PO-26124

Ombudsman's Determination

Applicant	Ms N
Scheme	Local Government Pension Scheme
Respondent	London Borough of Redbridge (**Redbridge**)

Outcome

1. Ms N's complaint against Redbridge is partly upheld, but there is a part of the complaint I do not agree with. To put matters right (for the part that is upheld), Redbridge shall pay Ms N £500 for the significant non-financial injustice which she has suffered.

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

Complaint summary

3. Ms N disagrees with the decision not to pay her deferred benefits early on the grounds of ill health. She has also complained that she was not properly considered for ill health retirement from active service at the time her employment ceased. Ms N also complains about the time taken to deal with her case.

Background information, including submissions from the parties

Background

4. The relevant regulations are The Local Government Pension Scheme Regulations 2013 (SI2013/2356) (as amended) (the **2013 Regulations**). Extracts from the 2013 Regulations are provided in Appendix 1.

5. Ms N was employed by Redbridge until 13 February 2015. Her employment was terminated on the grounds of capability. Ms N had been on long-term sickness absence since July 2014. She had been diagnosed with Chronic Fatigue Syndrome (**CFS/ME**) in 2012.

6. Redbridge sought advice from its occupational health physician, Dr Kennedy, in July and October 2014 and February 2015. In his report dated 2 September 2014, Dr Kennedy said Ms N was currently unfit for work and there were no adjustments which

would facilitate a return to work at that time. He estimated a likely recovery time of two to three months, depending upon Ms N's access to treatment. Dr Kennedy concluded:

> "I would not myself consider [Ms N] as likely to be permanently incapable of regularly and efficiently undertaking the duties of her role for reasons of ill health or infirmity, based on current medical evidence and on a balance of probabilities. However, she does have a long-term condition and if she was to leave the Borough in the future, I would support referral to an independent registered medical practitioner (IRMP), with her consent."

7. Dr Kennedy prepared a further report in November 2014. A draft copy of this report was sent to Ms N for comment and consent to release. Ms N raised some issues with Dr Kennedy and did not consent to the release of his report. In December 2014, Redbridge decided to terminate Ms N's employment. The last day of her contract of employment was 13 February 2015.

8. Ms N appealed the decision to terminate her employment. She submitted a report, dated 1 February 2015, by a registered osteopath and specialist in CFS, Dr Perrin. A summary of Dr Perrin's report is provided in Appendix 2, together with summaries of and extracts from other medical evidence relating to Ms N's case.

9. On 17 February 2015, Redbridge asked Dr Kennedy to review Dr Perrin's report. It asked Dr Kennedy to give his opinion as to whether it would be appropriate to refer Ms N to an IRMP. Dr Kennedy responded on 17 March 2015. He said:

> "There is no medical contraindication to [Ms N] returning to the duties of a Senior Auditor. However, her overall suitability for the duties would have to be duly considered. She has previously referred to lacking CPD … If she does, then returning to the full demands and performance expectations of a Senior Auditor role would be stressful to a degree that is likely to exceed her coping capacity, exacerbate her medical condition and prolong her recovery …
>
> Decisions on referral to an IRMP are for the Borough as employer to take. I have already opined that I do not myself consider [Ms N] as likely to be permanently incapable of undertaking her role. However, given the long-term nature of her condition and need for a 'balance of probability' judgment by an independent practitioner to assist pension benefit considerations, I advised that if [Ms N] was to leave the Borough's employment I would support referral to an IRMP with her consent … However, whilst decisions on benefit entitlement would only arise in the event of termination/leaving local authority employment, I believe that the Borough could consider and request IRMP referral in advance of final employment decisions, which could proceed with the individual employee's consent. You may wish to refer to LGPS statutory guidance in this regard."

10. In June 2015, Ms N raised a claim for disability discrimination, failure to make reasonable adjustments and unfair dismissal in the Employment Tribunal. This was unsuccessful.

11. On 9 September 2015, Ms N wrote to Redbridge saying she had not been advised of her right to apply for ill health retirement. She referred to an email she had sent, on 13 February 2015, in which she had said that she felt that an application for ill health retirement should be considered. Ms N enclosed a report from Dr Perrin, together with his c.v. and a book he had written. She also enclosed a 2002 report by the Chief Medical Officer's Working Group on CFS/ME and a 2004 report by her GP.

12. In response, Redbridge said its sickness absence management procedure required a manager to seek advice from its occupational health physician as to whether the employee might be eligible for ill health retirement. Redbridge said Ms N had been made aware that such advice was being sought in July 2014. It referred Ms N to a statement she had made that she had attended the occupational health unit, in August 2014, to discuss ill health retirement. Redbridge said there was no need for an employee to make a formal application for ill health retirement because this was undertaken by management.

13. Redbridge referred to the comment by Dr Kennedy that "if [Ms N] was to leave the Borough's employment [he] would support referral to an IRMP". It said Dr Kennedy's advice, in September 2014 and March 2015, had been that he did not consider Ms N permanently incapable of undertaking her role. Redbridge said, based on Dr Kennedy's report in September 2014, ill health retirement was not considered appropriate.

14. Redbridge referred Ms N to a letter, dated 16 June 2015, from its Pensions Officer and paragraphs relating to the payment of her deferred pension on the grounds of permanent ill health. It said, if Ms N wished to progress with this, she should complete and return a form authorising its occupational health physician to contact her doctor.

15. In response, Ms N said she had been advised that, as she had applied for a pension as an active member, Redbridge must refer her to an IRMP. Redbridge issued a further response on 26 November 2015. This largely reiterated what it had previously said and referred Ms N to the internal dispute resolution (**IDR**) procedure.

16. Ms N submitted a request for the early payment of her deferred benefits in January 2016. She said her application had been made notwithstanding her strong belief that her claim for ill health retirement as an active member should be progressed. Ms N subsequently submitted a report from a Dr Godlee in support of her claim (see Appendix 2).

17. Ms N also submitted a complaint in relation to her claim for ill health retirement from active service.

18. Redbridge referred Ms N's case to an IRMP in January 2016. Ms N met with the IRMP, Dr Gration, on 16 May 2016.

19. On 6 June 2016, Dr Gration provided a certificate indicating that, in his opinion, Ms N was not permanently incapable of discharging efficiently the duties of her former employment. A summary of Dr Gration's accompanying report is provided in Appendix 2.

20. On 9 June 2016, Redbridge wrote to Ms N informing her that her application for ill health retirement had been declined. It said the IRMP had certified that, in his opinion, Ms N was not permanently incapable of discharging efficiently the duties of the employment she had been engaged in at the date she became a deferred member.

21. The Employment Tribunal issued its decision on 9 August 2016.

22. Ms N submitted an appeal on 29 September 2016. This was acknowledged by Redbridge on 3 October 2016. It referred Ms N's case to Hymans Robertson, on 19 October 2016, asking that it act as a stage one IDR adjudicator.

23. In January 2017, Ms N enquired about progress and provided a further report from Dr Perrin in support of her appeal. Ms N also pointed out what she considered to be factual inaccuracies in Dr Gration's report. These were:-

    - Dr Gration referred to her travelling by car and train. She travelled by car and bus. It was less distance than her journey to Redbridge and less stressful. She did not have to walk for more than a few hundred yards and it involved no steps.

