PO-24083

Ombudsman's Determination

Applicant	Mr S
Scheme	The GKN Group Pension Scheme 2012 (**the Scheme**)
Respondent	Trustee of the GKN Group Pension Scheme 2012 (**the Trustee**)

Complaint Summary

Mr S has complained that the Trustee has based its decision to decline his application for ill health early retirement (**IHER**) on flawed medical advice and an incorrect interpretation of the Scheme Rules.

Summary of the Ombudsman's Determination and reasons

The complaint should not be upheld against the Trustee because although the medical evidence relied upon was not wholly clear in the context of the Scheme Rules, the Trustee has clarified it and can rely upon the medical evidence to make a legitimate decision.

Detailed Determination

Material facts

1. In February 2014, aged 56, Mr S was made redundant from GKN. On redundancy, Mr S became a deferred member of the Scheme and was entitled to take his deferred benefits from the Scheme on a reduced basis. An accepted application for IHER from deferred status would allow Mr S to take benefits without reduction.

2. In September 2015, Mr S applied for IHER. The application was declined in October 2015.

3. Between October 2015 and September 2016, Mr S made further applications for IHER which were declined.

4. In September 2016, Mr S raised a complaint about the process and the medical evidence relied upon. That complaint was eventually referred to this Office.

5. In February 2018, it was determined that the Trustee had relied upon flawed medical advice when reaching its decision. So, the case was remitted back to the Trustee for a further medical assessment and review.

6. On 19 May 2018, Dr McVittie issued a new medical report. This report identified the relevant rule, under the Trust Deed & Rules as Rule 11(D)(1)(c) and Rule B.12.2 for the CARE section of the Scheme. Dr McVittie made the following notable comments:

> "The diagnosis of Generalised Anxiety Disorder (GAD) is not in doubt… Currently, the condition would reasonably be considered as sufficient to prevent him from following his normal employments.
>
> The key test is whether Mr [S]' condition is likely to remain so for the foreseeable future.
>
> …
>
> In order to be assured that a medical condition will last for the foreseeable future, as a clinician one needs to be confident that all reasonable treatment avenues have been explored and failed. In my opinion that point has not been reached. For example, there remain options for treatments with alternative medication. Mr [S] is intolerant of the SSRI group of drugs, but referral to standard texts indicates alternatives outwith that group that can be prescribed for him at a primary care level.
>
> Mr [S] has never had the benefit of a consultant psychiatric opinion. His GP has taken a view about this, as is his professional right. However, the remit and viewpoint of an OH physician is somewhat different from a GP, and given the fact that Mr [S]' symptoms have persisted thus far, that he hasn't been able to tolerate standard 'first line' medication, and that he is going through a process in which there is a lot at stake, I consider that a referral to a consultant psychiatrist for a higher tier opinion and treatment is now a reasonable option.
>
> …
>
> When the above considerations are borne in mind, it is my independent, clinical opinion that Mr [S]'s condition of Generalised Anxiety Disorder (GAD) has not been proven as having the impact to seriously impair his earning capacity for the foreseeable future.
>
> Similarly, whilst Mr [S] may be considered incapable of carrying on his occupation at present because of this ongoing mental health disorder, there is no evidence that he will continue to be so incapacitated (and I refer to my comments about outstanding treatment options)."

7. Having considered Dr McVittie's report, the Trustee declined Mr S' application.

8. Mr S subsequently provided further comments on the report, highlighting factual inaccuracies and inconsistencies with the Scheme Rules.

9. On 19 May 2018, having considered Mr S' comments on the original report, Dr McVittie provided a follow up letter. Dr McVittie acknowledged certain factual inaccuracies but reiterated that he considered there remained avenues of treatment which had not been tried. He also highlighted that Mr S' counter arguments were indicative of higher cognitive functioning and that four consultant occupational health physicians had independently arrived at the same conclusion that Mr S did not meet the criteria.

10. On 21 June 2018, dissatisfied with the Trustee's stance, Mr S referred the matter to this Office.

11. Following further enquiries by this Office, a further letter was received from Dr McVittie, dated 10 November 2018, clarifying his stance. The key points were:-

- The diagnosis of Mr S' condition, GAD, was accepted.
- There were alternative medications available to Mr S, along with referral to a consultant psychiatrist.
- These alternative treatments had a much better than 50% chance of being effective.
- Mr S' condition was not proven to seriously impair his earning capacity for the foreseeable future.

