Ms S found that she was extremely imbalanced in the dark or in badly lit places. She struggled on uneven ground or with stairs. She often stumbled and had had falls recently. Her balance worsened when she was tired. Her balance function would never fully recover. Ms S struggled with day to day energy levels and fatigued, as the brain had to work extra hard to compensate for the balance function loss. Normally fatigue settled down within a year or two of surgery, but Ms S was in the minority group for whom that did not occur.

- Physiotherapy had been suggested to Ms S, but it was not likely to correct her balance significantly.

- Ms S' anchored hearing aid would never give her stereo hearing.

- Ms S also struggled with facial symptoms and sharp pain into the face. She had numbness on the right side of her face which meant she persistently bit her inner cheek and tongue.

- Ms S also described a difficulty with swallowing.

- An up to date scan and follow-up was to be arranged.

Dr Sarangi, IRMP, report dated 17 May 2018

76. The report listed the information considered as:-

- Previous OH records.
- A personal statement from Ms S detailing her medical conditions and their impact on her.
- A Job Description and specific details clarified by Ms S and her former Manager. The latter dated 7 September 2016.
- Skull Based Specialist Nurse report dated 11 August 2017.
- Report from Mrs Hammerback-Ward, Consultant Neurosurgeon, dated 11 September 2017.
- Report from Ms Stapleton, ENT Consultant, date 27 October 2017.
- Report from Dr King, Clinical Neuropsychologist, dated 14 February 2018.

77. Prior to surgery in 2008 for an acoustic neuroma, Ms S had been experiencing problems with her hearing, trigeminal symptoms [facial pain] and tinnitus. After surgery these significantly worsened. She had single sided deafness, balance problems, tinnitus, trigeminal neuralgia and headaches. She described ongoing fatigue and lethargy. Her condition and management of various problems also appeared to be complicated by diabetes managed with insulin and chronic back pain.

78. Ms S had been able to perform some work, but her ability had deteriorated over time. She had briefly worked at Sainsbury's but due to her deafness and tinnitus had been unable to cope with the environment. She also described sensitivity to sound (hyperacusis). Fatigue also played a role in reducing her ability to work.

79. On prognosis Dr Sarangi said:

"[Ms S] has a small and slow growing tumour remint which will continue to be monitored and may require further surgery in the future. More recently she has been diagnosed with a cholesterol granuloma which also may require further intervention. These are unlikely to resolve any of her ongoing issues that may result in complications.

There is the possibility of some improvement with Neuropsychological intervention as well as rehabilitation for balance and tinnitus. However, this is unlikely to result in significant resolution of her difficulties, but may support [Ms S] with her ongoing symptoms".

80. Dr Sarangi concluded:

> "With further support there is the possibility that [Ms S] will be able to perform some work in the future. However, this would be with various parameters, taking into account her Hyperacusis, balance, tinnitus and hearing problems. In addition, I also feel that her fatigue will have a significant impact on the hours worked. Consequently, on the balance of probabilities, she may only be able to return to work in the future in a very limited capacity and with adjustments. Certainly, her previous employment and gainful employment are unlikely until normal pension age."