    - Dr Gration referred to her working a little under 30 hours per week. She worked 22 hours per week for John Lewis and did an hour or two bookwork at home. Her work at John Lewis was on non-consecutive days. When she had more bookwork to do, she took annual leave from John Lewis.

24. The stage one IDR adjudicator issued a decision on 30 March 2017. The adjudicator's decision is summarised below:-

    - With regard to Ms N's complaint about the failure to refer her to an IRMP at the time her employment terminated, the adjudicator found she was outside the time limits specified in the 2013 Regulations to bring a complaint.

    - The adjudicator also determined that there were no grounds for him to extend the time period within which Ms N should have made her complaint. He noted that Redbridge had provided a response to her, on 26 November 2015, despite it already being more than six months after the decision which was the subject of her complaint. He noted that the letter referred Ms N to the IDR procedure but she had not submitted an IDR appeal within six months of this letter either.

    - Before making a decision under Regulation 38, the employer was required to obtain a certificate from an IRMP as to whether, in their opinion, the member was permanently incapable of discharging efficiently the duties of their former employment. In Ms N's case, the IRMP had provided a certificate and report

which had been sent to Redbridge on 6 June 2016. The relevant provisions had, therefore, been correctly applied.

- Whilst the IRMP's certificate should form part of the decision making process, the IRMP could not determine whether the benefits were payable.
- The employer was also required to consider guidance issued by the Secretary of State. This made it clear that an employer could consider other available information, as well as the IRMP's opinion, in making a decision. This approach was expected by The Pensions Ombudsman.
- Redbridge had not set out, in detail, why it had reached the decision it had. The very detailed evidence presented in Ms N's favour required a more detailed explanation from Redbridge as to why it disagreed.

25. Redbridge referred Ms N's case back to Dr Gration on 8 May 2017. It asked him to address two questions:-

- Why his opinion differed from that expressed in the specialist's reports?
- Why it was his opinion that Ms N would be capable of attaining working hours of 30 or more?

26. Dr Gration provided a supplementary report on 30 May 2017 (see Appendix 2). It was sent to Ms N first for her comment and consent to issue.

27. Ms N wrote to Dr Gration, on 19 June 2017, setting out her comments on his report. Briefly, these were:-

- She disagreed that her symptoms had improved since 2015;
- She disagreed that she was undertaking a little under 30 hours of work per week and was able to increase those hours;
- She did not travel to work by train or undertake any significant commuting;
- He had not referred to the Chief Medical Officer's 2002 report on CFS with regard to prognosis;
- She was able to pace herself by working no more than five and a half hours over five non-consecutive days;
- She disagreed with his comparison of her current employment with her former role.

28. On 20 July 2017, in an email to Ms N, Dr Gration said he had not amended his report but he had no objection to Ms N including her comments when the report was issued. He said this did not imply that he agreed with her comments.

29. On 14 August 2017, Redbridge issued a further decision. The decision-maker said she had had no previous involvement with Ms N's case. The decision is summarised as follows:-

- Ms N's application was made and considered under Regulation 38 of the 2013 Regulations.
- As required by Regulation 36, a certificate had been obtained from an IRMP and the decision-maker had had regard for the Guidance issued by the Secretary of State.
- The LGPS Regulations were underpinned by an expectation of transparency and robust medical evidence from the IRMP. This was reinforced by the Guidance, which highlighted an obligation on the IRMP to act professionally and independently.
- Dr Gration met the requirements for an IRMP as defined in the 2013 Regulations. He was a doctor registered with the General Medical Council (**GMC**) and held a recognised qualification in occupational health medicine.
- The decision-maker was satisfied that Dr Gration had fully discharged his duty in completing the June 2016 certificate and his reports of June 2016 and May 2017.
- Dr Gration had certified that, in his opinion, Ms N was not, on the balance of probabilities, permanently incapable of discharging efficiently the duties of her former employment.
- Dr Gration had had regard for the evidence available to him, including a face-to-face consultation with Ms N and the reports provided by Dr Perrin. It was for Dr Gration to assess the evidence and form his own medical opinion.
- If an IRMP disagreed with another registered medical practitioner, s/he could be expected to explain why. It was not reasonable to expect an IRMP to explain why he did not agree with a specialist practitioner who was not a registered medical practitioner.
- Dr Gration had set out his professional rationale for reaching the opinion that Ms N did not meet the criteria for payment of her benefits under regulation 38.
- The decision-maker had considered Dr Perrin's opinions but given them limited weight because:-
  - Dr Perrin was not a registered medical practitioner certified by the GMC.
  - As such, he was not on a par with a specialist registered medical practitioner.

- Dr Perrin was Ms N's chosen specialist and was not bound by the GMC's professional standards.

- Dr Perrin's opinion was informed by a single source; namely Ms N. It was devoid of any recent input from a registered medical practitioner, such as Ms N's GP.

- Ms N had been given the opportunity to submit medical evidence from her GP or specialist practitioner. It was implicit that the specialist should be on a par with her GP.

- It was evident that the IRMP had referred to Ms N's occupational health file. This contained numerous reports offering different opinions as to the immediate and long term prognosis.

- Dr Gration had explained why his opinion differed from that of Dr Perrin.

- The decision-maker had reviewed Ms N's occupational health file and the reports provided by Dr Kennedy. Whilst Dr Kennedy could not act as an IRMP, he had expressed his professional opinion that Ms N did not meet the criteria for ill health retirement. Since February 2015, two occupational health physicians had expressed the view that Ms N did not meet the LGPS criteria for ill health retirement.

- Ms N had claimed, in her Employment Tribunal claim, that she was fit to work and sought an order for re-engagement. The Employment Tribunal hearing had taken place one month after her consultation with Dr Gration. She had been able to commute to the four-day hearing and was fully engaged with the proceedings and preparations.

30. The decision-maker said she had no reason to question the professional analysis and opinion offered by Dr Gration. She said, weighing up all of the evidence, she was not satisfied that Ms N was permanently incapable of discharging the duties of her former employment. The decision-maker said Ms N had the option to appeal the decision at stage two of the IDR procedure.

31. Ms N submitted a stage two appeal on 24 August 2017. Redbridge decided to refer Ms N's case to another IRMP. It initially proposed to arrange for a Dr Cooper to review Ms N's case. Redbridge agreed to pay half the cost for Ms N to travel to Dr Cooper. Ms N asked if it was possible to find an IRMP located closer to her home. Redbridge eventually arranged for her case to be reviewed by a Dr Williams. He did so on the basis of a paper review.

32. Dr Williams provided his report on 23 March 2018 (see Appendix 2). Ms N submitted her comments on Dr Williams' report on 8 June 2018. Redbridge issued a stage two decision, on 2 July 2018, declining Ms N's appeal. The decision maker said he had reviewed all the evidence, including reports and correspondence submitted by Ms N. He said he had obtained a report from a second IRMP. The decision maker said the

IRMP had certified that, in his opinion, Ms N was not permanently incapable of discharging efficiently the duties of the employment she was engaged in at the date she became a deferred member. The decision maker said, having considered the IRMP's report and the other evidence provided by Ms N, he was unable to support her request for payment of her deferred benefits on the grounds of ill health.

Ms N's position

33. Ms N submits:-

- She was dismissed by Redbridge on the basis of a report from Dr Perrin. Prior to this, she had asked to be referred to an IRMP for an opinion as to whether she would be eligible for ill health retirement as an active member. This did not happen, despite Dr Kennedy recommending referral. When she was told her application as an active member was not going to be considered by an IRMP, she was forced to apply as a deferred member.