12. The Trustee also reiterated its stance that there is no evidence that Mr S' earnings capacity is severely impaired for the foreseeable future.

Summary of Mr S' position

13. Dr McVittie's report contains factual inaccuracies about: his treatment (he had 16, not 15, CBT appointments); periods of sick leave; date of redundancy; the number of times his application had been declined; and, who had made the decision not to refer Mr S to a consultant psychiatrist, this was his GP's decision, not his own.

14. Dr McVittie has ignored and failed to address the medical evidence provided by Mr S' GP and other medical professionals, whose opinions contradict Mr McVittie's. This demonstrates that Dr McVittie cannot logically counter the medical evidence that supports Mr S' position. Because Dr McVittie has not addressed the medical evidence in a comprehensive manner, his opinion is not fair or objective.

15. Under a previous determination issued by The Pensions Ombudsman in relation to Mr S' application, it was found that evidence had been ignored, leading to that case being upheld, and the same is true in Dr McVittie's review.

16. Given the previous, and multiple, assessments by medical advisers, Dr McVittie should be required to justify his opinion by addressing all the medical and

circumstantial evidence. The fact that Dr McVittie has concluded there is no evidence that Mr S' incapacity will continue, implies that he has not adequately reviewed the body of evidence.

17. Dr McVittie has concluded that Mr S is prevented from following his normal employment, but not that he is sufficiently impaired from following an alternative hypothetical employment. However, Dr McVittie has not indicated the alternative employment or why that employment would not severely impair his earning capacity for the foreseeable future.

18. Dr McVittie has reached a view based solely on medical evidence, but Mr S cannot understand how an opinion of earning capacity can be reached without also considering employment criteria. This could only be possible if the medical evidence is unequivocal and conclusive in determining an individual's incapacity to work, which is not the case here.

19. An Occupational Health Professional (**OHP**) ought to be able to assess earning capacity in the context of a type of employment, an individual's health, and the medical evidence.

20. On a point of law, this determination has created an information asymmetry, in that if the earning capacity is not compared against his normal or former employment, he cannot know what is the comparator employment in these circumstances. A failure to have specified this to date is inequitable and unfair, and Mr S cannot know why this arbitrary standard has not being disclosed. This information asymmetry is restricting Mr S' ability to contest the decision and is being used to defeat Mr S' application without justification.

21. The most relevant method to assess his earning capacity for the foreseeable future is against his normal role and occupation, that is, the role he undertook for GKN. This is supported by the fact that all of his pension contributions and 35 years of service, were made whilst working for GKN and essentially in the same role. To make a comparison against a hypothetical employment is a subjective contest of imagination with no guiding principles.

22. The definition of normal employment is not provided within the Scheme Rules and has been a point of contention throughout his application. This demonstrates the inadequacy of the Scheme Rules. The fact that the Trustee has now conceded that the earning capacity test is against his normal role, his previous role, makes the 50% policy statement irrelevant in a free employment market economy.

23. The Trustee has now confirmed that it does not have a documented policy statement confirming the 50% requirement, despite Mr S' being specifically advised that such a formal document existed and has existed since the inception of the Scheme. The policy statement should be documented otherwise it has been imposed upon Mr S on an ad hoc basis and has now been reduced to an informal guiding principle by the Trustee. This further demonstrates the inadequacy of the Scheme Rules, implies that

the Trustee was attempting to deceive him, and is further evidence of the information asymmetry used to deny his ill health application.

24. The Trustee has attempted to make parts of the relevant Scheme rules irrelevant and redundant (Mr S refers, in particular, to (i) and (ii) of the definition of ill health (see Appendix below)); in fact, they should be used together to properly determine the matter.

25. Dr McVittie has suggested that he should seek a higher tier consultant psychiatric opinion, but the Rules do not allow for additional requirements such as this to be imposed by the medical adviser. The test is that the decision be based "in light of medical evidence produced" by a "registered medical practitioner". Dr McVittie should not place additional 'higher standard' evidentiary burdens on his application, where these are not a requirement under the Rules.

26. In doing this, Dr McVittie has extended the Rules to suit his opinion, rather than assessing the evidence within the scope of the Rules. In doing so, Dr McVittie is denying an otherwise justifiable application.