- There were many factual inaccuracies in Dr Gration's report and he did not explain why his decision contradicted Dr Perrin's report. Dr Perrin has a PhD in two of the illnesses she suffers from; CFS and fibromyalgia.

- Following the IDR decision, Dr Gration did not provide any more medical reasons for his decision.

- She also suffers from mental illness but this was not taken into consideration.

- There are no references to Dr Perrin's reports or the accompanying reference material in any of the reports and letters issued in connection with her case. It is, therefore, not possible to say whether they were read and/or considered. She is aware that Dr Williams did not read Dr Perrin's book because this was returned to her after stage one of the IDR procedure. Neither the IRMPs nor Redbridge considered the Chief Medical Officer's 2002 report or the 2017 British Medical Journal (**BMJ**) article.

- Dr Gration and Dr Williams are not specialists in CFS/ME and fibromyalgia. It makes no sense for their reports to be considered more reliable than Dr Perrin's. Their reports did not give a clear explanation of her symptoms or how the demands of her role would be affected by her illness. She accepts that there is no requirement for the IRMP to be a specialist in any particular illness. However, it would be reasonable to consider a detailed report from an expert to be more reliable than an opinion from a generalist occupational health doctor.

- Dr Williams wrote his report without making any enquiries about her current health. Nor did he ask her to complete any questionnaires relating to her physical or mental health symptoms. He wrote an unbalanced, ill-informed and defamatory report, omitting any information which would support Dr Perrin's opinion.

- Even when instructed to at stage one of the IDR procedure, Redbridge failed to obtain sufficient information to address the points which required clarification.

- Redbridge should have asked the IRMP to given an opinion on the NHS trials undertaken by Dr Perrin. The results of these trials were published in the BMJ in November 2017.

- There was no comment from the IRMPs or Redbridge as to what the job description and person specification for her former role were or why her symptoms would not hinder her from performing this role.

- Redbridge failed to give reasons for its decision. It referred to the IRMP's opinion but failed to give its own reasons. It therefore appears that it simply endorsed a decision by the IRMP. This is contrary to the LGPS regulations.

- She feels strongly that allowing a council to hold the pension purse, select and employ IRMPs, make eligibility decisions and string out the process is unfair because it lacks true independence.

- Dr Kennedy is employed by Redbridge. His correspondence with Redbridge and his unwillingness to clarify ambiguities in his reports indicates he has a poor relationship with the council. There is a clear conflict of interest. He lacks independence and his opinion should be completely disregarded.

- Unnecessarily delaying matters meant that Redbridge would not have to backdate her benefits if it was determined that she met the criteria for early payment of her deferred benefits.

- Her physical and mental health has suffered from having to deal with the situation. She has also lost three years of pension. She has been unable to pay the capital on her mortgage and has had to pay more interest than she would have done if she had received a pension. She has had to forego holidays and cannot afford the supplements she was taking to mitigate her symptoms. Her partner has had to take on a second job.

- The main issue is that Redbridge accepted Dr Gration's explanation that she had improved in the 16 months between seeing him and seeing Dr Perrin. Redbridge had a report dated nearly eight months after Dr Gration's report saying she had not improved sufficiently to be gainfully employed.

- Dr Perrin is not her treating physician. She is being treated by a registered osteopath who uses the Perrin Technique. She went to Dr Perrin for an expert report.

- Redbridge knew Dr Gration's report was inaccurate because she had explained this to the stage one IDR decision-maker. The stage one IDR decision-maker also had access to Dr Godlee's report which supported ill

health retirement. Dr Gration had omitted information about post-exertional malaise and fluctuation of symptoms. He did not mention any mental health issues, which had been entered on her sickness absence record at Redbridge. These omissions were not resolved in Dr Gration's second report.

- Redbridge said Dr Perrin was not a registered medical practitioner subject to the GMC professional standards. He is a registered osteopath and neuroscientist and is subject to the Institute of Osteopathy's professional standards. In 2015, he was awarded a research and practice award by the Institute for his 26 years' research into CFS/ME. The outcome of successful NHS trials was published in the BMJ in 2017. It was unreasonable to give such a feeble reason to disregard Dr Perrin's expertise.

- Dr Perrin's report was not solely based on her input. She had provided him with notes from her osteopath and her GP. He also examined her and gave her a formal diagnosis of CFS/ME.

- Dr Perrin's knowledge far exceeds that of her GP. Nevertheless, she provided Redbridge with reports from her GP and notes from her osteopath. It also obtained reports from West Essex Mind. It did not consider this information.

- It was disingenuous of Redbridge to say two occupational health physicians had expressed the view that she did not meet the criteria for ill health retirement. These opinions related to retirement from deferred status only. In addition, Dr Williams did not examine her, did not ask for updated information and based his report on the occupational health file and Dr Gration's inaccurate report. Redbridge did not refer to the fact that Dr Godlee and Dr Perrin had confirmed that she did meet the criteria for ill health retirement.

- At the Employment Tribunal, she had been seeking part-time employment. She had been fuelled by adrenalin and cortisol, which had enabled a "fight or flight" response. Her condition had deteriorated over the week and, despite being driven to the hearing, she was extremely unwell afterwards.

- Had Dr Gration asked her about her hours of work, she would have explained how she had arrived at the figures quoted. Dr Gration was clearly not fully aware that the symptoms of CFS/ME and fibromyalgia fluctuate and increase significantly post-exertion. She might be capable of activity, such as attending the Employment Tribunal hearing, one week but unable to sustain this day after day; certainly not for every week of an entire year.

- Her role at Redbridge was mostly desk-based. She reduced her hours to 29 per week and was unable to cope with this. For Dr Gration to say she would be able to do more than 30 hours in a less physical role is just not true. Working only 22 hours per week leaves her chronically fatigued and with unmanageable symptoms. Nor did Dr Gration refer to the cognitive symptoms which would prevent her from being gainfully employed in a desk-based role.

Such a role would increase her fibromyalgia symptoms, result in more migraines and increase her anxiety and depression.

- Her predecessor at Redbridge also had CFS/ME and had been taken through the poor performance procedure. He was allowed to resign. Unlike her, he was not, to her knowledge, suffering from any mental health issues; she did speak to him. If Redbridge was aware that her predecessor was unable to meet the standards required of that role, it knew there was a high probability that she would also be unable to perform to the required standard; particularly with her additional condition of fibromyalgia.

- Any reasonable layperson would have concluded, on the basis of her medical history and Dr Perrin's report, that she met the criteria for ill health retirement.

- It took Redbridge five months to refer her case to Dr Williams. She would have been happy to attend an appointment with another IRMP in the Autumn of 2017 or January 2018. No reason was given for the delay and this is further maladministration.

Redbridge's position

34. Redbridge submits:-

- Ms N has referred to events dating back to February 2015. Claims concerning events prior to January 2016 are disingenuous and an abuse of process.

- It relies on the Employment Tribunal decision which dismissed Ms N's complaint of unfair dismissal. This judgment was not appealed. It is, therefore, a matter of fact that Ms N was dismissed fairly on the grounds of incapability due to ill health. An application for ill health retirement did not precede her dismissal.

- It has, at every stage, acted in accordance with the LGPS regulations in seeking a report from an IRMP before making a decision.

- Where an IRMP would not certify that Ms N met the criteria for ill health retirement and the assessment as to her ability was consistent with other information available to the authority, it has maintained its decision to reject her application.

- At the time of Ms N's dismissal, it had reports from its occupational health service which opined that Ms N would be fit to return to her substantive role in time. There was no occupational health indication for redeployment on a permanent basis. The occupational health physician did not consider Ms N likely to meet the criteria for ill health retirement. Ms N disagreed with the assessment on medical redeployment and was given time to present a medical report to support her proposition for redeployment. She provided a report from Dr Perrin supporting ill health retirement. Ms N had not previously requested ill

health retirement. Such an application would have been inconsistent with her claim to be fit and willing to return to work on the grounds of medical redeployment.

- Dr Perrin's report post-dates the decision to terminate Ms N's employment. It was not seen by the dismissing officer. The report could not and did not contribute to the decision to dismiss Ms N.

- Ms N applied for ill health retirement from active service on 9 September 2015. Her employment had terminated on 13 February 2015. Accordingly, her application was rejected. Ms N did not challenge this decision.

- Ms N applied for the early payment of her deferred benefits on 11 January 2016. In accordance with Regulation 36, it sought a report from an IRMP.

- Dr Gration met the criteria for an IRMP.

- It does not accept that Dr Gration's report contained any factual inaccuracies. The IDR stage one decision concluded that specific reasons were required from Dr Gration; it did not refer to any factual inaccuracies.

- It dealt with Ms N's application appropriately and holistically. It did not have a strategy to refuse payment.

- Ms N's appeal against the stage one and two IDR decisions were considered fairly. The stage two decision concluded that the second IRMP's report supported the evidence set out in the stage one decision and agreed with the reasons given.

Adjudicator's Opinion

35. Ms N's complaint was considered by one of our Adjudicators who concluded that there had been some maladministration on the part of Redbridge. The Adjudicator's findings are summarised below:-

- The Adjudicator began by explaining that her Opinion related solely to Ms N's application for a pension. She noted that, in her submissions, Ms N had made reference to matters relating to the period before her dismissal. These were more properly considered to be employment matters and, fell outside the Ombudsman's jurisdiction. The Adjudicator explained that it was for this reason that she would not be commenting on these matters in her Opinion.

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

- In Ms N's case, the relevant regulations were the 2013 Regulations. Regulation 38 provided for the early payment of deferred benefits on the grounds of ill health. Briefly, in order to receive her benefits under Regulation 38, Ms N had to be:-

  - permanently incapable of discharging efficiently the duties of the employment that she was engaged in at the date she became a deferred member, and

  - unlikely to be capable of undertaking gainful employment before her normal pension age, or for at least three years, whichever was the sooner.

- Permanently incapable meant that Ms N was likely to be incapable at least until her normal pension age. Gainful employment meant paid employment for at least 30 hours a week for a period of not less than 12 months.

- The decision as to whether Ms N met the eligibility requirements of Regulation 38 was for Redbridge to make. This was a finding of fact; Ms N either met the conditions set out in Regulation 38 or she did not. Had Redbridge determined that Ms N met the requirements for early payment of her benefits, it would then have been required to decide whether or not to agree to her request. This was a discretionary power exercisable by Redbridge.

- Before making any decision under Regulation 38, Redbridge was required to obtain a certified opinion from an IRMP. The 2013 Regulations set out the specific qualifications required of an IRMP. These were qualifications in occupational health medicine. The Adjudicator noted that Ms N had made the point that neither Dr Gration nor Dr Williams were specialists in CFS. They were not required to be by the 2013 Regulations.

- The Adjudicator also noted Ms N's concern that allowing a council to select the IRMPs and make eligibility decisions was unfair because it lacked true independence. However, in engaging Dr Gration and Dr Williams as IRMPs, Redbridge was carrying out a statutory obligation to do so. Both Dr Gration and Dr Williams met the other regulatory requirements to act as IRMP; namely, they had no previous involvement in Ms N's case and were not acting as representatives of either Redbridge or Ms N.

- Whilst Redbridge was required to seek a certified opinion from an IRMP, it was also required to come to a decision itself as to Ms N's eligibility for benefits under Regulation 38[1]. In order to do so, Redbridge could be expected to consider all relevant information which was available to it and ignore any irrelevant information. That being said, the weight which it attached to any of the available relevant information was for Redbridge to decide, including giving some of it little or no weight. It was open to Redbridge to prefer the advice it received from the IRMPs unless there was a cogent reason why it should not

[1] Regulation 72(4)

have done or should not have done without seeking clarification. The Adjudicator explained that the kind of reasons she had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations on the part of the IRMP.

- The Adjudicator noted that Ms N had pointed out that Dr Gration referred to her travelling to her current employment by train, rather than by bus. In the Adjudicator's view, an error of this kind would not have required Redbridge to seek further clarification from Dr Gration; it was unlikely to have affected his opinion. Ms N also disagreed with Dr Gration's assessment of the number of hours of work she was undertaking. However, Dr Gration appeared to have based his assessment on information previously provided by Ms N. The Adjudicator took the view that this was a difference of opinion rather than an error of fact on Dr Gration's part.

- When reviewing the IRMP's advice, Redbridge would not have been expected to challenge a medical opinion. Whilst it could be expected to review all the available medical evidence, it could only be expected to do so from a lay perspective. This was the approach the Ombudsman would take. So far as their medical opinions were concerned, the IRMPs did not come within the Ombudsman's jurisdiction. They were answerable to their own professional bodies and the GMC.

- However, where an IRMP's opinion was very different to those held by the member's treating physicians, Redbridge should be able to give reasons for preferring it. In its letter to Ms N dated 9 June 2016, Redbridge said it had taken all the available evidence into account, including the medical reports supplied by Ms N. This would have included Dr Perrin's report. Redbridge then said the IRMP had certified that Ms N was not permanently incapable of discharging her former duties. It said, having considered the IRMP's opinion as well as the medical reports and other information provided by Ms N, it did not support her request for early payment of her deferred benefits. In the Adjudicator's view, this fell short of what could be expected by way of explanation. There was no acknowledgement that the IRMP had come to a very different view to that held by Dr Perrin and no reason given for preferring the IRMP's view.

- The Adjudicator noted that, following the IDR decision to remit Ms N's case for review, further detail was sought from Dr Gration. In particular, Dr Gration was asked to clarify why his opinion differed from that of Dr Perrin and why he thought Ms N capable of attaining working hours of 30 or more. On the former, Dr Gration said Ms N's levels of work and activity appeared to be indicating a more positive prognosis than Dr Perrin had anticipated in 2015. On the latter, he referred to the hours of work Ms N had stated in a health and capability form. Ms N had referred to doing, on average, four hours of bookwork at home and 21.93 hours for John Lewis. Dr Gration expressed the view that, given the

nature of her work with John Lewis, this indicated that Ms N would be capable of undertaking 30 or more hours of less physically demanding work in the future.