27. Dr McVittie is also requiring a higher burden of proof for mental health claimants such as Mr S, than those with physical conditions. This is blatant discrimination under the Equalities Act 2010, and the Scheme Rules do not require a different standard of proof for mental health applications.

28. The only requirement under the Scheme Rules for medical evidence to be admissible is that it comes from a "registered medical practitioner", but Dr McVittie is now raising the bar to a higher tier consultant psychiatrist. This is despite Dr McVittie otherwise concurring with Mr S' GP's treatment of his condition and without Dr McVittie adequately considering the GP's medical evidence.

29. Further, Dr McVittie's stance on a higher tier opinion implies that the required standard is not that of "a registered medical practitioner", and that there are higher or lower tiers to the sources of evidence; yet that is inconsistent with the Scheme Rules and Dr McCrea's opinion that his GP was correct and referral to a Psychiatric Specialist was not justified.

30. Dr McVittie's prognosis, that resolution of Mr S' disorder is very favourable, is inconsistent with the previous OHP's opinion that, having undertaken "extensive literature search", he "failed to produce unequivocal evidence in terms of prognosis when applied to Mr [S]' situation." That physician also indicated that "perhaps the most significant fact in the success of treatment is the use of an appropriate drug for an appropriate length of time."

31. Mr S argues that given he continues to suffer from the condition, despite it stabilising through the use of medication and counselling over the past five years. In his view, it is fair to say that his GP has taken the view that appropriate medication and treatments have been and are being administered over an appropriate length of time.

It is obvious, given the circumstances and time frame around his condition that the time frame for healing has not been achieved and that “the time frame required is now the key for the propensity of success for the treatment.”

32. It is hard to accept that, having been ill for six and a half years, with no earnings for four, and with his normal retirement date only three years away, his illness cannot be said to severely impair his earnings capacity for the foreseeable future. Nor can it be said there is no evidence that this will remain the case. Therefore, Dr McVittie’s evidence is illogical.

33. Mr S does not agree that he should attempt Dr McVittie’s proposed alternative treatments. His GP’s actions to date have improved and stabilised his condition through numerous medication trials, counselling and CBT sessions. Mr S is intolerant of certain medications and dosages, but the fact they were tried and retried demonstrates his GP’s commitment to improving his condition. To date, medication used by Mr S has proven at best to be 14% successful, but Dr McVittie believes further trials are likely to be at least 50% successful. This conclusion should not be relied upon.

34. Dr McVittie’s comments bring his GP’s professional competence into question, which is wholly unacceptable, considering his right to have an alternative view, which Dr McVittie accepts. Mr S’ view is that:

> “Dr McVittie should not hide behind his comments that the remit and view point of an OH Physician is somewhat different from a GP in regard to this matter.”

35. This tension between Dr McVittie’s view and his GP is intolerable because it would require him to challenge his GP’s professional opinion. Mr S has “extreme confidence” in his GP and if it was appropriate for other treatments to have been tried, they would have been. The GP knows Mr S and his illness best and does not believe further treatment to be in his best interests.

36. Dr McVittie’s opinion that other treatments be attempted ignores the various treatments which have been tried and failed, and in the course of which considerably extended and exacerbated his attempts to recover. Further trials are likely to jeopardise the progress that has been made and extend his period of recovery. Dr McVittie’s opinion is unsubstantiated and nothing more than a hypothesis.

37. Mr S’ GP has recently confirmed that Mr S is sane and not suffering from psychosis. He has a full understanding of his condition and the capacity to make decisions about the appropriate treatments, this is particularly in reference to the negative and destabilising side effects of many of the medications he has been prescribed. Mr S is within his rights to choose whether to accept suggested medications or treatments and his GP would not recommend any further medications or a referral to a consultant psychiatrist. Mr S is not willing to risk additional or higher dosages of medication regardless of the IHER application. The success of the IHER application should not be contingent on his willingness to take further drugs.

38. Dr McVittie's opinion that alternative treatments should be tried is untenable, as it places Mr S' financial interests against the view of what is in the best interests of his health and possible recovery.