- The decision issued by Redbridge on 14 August 2017 contained a much more detailed explanation for its preference for Dr Gration's opinion (see paragraph 31). Briefly, this was:-
  - Dr Gration met the requirements for an IRMP and was registered with the GMC.
  - Dr Perrin was not registered with the GMC and not bound by its professional standards.
  - Dr Perrin's opinion was based solely on information from Ms N and did not refer to any input from other medical practitioners, such as her GP.
  - Dr Gration had referred to Ms N's occupational health file which contained reports from a number of sources.
  - Whilst Dr Kennedy could not act as an IRMP in Ms N's case, he had given an opinion, as an occupational health specialist, that Ms N did not meet the criteria for ill health retirement.
  - Since February 2015, two occupational health physicians had expressed the view that Ms N did not meet the LGPS criteria for ill health retirement.
  - In her Employment Tribunal claim, Ms N had claimed that she was fit to work and had sought an order for re-engagement. She had attended the tribunal hearing and engaged with the process.
- In the Adjudicator's view, this more detailed response indicated that Redbridge had come to a decision of its own and had not simply endorsed Dr Gration's opinion, as Ms N has suggested. It appeared to have considered the available relevant information and did not take any irrelevant information into account.
- The Adjudicator acknowledged that Ms N had concerns about the extent to which Dr Perrin's reports were taken into account. She had said there were no specific references to Dr Perrin's reports or to the accompanying reference material in any of the IRMPs' reports or any of Redbridge's letters. She suggested that it was not possible to say whether they were read or considered. Ms N said she was aware that Dr Williams had not read Dr Perrin's book because this was returned to her after stage one of the IDR procedure. She also said neither the IRMPs nor Redbridge considered the Chief Medical Officer's 2002 report or the 2017 BMJ article.
- The Adjudicator did not consider it entirely accurate to say that there were no references to Dr Perrin's reports in the IRMPs' reports. Dr Gration had not specifically referred to Dr Perrin's opinion in his initial report but he did do so in

his supplementary report. Dr Williams had discussed Dr Perrin's opinion in his report of 23 March 2018.

- Redbridge could expect the IRMP to provide some explanation if s/he came to a very different view to that held by the member's treating physicians. However, the IRMP was being asked to give a professional opinion as to the member's capacity for employment; not to refute that put forward by another medical professional. In addition, the IRMP was being asked to provide a report for a layperson. In the Adjudicator's view, the LGPS regulations did not envisage or require the kind of in-depth discussion of reference and trial material which Ms N had suggested.

- There was clearly a difference of opinion, between Dr Perrin on the one hand and Drs Gration and Williams on the other, as to Ms N's likely capacity to undertake her former role at some time before her normal pension age. A difference of opinion, in and of itself, was not sufficient reason for the Ombudsman to remit a decision for review. There would have to be some other reason for finding that Redbridge should not have relied on the IRMPs' advice in coming to its decision, such as those the Adjudicator had referred to previously. She said she had not identified any such reason in Ms N's case.

- The Adjudicator did not consider that there were grounds for the Ombudsman to require Redbridge to re-take its decision not to pay Ms N's benefits early under Regulation 38.

- Ms N had also referred to the process by which Redbridge determined not to award her benefits under Regulation 35; that is, ill health retirement from active status. As at February 2015, Regulation 35 provided that an active member was entitled to early payment of a pension when his/her employment was terminated on the grounds of ill health if s/he met the two following conditions:-

  - S/he was permanently incapable of discharging efficiently the duties of the employment s/he was engaged in; and

  - S/he was not immediately capable of undertaking any gainful employment.

- If Ms N had met those conditions in February 2015, she would have been entitled to, and required to take, a retirement pension. There was no requirement for Ms N to make an application in order to receive a pension under Regulation 35. This point was made by Redbridge in correspondence with Ms N. It said its sickness absence management procedure required a manager to seek advice from its occupational health physician as to whether the employee might be eligible for ill health retirement. However, in the Adjudicator's view, this approach did not meet the requirements of the 2013 Regulations.

- Regulation 36(1) required Redbridge to obtain a certificate from an IRMP before making a decision as to whether Ms N was entitled to a pension under

Regulation 35. Dr Kennedy could not act as an IRMP in Ms N's case because of his previous involvement in her case. Although he expressed an opinion as to her eligibility, he did not purport to provide a certified opinion as required by Regulation 36(1). In fact, Dr Kennedy advised Redbridge to seek an IRMP's opinion.

- Redbridge appeared to have taken the approach that deciding that Ms N would not be eligible for ill health retirement on the basis of Dr Kennedy's opinion was not making a decision under Regulation 35. It appeared to have viewed this as some kind of preliminary step in the process. However, a decision to the effect that a member would not be eligible for ill health retirement is a decision under Regulation 35 and required a certified opinion from an IRMP. Redbridge's failure to obtain an opinion in Ms N's case amounted to maladministration.

- The Adjudicator noted Redbridge's reference to the Employment Tribunal judgment. In her view, this did not alter the fact that it was required, by Regulation 36(1), to obtain an IRMP's opinion at the time it terminated Ms N's employment. The fact that its decision to dismiss Ms N was found to be fair did not remove its statutory obligations under the 2013 Regulations.

- The Adjudicator went on to consider what, if any, injustice arose out of the maladministration she had identified. Not all procedural defects would mean that the decision could not be allowed to stand. For example, if procedural failings occurred at an early stage in the process and the impact of the failing was corrected later, the Ombudsman might take the view that the procedural failings did not invalidate the decision.

- The Adjudicator noted that Dr Gration, in his June 2016 report, had said his opinion was unlikely to have been different if he had been considering Ms N's application whilst she was in employment. This was because most of the reasons he had given would have been evident then. However, Dr Gration was giving his opinion some 15 months after Ms N's employment had been terminated. The question was whether Ms N's circumstances had changed significantly in that time.

- The Employment Tribunal's judgment indicated that, at the time of her dismissal, Ms N was actively seeking redeployment. Dr Kennedy had indicated that he was supportive of temporary redeployment. Ms N began to undertake some bookkeeping work in April 2015 and to work for John Lewis in November 2015. It was likely that, if Redbridge had followed due process, the IRMP would have been giving his/her opinion at some time between those two dates. Thus, the information relating to Ms N's employment situation which would likely have been available to an IRMP was that she wished to be and was considered suitable to be redeployed and that she was undertaking some bookkeeping work at home. Ms N would not, by then, have started her employment with John Lewis.

- On the balance of probability, it was unlikely that an IRMP would have come to a different opinion in 2015, as to Ms N's capacity to discharge efficiently the duties of the employment she was engaged in, to that reached by Dr Gration in June 2016. On that basis, Redbridge would have made the same decision as it did; namely, that Ms N was not eligible for a pension under regulation 35. Since the outcome was likely to have been the same despite the maladministration the Adjudicator had identified, Ms N did not suffer any injustice as a result.

- Ms N had also complained that Redbridge had delayed matters unnecessarily. She had suggested that this was so that it would not have to backdate her benefits. Having reviewed the chronology of Ms N's case, the Adjudicator noted that there were periods of inactivity. There was a substantial delay between Ms N's first appeal in September 2016 and the IDR adjudicator's stage one decision in March 2017; a period of six months. This was well outside the two months envisaged by the 2013 Regulations and there appeared to be no obvious reason for it. There was another, even longer, delay between Ms N's appeal in August 2017 and the stage two decision in July 2018. However, this appeared to have been the result of difficulties in identifying and arranging for an IRMP to review her case.

- The Adjudicator acknowledged that Redbridge was relying on a third party for the IDR stage one decision. However, she considered that it could have been more proactive at this time; particularly since it was dealing with someone whose health was not good. A delay of this kind would have added unnecessarily to the stress of Ms N's appeal and the Adjudicator was of the opinion that it amounted to maladministration. With regard to the second period of delay, some of this was the result of accommodating Ms N and allowing her to comment on Dr Williams' report. The Adjudicator did not consider this to amount to further maladministration on Redbridge's part. Nevertheless, this element of Ms N's complaint could be upheld on the basis that there was avoidable delay which resulted in injustice in the form of unnecessary additional stress for Ms N. The Adjudicator did not agree that there was any evidence that Redbridge deliberately delayed matters.

- The Adjudicator suggested that, in order to put matters right, Redbridge should pay Ms N £500 for the distress and inconvenience caused by the delay in dealing with her IDR appeal.

36. Redbridge indicated its willingness to accept the Adjudicator's Opinion. However, Ms N did not accept it and the complaint was passed to me to consider. Ms N provided her 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 Ms N for completeness.

Ombudsman's decision

37. There are two main elements to Ms N's complaint:-

    - She disagrees with the decision not to pay her deferred pension early under Regulation 38; and
    - She is of the view that, in fact, she should have been referred to an IRMP when her employment terminated in 2015.

38. Under Regulation 38, Ms N could ask to have her deferred pension paid early if she:-

    - became permanently incapable of discharging efficiently the duties of the employment in which she was engaged at the date she became a deferred member; and
    - was unlikely to be capable of undertaking gainful employment before normal pension age, or for at least three years, whichever was the sooner.

39. Before deciding whether or not to agree to Ms N's request for early payment of her deferred pension, Redbridge was required to obtain a certificate from an IRMP. The IRMP was required to say whether or not Ms N met the conditions set out in paragraph 38 above. Neither Regulation 36 nor Regulation 38 make the IRMP's certificate binding on Redbridge. Regulation 72(4) provides that "A person's Scheme employer must decide any question … relating to the person's rights or liabilities under the Scheme"; other than certain specific exceptions which do not apply in Ms N's case. Redbridge was required to come to a decision of its own as to Ms N's eligibility under Regulation 38; albeit that decision could be informed by the IRMP's advice.

40. Although it is required to obtain the opinion of an IRMP, Redbridge is expected to review all of the relevant evidence. It may choose to accept the advice provided by the IRMP but should do so having satisfied itself that there are no obvious errors or omissions of fact and no matters requiring clarification. Redbridge should then be able to give reasons for preferring the IRMP's opinion; particularly if that opinion differs from that of other medical advisers in the case. Its June 2016 letter to Ms N lacked any kind of explanation as to why it preferred Dr Gration's advice. In view of the fact that Ms N had provided it with a medical report coming to a very different conclusion, more explanation was called for.

41. Having been directed to review Ms N's case at stage one of the IDR procedure, Redbridge obtained further input from Dr Gration. Its August 2017 letter provided a more detailed explanation for its decision. Ms N disagrees with the reasons given but they do evidence that a genuine decision-making process had been undertaken by Redbridge.

42. Essentially, Ms N argues that Redbridge should have given far more weight to Dr Perrin's advice than that from Dr Gration and, later, Dr Williams. The weight which it attaches to any of the evidence is for Redbridge to decide, including giving little or no

weight to such evidence as it considers appropriate[2]. Giving Dr Perrin's view little or no weight is not the same as failing to give it any consideration at all.

43. I note Ms N's argument that, because Dr Gration and Dr Williams are not specialists in CFS/ME and fibromyalgia, it makes no sense for their reports to be considered more reliable than Dr Perrin's. Ms N has acknowledged that the 2013 Regulations do not require the IRMP to be a specialist in the condition under consideration. The 2013 Regulations require the IRMP to hold certain specific qualifications in occupational health medicine.

44. Ms N describes Drs Gration and Williams as generalists but, in reality, they are specialists in the field of occupational health medicine. This would seem appropriate since the main focus of the advice they are being called upon to give relates to the member's capacity for employment. Ms N has suggested that Dr Gration may not have been aware that the symptoms of CFS/ME and fibromyalgia fluctuate and increase significantly post-exertion. I consider this unlikely. CFS/ME is a not uncommon reason for individuals to seek ill health retirement and Dr Gration is more than likely to be familiar with its symptoms.

45. In order for me to find that it was not appropriate for Redbridge to rely on the advice it received from Dr Gration or Dr Williams, there would have to be a flaw in that advice which would be obvious to a layperson. A difference of opinion, such as that which Ms N has highlighted, would not be sufficient reason. I have alluded to the kind of issues which might have meant Redbridge should not have relied on Dr Gration's or Dr Williams' advice in paragraph 40; namely, errors or omissions of fact. Another reason might be a misunderstanding of the eligibility conditions on the part of the IRMP.

46. Ms N disagrees with Dr Gration's comments on the number of hours she was working. She says, had Dr Gration asked her about this, she would have explained how she had arrived at the figures quoted. Dr Gration based his summary of Ms N's current employment on information supplied by her. He noted that she had referred to an average of four hours per week bookkeeping from her home. He took this to mean that these hours varied, which is entirely reasonable. In total, therefore, Ms N had said that she was working for an average of around 26 hours per week. Dr Gration had then factored in Ms N's travelling to her sales assistant job, which included a half an hour's drive each way to a park and ride, followed by a bus journey. He concluded that this amounted to the equivalent of "a little under 30 hours per week". I do not consider this to amount to an error of fact on Dr Gration's part. I note that Dr Godlee used similar information in his report, which Ms N has not questioned.

47. The key difference between the advice given by Dr Gration and Dr Williams and that provided by Dr Perrin lies in their assessment of Ms N's likely capacity for employment over the period to her normal pension age. This amounts to a difference of opinion between medical practitioners; each of whom was qualified to give such an

[2] *Sampson v Hodgson* [2008] All ER (D) 395 (Apr)

opinion. Redbridge opted to accept the advice from the IRMPs. I have not identified any reason why it should not have done so. I find that the decision by Redbridge not to pay Ms N's pension under Regulation 38 is supported by the evidence it has relied upon. There are no grounds for me to direct Redbridge to re-take its decision.

48. Ms N has also complained that her case was not referred to an IRMP at the time her employment was terminated. Redbridge did not obtain a certificate from an IRMP at this time, having received an opinion from Dr Kennedy to the effect that he did not consider Ms N likely to meet the eligibility conditions under Regulation 35. However, Dr Kennedy was not an IRMP for the purposes of Regulation 35.

49. Redbridge terminated Ms N's employment on the grounds of ill health (capability). Its decision, that she did not meet the conditions for payment of a pension, was a decision under Regulation 35. In order to make that decision, it should have first obtained a certificate from an IRMP. The failure to do so amounts to maladministration on Redbridge's part.

50. In order to uphold this part of Ms N's complaint, I must consider whether she has sustained injustice in consequence of the maladministration I have identified.

51. At the time Ms N's employment was terminated, the conditions for payment of a pension under Regulation 35 were that, as a result of ill health, the member was:-

- permanently incapable of discharging efficiently the duties of the employment s/he was engaged in; and
- not immediately capable of undertaking any gainful employment.

52. The first condition is practically identical to the eligibility condition set out in Regulation 38(1)(a) (see Appendix 1).