39. Dr McVittie's view that the closure of the application, whatever the outcome, is an essential step in Mr S' recovering is flawed. It is illogical, and fails to appreciate the practical circumstances he finds himself in. His continuing diminishing financial circumstances, due to being unable to work, is not going to aid his recovery. The length of time it has taken for the application to reach this stage is a reflection of the Trustee's inability to adequately handle his application, and that delay should not be held against him.

40. Mr S highlights that his marital split was a direct consequence of his condition, which is a consequence of his employment with GKN. It is inequitable that the failure of his marriage and his struggle to accept it is being used to deny his pension application.

41. Dr McVittie's report gives an erroneous impression that the majority of the evidence submitted by Mr S was in the form of his statements, which is a deliberate attempt to diminish the value of the medical evidence he had otherwise submitted.

42. Mr S does not consider predisposition to be relevant as it is not a definitive indicator of whether an individual will develop a condition. But it has been observed by his family that he has a nervous disposition.

43. The argument made by Dr McVittie, that Mr S displays a high level of cognitive function through his letters and therefore should be able to work, fails to take account of the considerable support and advice he has received throughout the IHER application from professionals. Additionally, successful employment requires more than merely higher degrees of cognitive function. This should not be used to deny his application.

44. Dr McVittie has considered Mr S' recently diagnosed ankle problem as if he were still in employment but has not considered the fact that a future employer is highly unlikely to take on an individual in his circumstances, due to the complications this issue is likely to have in the long term. It is unrealistic to think this condition will not impair his earning capacity.

45. Dr McVittie has indicated that a return to an appropriate role is a therapeutic objective, but this is irrelevant as he is not well enough to undertake the demands of such a role.

46. Dr McVittie's interpretation of the evidence is inadequate, unsubstantiated, does not deal with the facts of the case and does not comply with the Scheme Rules.

47. It is a misrepresentation that other OHPs had reached the same conclusion, as on each prior occasion an OHP has considered his case, the response has been flawed. Dr McVitties' report should be viewed in the context of the medical reports previously relied upon by the Trustee.

48. Given the evidence provided to the Trustee and the Ombudsman to date, it is indeed possible to conclude that Mr S' earning capacity has been severely impaired for the foreseeable future.

Summary of the Trustee's position

49. Dr McVittie's medical opinion is that Mr S does not meet the IHER criteria.

50. There were minor factual inaccuracies in Dr McVittie's report, but they did not alter his medical opinion.

51. The "key test" in determining whether Mr S meets the criteria is whether his earning capacity is severely impaired for the foreseeable future, Rule 11(D)(1)(c)(i), which states:

> "where the physical or mental condition of the member is accepted by the Trustee in the light of medical evidence produced in respect of the member as severely impairing his earning capacity for the foreseeable future, the deferred pension shall not be subject to an actuarial reduction and provisos (a) and (b) of Rule 11(C)(1) shall apply as if the Member had retired on account of Ill-health."

52. The decision as to whether the criteria is met is for the Trustee to make, based on the medical evidence.

53. It is not for the Trustee to prove that Mr S' condition does not severely impair his earning capacity for the foreseeable future. If that were the test, it would provide scope for indefinite challenge on the basis that it had failed to prove a negative, which is not the test.

54. There have been procedural errors over the course of Mr S' application, but there have now been four experienced OHPs who have all independently reached the same conclusion.

55. Dr McVittie's report of 19 May 2018 contains an unfortunate misuse of terminology when suggesting that the key test is whether Mr S was prevented from following his normal employment for the foreseeable future. But Dr McVittie does go on to apply the correct test in his Conclusion and Opinion.

56. In the initial report, Dr McVittie clearly specifies "reasonable" alternative treatments available to Mr S at a "primary care" level. Although Dr McVittie does not specify a balance of probabilities finding on the likely outcome, that is not required in the Scheme Rules, and the likely effectiveness of the "reasonable" alternative treatments is implied in Dr McVittie's conclusion.

57. Dr McVittie has since provided further evidence, in the letter of 10 November 2018, confirming that he believes the alternative treatments have a "much better than 50% chance of treatment being effective", which is why he described them as reasonable.

This was not available to the Trustee at the time it made its decision but supports its conclusions.

58. The test for severely impaired earnings capacity is compared to the member's remuneration in respect of their "normal" employment.

59. The Trustee interprets severe to mean a reduction of 50% or more in the member's earning capacity.

60. This does not preclude the member from working in some other capacity, and other gainful employment does not prevent the criteria from being satisfied.