53. Dr Gration advised Redbridge that, had he been asked to provide an opinion whilst Ms N was still in its employment, he would have reached the same conclusions as he did in 2016. He said this was because most of the reasons he had given for his opinion would have been evident to him then. At the time, Ms N had indicated that she wished to be redeployed and Dr Kennedy had considered her suitable to be redeployed. She was also undertaking some bookkeeping work at home. Ms N had not yet started her employment with John Lewis. Dr Gration's assertion, that his advice would have been the same in 2015, is not incompatible with the available contemporaneous evidence.

54. Redbridge would have had sight of Dr Perrin's report of 1 February 2015, which offered a very different view of Ms N's capacity for employment. It would have had to have weighed this against all of the other evidence available to it; as it did in 2016 and 2017. It is noticeable that Dr Perrin's view is at odds with the other evidence available to Redbridge at the time, even without advice from an IRMP. He was saying that he could not see a time when Ms N would be able to cope with any work. On the other hand, Dr Kennedy was supportive of redeployment.

55. It is always difficult to determine what might have happened retrospectively and I must be careful to avoid applying hindsight. On the basis that an IRMP reviewing her case in or around February 2015 is likely to have come to the same or similar conclusions to Dr Gration in June 2016, the outcome would have been the same for Ms N. Redbridge would have decided that she was not eligible for payment of a pension under Regulation 35. She is, therefore, in the position she would have been in had there been no maladministration. She has not sustained injustice in consequence of Redbridge's failure to obtain an IRMP's certificate in 2015.

56. There remains the matter of the delays in dealing with Ms N's appeals. I find that some of the delay could have been avoided by Redbridge taking a more proactive approach. This does amount to maladministration on its part and Ms N sustained injustice in consequence in the form of additional stress and inconvenience. I uphold this part of Ms N's complaint.

Directions

57. Within 28 days of the date of the date of this Determination, Redbridge shall pay Ms N £500 for significant non-financial injustice arising out of the delays in dealing with her case.

Anthony Arter

Pensions Ombudsman
13 November 2019

Appendix 1

The Local Government Pension Scheme Regulations 2013 (SI2013/2356) (as amended)

58. At the time Ms N's employment ceased, Regulation 35:

"(1) An active member who has qualifying service for a period of two years and whose employment is terminated by a Scheme employer on the grounds of ill-health or infirmity of mind or body before that member reaches normal pension age, is entitled to, and must take, early payment of a retirement pension if that member satisfies the conditions in paragraphs (3) and (4) of this regulation.

(2) The amount of the retirement pension that a member who satisfies the conditions mentioned in paragraph (1) receives, is determined by which of the benefit tiers specified in paragraphs (5) to (7) that member qualifies for, calculated in accordance with regulation 39 (calculation of ill-health pension amounts).

(3) The first condition is that the member is, as a result of ill-health or infirmity of mind or body, permanently incapable of discharging efficiently the duties of the employment the member was engaged in.

(4) The second condition is that the member, as a result of ill-health or infirmity of mind or body, is not immediately capable of undertaking any gainful employment.

(5) A member is entitled to Tier 1 benefits if that member is unlikely to be capable of undertaking gainful employment before normal pension age.

(6) A member is entitled to Tier 2 benefits if that member -

(a) is not entitled to Tier 1 benefits; and

(b) is unlikely to be capable of undertaking any gainful employment within three years of leaving the employment; but

(c) is likely to be able to undertake gainful employment before reaching normal pension age.

(7) Subject to regulation 37 (special provision in respect of members receiving Tier 3 benefits), if the member is likely to be capable of undertaking gainful employment within three years of leaving the employment, or before normal pension age if earlier, that member is entitled to Tier 3 benefits for so long as the member is not in gainful employment, up to a maximum of three years from the date the member left the employment."

59. "Gainful employment" was defined as "paid employment for not less than 30 hours in each week for a period of not less than 12 months". "Permanently incapable" was defined as "more likely than not, be incapable until at the earliest, the member's normal pension age".

60. Regulation 36:

> "(1) A decision as to whether a member is entitled under regulation 35 (early payment of retirement pension on ill-health grounds: active members) to early payment of retirement pension on grounds of ill-health or infirmity of mind or body, and if so which tier of benefits the member qualifies for, shall be made by the member's Scheme employer after that authority has obtained a certificate from an IRMP as to -
>
> (a) whether the member satisfies the conditions in regulation 35(3) and (4); and if so,
>
> (b) how long the member is unlikely to be capable of undertaking gainful employment; and
>
> (c) where a member has been working reduced contractual hours and had reduced pay as a consequence of the reduction in contractual hours, whether that member was in part time service wholly or partly as a result of the condition that caused or contributed to the member's ill-health retirement.
>
> (2) An IRMP from whom a certificate is obtained under paragraph (1) must not have previously advised, or given an opinion on, or otherwise been involved in the particular case for which the certificate has been requested.
>
> (2A) For the purposes of paragraph (2) an IRMP is not to be treated as having advised, given an opinion on or otherwise been involved in a particular case merely because another practitioner from the same occupational health provider has advised, given an opinion on or otherwise been involved in that case.
>
> (3) If the Scheme employer is not the member's appropriate administering authority, it must first obtain that authority's approval to its choice of IRMP.
>
> (4) The Scheme employer and IRMP must have regard to guidance given by the Secretary of State when carrying out their functions under this regulation and regulations 37 (special provision in respect of members receiving Tier 3 benefits) and 38 (early payment of retirement pension on ill-health grounds: deferred and deferred pensioner members)."

61. Regulation 38:

"(1) A deferred member who, because of ill-health or infirmity of mind or body -

(a) becomes permanently incapable of discharging efficiently the duties of the employment that member was engaged in at the date the member became a deferred member, and

(b) is unlikely to be capable of undertaking gainful employment before normal pension age, or for at least three years, whichever is the sooner,

may ask to receive payment of a retirement pension whatever the member's age.

(2) A request under paragraph (1) must be made in writing to the deferred member's former Scheme employer or appropriate administering authority where the member's former Scheme employer has ceased to be a Scheme employer.

(3) Before determining whether or not to agree to a request under paragraph (1), the deferred member's former Scheme employer, or administering authority, as the case may be, must obtain a certificate from an IRMP as to whether the member is suffering from a condition that renders the member -

(a) permanently incapable of discharging efficiently the duties of the employment the member was engaged in because of ill-health or infirmity of mind or body; and, if so,

(b) whether as a result of that condition the member is unlikely to be capable of undertaking gainful employment before reaching normal pension age, or for at least three years, whichever is the sooner.

(4) …

(7) If the Scheme employer is not the deferred or deferred pensioner member's appropriate administering authority, it must obtain that authority's consent to the appointment of an IRMP under this regulation.

(8) An IRMP appointed under paragraph (6) may be the same IRMP who provided the first certificate under regulation 36(1) (role of the IRMP)."

Appendix 2

Medical evidence

Dr Perrin, registered osteopath and specialist in CFS, 1 February 2015

62. Dr Perrin began by explaining he had been involved in the treatment of patients with CFS since 1989. He provided details of his research projects and published articles.