61. Dr McVittie concluded that Mr S' earning capacity is currently "severely impaired", but the alternative "reasonable" treatments available to him mean there is no evidence that this impairment will continue for the "foreseeable future".

Conclusions

62. Mr S' application has undergone a number of reviews over the years and it is understandable that his confidence in the process has been undermined. It is clear that he has concerns that the Trustee is incapable of reaching a balanced decision in his case, and that the medical evidence it has relied upon is flawed.

63. My focus must be the most recent decision made by the Trustee and the evidence relied upon to reach that conclusion. The previous Trustee decision has already been subject to a determination by this Office. Whilst that determination, and the earlier medical opinions received by the Trustee, add context, they are not relevant to determining this complaint, as they have been set aside. This complaint centres on whether the Trustee has acted appropriately and in accordance with the Scheme Rules when making its decision to decline the application in mid-2018.

Procedural points

64. In the course of this Office's investigation of the complaint, certain concerns were highlighted about Dr McVittie's report, of May 2018, and the interpretation of the Rules. The intention being that the Trustee offer to revisit the application afresh in light of those comments in order to resolve the current complaint.

65. Instead of making the suggested offer to Mr S, the Trustee unilaterally went ahead and put the queries to Dr McVittie and provided its comments on the Scheme Rules. Dr McVittie has since reiterated his opinion of Mr S' application.

66. I have considered whether this was an appropriate course of action on the part of the Trustee. Having done so, I find that its decision to pursue the clarification immediately was reasonable. This Office's query over the interpretation of the Rules has been satisfactorily explained through the Trustee's response, without a material impact on the complaint. Further, the possible uncertainty about Dr McVittie's opinion has been clarified by way of his additional submission.

67. Regarding this Office's comment on Dr McVittie's opinion, although there was a lack of clarity about the relevant question in one paragraph, in the conclusions of that opinion, he does answer the relevant question. I therefore consider Dr McVittie's report did in fact comment on the necessary question appropriately prior to the Trustee seeking further clarity.

68. Additionally, this Office highlighted that Dr McVittie had failed to provide a balance of probabilities opinion on the effectiveness of the alternative treatments he had suggested. However, the Trustee has highlighted that this is not a specific requirement of the Scheme Rules and Dr McVittie described those alternative treatments as reasonable, implying that there was a better than 50% chance of success. Dr McVittie's later correspondence further confirmed that he considered that there was a better than 50% chance of the alternative treatments being successful.

69. In the circumstances, where the question had already been addressed in Dr McVittie's initial report, I do not think there has been an injustice in the Trustee's decision to seek additional clarification, following this Office's enquiries. I am satisfied that the actions of the Trustee in seeking further clarification from Dr McVittie has not significantly altered the underlying evidence relied upon, when declining Mr S' application in May 2018, to make its decision irrelevant.

The Trustee's Decision

70. The Trustee is required to reach a decision on the basis of the relevant evidence, having addressed the correct question and to reach an outcome which is not irrational. The Trustee has declined Mr S' application in light of the medical opinion provided by Dr McVittie.

71. In reaching its decision, the Trustee has concentrated on Dr McVittie's assessment as to the likelihood of Mr S' illness improving. Mr S highlights that the Trustee should have considered all the elements (referring to (i) and (ii)) of the definition of ill health). However, I do not think those sub clauses are significant here. The rule determining Mr S' entitlement for ill health early retirement is:-

> "Rule 11 (d) (1) (c)
>
> …provided that the Trustees may determine…where satisfactory evidence is produced to them of the Member's ill-health…
>
> Provided that:
>
> Where the physical or mental condition of the Member is accepted by the Trustees in light of medical evidence produced in respect of the Member as severely impairing his earning capacity for the foreseeable future, the deferred pension shall not be subject to discount and provisos (a) and (b) to (C)(1) of this Rule shall apply as if the Member had retired on account of ill-health;"

72. Although the sub clauses Mr S highlights are relevant to the definition of ill health, it is the above rule which determines his entitlement to ill health early retirement from deferred status without reduction. In this context, the central question is whether Mr S' earning capacity is severely impaired for the foreseeable future. I therefore do not agree that the Trustee's decision is invalidated by not addressing the sub-clauses Mr S has referred to.

Dr McVittie's Report

73. Mr S has concerns about Dr McVittie's report that extend beyond the points raised by this Office. Whilst I acknowledge those wide-ranging concerns, I consider the primary issue here relates to the presence of the untried alternative treatments proposed. Dr McVittie accepts that Mr S is currently incapable of undertaking his normal employment and currently has a "seriously" impaired earnings capacity. However, the application, in Dr McVittie's opinion, fails on the whether this situation will remain the case for the foreseeable future. I consider this is the issue which is the root cause of Mr S' not meeting the IHER criteria.

74. At this point, I note that throughout his correspondence with the Trustee, Dr McVittie has referred to Mr S' condition as "seriously" impairing his earning capacity, as opposed to the term used in the relevant rule, "severely". There is a distinction between the terms and they are not synonymous; however, I am not persuaded that the use of this mistaken word assists Mr S' case. I consider that severe is a higher bar than serious; therefore, whilst not strictly applying the relevant terminology, if Dr McVittie is not satisfied that Mr S' condition would seriously impair his earning capacity for the foreseeable future, then I think it is reasonable for the Trustee to conclude that his condition was not severely impaired for the foreseeable future either. I note that the Trustee has made reference to severe throughout and it is ultimately the Trustee which makes the decision.

75. Mr S has asked for clarity on what the Trustee considers to be his 'normal employment' and for evidence of a policy document that requires an individual's earning capacity to be impaired by 50% or more in order to be deemed severe. The Trustee has confirmed that his 'normal employment' is viewed to be his previous role immediately prior to leaving pensionable service "or work of the same general nature." Regarding whether a 50% reduction in earnings can be deemed a severe impairment, the Trustee has been unable to produce documentary evidence, e.g. a policy statement, that this is actually its policy. However, it has highlighted that this is a reasonable guiding principle rather than a "policy", and such policies or principles do not need to be codified in writing.

76. Whilst I understand Mr S' concern that this policy is not set out in writing, despite what he was previously told, and was only disclosed to him at a late stage in the process, there is no dispute that Mr S' earning capacity is "severely impaired". So, this policy is not in fact obstructing a successful application. It is whether this will remain the case for the foreseeable future which is stopping the Trustee from

accepting his application. In any event, I consider it is appropriate that there is some guide to what "severe" means, and I consider 50% is appropriate in this context. The lack of a policy document explicitly stating this is disappointing, given what Mr S was previously told, but that does not mean that the Trustee's approach to the situation is wrong.

77. Mr S is concerned that Dr McVittie is placing a higher burden of proof on him unfairly as a sufferer of a mental health condition, as opposed to a physical condition, by suggesting that further opinion be sought from a consultant psychiatrist. However, I consider this misconstrues Dr McVittie's reference to a consultant psychiatrist. Dr McVittie is not suggesting that Mr S seek a further opinion from a consultant psychiatrist in relation to whether he meets the criteria for ill-health; he is suggesting that Mr S seek further opinion on potential treatment from a consultant psychiatrist.

78. I find that Dr McVittie's proposal is reasonable when placed in a similar context to a physical ailment, where it would be appropriate to seek treatment from a consultant in an attempt to treat a physical condition. Further, referral to a consultant psychiatrist is listed as the appropriate next step treatment for GAD on the NHS' website [1]. I do not agree that Dr McVittie is discriminating against Mr S by suggesting this route to treatment.

79. It may be that the consultant psychiatrist reviews the matter and agrees with his GP that no alternative treatments would be appropriate, at which point Mr S could make a new application for IHER with this additional evidence that supports his application.

80. This position is not a reflection on Mr S' GP's professional competence or ability. GPs do have a different remit from OHPs, in that an OHP is assessing the condition in the context of employment or a potential return to work, whereas a GP has a wider remit. An OHP cannot ignore a reasonable potential alternative treatment which might assist a return to work, simply because the patient does not want to go down that route, whereas a GP can be more responsive to a patient's preferences.

81. I appreciate Mr S' concerns about attempting alternative treatments and the potential side effects. However, where there are reasonable alternative treatments available to him, as there appear to be in this case, provided by the NHS, and as Dr McVittie has highlighted, I consider it is reasonable for the Trustee in these circumstances to anticipate all reasonable available treatments to be attempted before concluding an individual will not improve in the future.

82. Mr S has argued that Dr McVittie has failed to take account of or adequately engage with the medical evidence he has provided which supports his position that he meets the criteria for IHER. I acknowledge that Dr McVittie has not engaged with each piece of evidence individually, but he is not required to. Dr McVittie's role is not to validate or disprove evidence submitted, but to reach an independent opinion on the circumstances as a whole. Dr McVittie does specify that he has reviewed the 'bundle'

[1] https://www.nhs.uk/conditions/generalised-anxiety-disorder/treatment/

as agreed between Mr S and the Trustee. There is no indication that he has not considered all of the evidence presented, even if he reaches an opinion which differs from Mr S' or the other medical professionals; this does not mean that Dr McVittie is disregarding relevant evidence.

83. In a previous determination I issued in relation to Mr S' application, I concluded that relevant evidence had been overlooked because pages were missing from a particular document. That is not the case here.

84. Mr S has highlighted that a previous OHP who considered his application was unable to produce clear evidence on the prognosis for individuals in his situation, and Mr S argues that to date, medication has only been 14% successful. Whereas Dr McVittie concludes that there is a better than 50% chance of success and that the resolution is very favourable. I can see the inconsistency between the stances of the two medical professionals and the fact that, to date, the treatments Mr S has tried have not been consistently successful, but that does not alter the fact that Dr McVittie has laid out legitimate treatments available through the NHS and that these are established next steps in the NICE guidance, where there continues to be marked functional impairment and there has been no improvement following earlier steps [2]. It is reasonable to take the view that, overall, these treatments are offered because they have an appropriate level of success in most cases.

85. I appreciate Mr S has been unemployed with no earnings for some time, and his normal retirement date is reasonably close; but, without attempting the proposed alternative treatments, it is not possible for the Trustee to say that he will continue to have a severely impaired earnings capacity for the foreseeable future. If all reasonable treatments had been exhausted I would agree, but they have not been.

86. Mr S has highlighted other perceived flaws in Dr McVittie's report, including: reference to the closure of the application facilitating recovery; the impact of his marital split; Mr S' statements within the bundle; his predisposition towards anxiety; and, the cognitive functions displayed in his submissions. Whilst I have considered the points made by Mr S, they do not change the fact that the underlying reason his application failed was the availability of alternative treatments.

87. Mr S has also challenged Dr McVittie's comments on his recent ankle problem, arguing that this has been considered as though he was currently employed, and the employer was making reasonable adjustments to accommodate him, when in fact the practical issues with this condition, such as treatment needs, would prevent him from being employed in the first place. Whilst I appreciate the point Mr S is making, if an employer discriminates against him in the course of a job application due to this condition, that does not equate to him being prevented from doing the job because of the condition.

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[2] https://cks.nice.org.uk/generalized-anxiety-disorder#!scenario

88. I find that Dr McVittie's opinion can be relied upon by the Trustee when reaching its decision as to whether to accept Mr S' application. Dr McVittie had considered all the relevant evidence, in the context of the correct question, and reached an opinion which is rational.

Anthony Arter

Pensions Ombudsman
8 March 2019

Appendix

Definitive Trust Deed and Rules 2012

Rule 11 (d) (1) (c)

"…provided that the Trustees may determine…where satisfactory evidence is produced to them of the Member's ill-health…

Provided that:

(i) Where the physical or mental condition of the Member is accepted by the Trustees in light of medical evidence produced in respect of the Member as severely impairing his earning capacity for the foreseeable future, the deferred pension shall not be subject to discount and provisos (a) and (b) to (C)(1) of this Rule shall apply as if the Member had retired on account of ill-health;"

Ill-health is defined as:

""ill-health" in relation to a Member means physical or mental deterioration of health since commencing service with the Employers to a degree which

(i) In the opinion of the Employers prevents the Member from following his normal employment;

(ii) Is accepted by the Trustees in the light of medical evidence produced in respect of the Member as severely impairing his earning capacity for the foreseeable future; and

(iii) The Trustees have established, based on medical evidence from a registered medical practitioner (for the purpose of the ill-health condition under the Finance Act 2004), that the Member is/and will continue to be incapable of carrying on his occupation because of physical or mental impairment, and the member has in fact ceased to carry on that occupation.