63. Dr Perrin's report included a detailed statement from Ms N covering the development of her condition and her recent employment situation. Dr Perrin then provided details of Ms N's symptoms and the results of his examination. He concluded:

> "The patient's life is severely affected by the condition which have [*sic*] rendered her weak and in constant distress. At present, too much activity or any stress whatsoever even at home aggravates her condition.
>
> Unfortunately, [Ms N] is struggling to cope with her daily activities at home. She is receiving regular treatment to help her symptoms but although in time I feel she will recover and will be able to carry out household activities in the future, I cannot see a time when she will be able to cope with extra physical and mental stress of any work however minimal.
>
> Due to the length of time the patient has struggled to cope with work whilst her illness has continually worsened and due to the nature of her work, on balance of probabilities I cannot see a time in the future when [Ms N] would be healthy enough to return to work safely and without the chance of a recurrence of the present condition. Indeed in my professional opinion any future return to her present employment in any of the available positions, would place too much of a strain on the sympathetic nervous system, exacerbating the symptoms and she would most definitely be in a worse state of health than at present. The only option that I can advise to aid her long term recovery is to take early retirement and gradually build up her health and stamina over the next few years, and hopefully she will be able to enjoy some quality of life on her pension."

Dr Perrin, 28 August 2015

64. Dr Perrin's report took the form of answers to a series of questions. It reiterated the information provided in his previous report. With regard to "long-term illness", Dr Perrin said:

> "Due to the length of time the patient has struggled to cope with work whilst her illness has continually worsened, I consider [Ms N] to be permanently unable to carry out work of a similar nature to her contracted job. This is supported by the finding of The Chief Medical Officer's report on CFS/M.E (2002), which states that the prognosis for someone who has been severely affected for four years is that the illness is likely to be permanent. I concur with this finding …"

Dr Godlee, GP, 28 January 2016

65. Dr Godlee provided an open letter at the request of Ms N's solicitor in connection with a claim that Redbridge had failed to offer Ms N suitable employment conditions.

66. Dr Godllee set out a brief summary of Ms N's medical and employment history. He mentioned that Ms N had been on sick leave from April 2013 and had tried to return to work in July 2013 on a phased basis. Dr Godlee said Ms N's manager had initially refused to agree a phased return over seven weeks and had only agreed to five weeks. He noted that Ms N had begun to improve in December 2013 and her management had suggested reducing her hours. Dr Godlee noted that Ms N had taken out a grievance against her manager in 2014 and her hours were reduced. He said she went on sick leave in July 2014 and did not return. Dr Godlee noted that, in April 2015, Ms N had begun part-time bookkeeping from home and, in November 2015, she began working 22 hours per week for John Lewis. Dr Godlee said:

> "The issue at Redbridge was being offered full time work in a department where there were relationship management issues, and where CPD was lacking in the audit work. There was apparently no leeway on meeting [Ms N's] need to work less hours (22 hours) in a department away from auditing with a different manager. They did offer her to start at 11am but she would still have had to work full time."

67. Dr Godlee said Ms N was not capable of full time work but could have managed up to 25 hours per week.

Dr Gration, IRMP, 6 June 2016

68. Dr Gration said he had reviewed Ms N's occupational health file and related correspondence, including submissions from Ms N. He referred to the fact that Ms N had found alternative employment in the retail sector. He said he understood that she was undertaking a little under 30 hours per week of work and that her last work with Redbridge involved a similar number of hours.

69. Dr Gration said that the prognosis for conditions such as CFS was difficult; some people do extremely well and others do much less well in terms of recovery and/or management of their condition and symptoms. He said Ms N was familiar with the importance of pacing and graded activities and had been successfully implementing such approaches.

70. Dr Gration said he had been asked to give an opinion as to whether Ms N was permanently incapable of discharging the duties of her former employment for the purposes of the LGPS Regulations. He said, in his opinion, Ms N was not permanently incapable of such duties and gave the following reasons:-

    - Even though opinions had been given which suggested long-term incapacity, it would appear that Ms N had been largely working the sort of hours she had been with Redbridge.

- He understood there had been management matters and concerns which Ms N might have, which might be ongoing. Such matters impact on an individual, their condition and its management. It might not be until some time after such matters had been resolved that her condition might progress in a positive manner.

- Whilst noting the other opinions on Ms N's file, his impression was that her medical and occupational history, capabilities and adaptation gave encouragement for a good prognosis.

- He considered Ms N's faculties to be compatible with her former role and she would be capable of such work in the future; either at her current level, of just under 30 hours, or above.

- His opinion was unlikely to have been different if he had been considering Ms N's application whilst she was in employment because most of the reasons he had given would have been evident then.

Dr Perrin, 5 January 2017

71. In an open letter, Dr Perrin said Ms N had consulted his practice for specialist osteopathic treatment for CFS. He described Ms N's symptoms and said she was undergoing monthly treatment with a colleague. Dr Perrin said Ms N's activities on some days were still extremely limited; particularly after working for five and a half hours. He said CFS caused severe stress which was exacerbated by the likelihood that pushing herself would lead to relapse. Dr Perrin expressed the view that Ms N was not fit for part-time work at that time and that her continuation at work had compromised her health. He said Ms N would be at severe risk of further limiting her functional ability if she were to increase her activity at work.

Dr Gration, 30 May 2017

72. Dr Gration's further comments are summarised as follows:-

- Ms N had stated that, since April 2015, she had been doing some bookkeeping from home for an average of four hours per week. Since November 2015, she had been employed as a part-time sales assistant for an average of 21.93 hours over four days per week. She drove half an hour each way to a park and ride and took a bus which dropped her outside her place of work. He took Ms N's use of the word average to mean that her hours varied. Her indication of doing some 26 hours per week plus significant travel on four days led him to conclude that she was undertaking "a little under 30 hours per week".

- Ms N had said that she found work beneficial for her mental health but it increased her fibromyalgia symptoms. She had said this was because it was more physically demanding than a desk job but her manager had made adjustments for her so that she did not become over fatigued. Ms N was doing some 22 hours per week of physically demanding work plus four hours of more

sedentary work. This indicated that she was likely to be able to undertake a greater number of hours of less physically demanding work.

- The overall situation was different to the opinion offered by Dr Perrin in his 2015 report. Ms N's levels of work and activity appeared to be presenting more positive progress and prognosis than Dr Perrin had anticipated.
- His report had referred to management matters which other health professionals may not have been aware of. They were matters which an IRMP may need to consider when providing an opinion.
- His impression was that Ms N's former role was less physically arduous than her current sales assistant employment.
- While considering and respecting other professionals' opinions, with the passage of time and the benefit of some hindsight, he provided a considered opinion in June 2016. His opinion had not changed after undertaking a further review of Ms N's occupational health file.

Dr Williams, IRMP, 23 March 2018

73. Dr Williams set out in some detail the medical evidence relating to Ms N's case, including the reports from Dr Kennedy, Dr Perrin, Dr Godlee and Dr Gration, and Ms N's occupational health notes. Dr Williams included a general discussion on the background to and research into CFS.

74. With regard to Dr Perrin's work, Dr Williams referred to a quote from the ME Association's honorary medical adviser, Dr Shepherd, taken from its website. Dr Shepherd had said that he was not convinced that the scientific theory upon which Dr Perrin's treatment was based was correct. Dr Williams said he agreed with this and that Dr Perrin's opinion would not be within the normal range of expert opinion on CFS. He referred to a 2015 study in America, which he described as the most substantial recent review of evidence for CFS, and said this had not considered Dr Perrin's research.

75. Dr Williams' discussion of Ms N's case is summarised below:-

- The LGPS Regulations required an assessment by an occupational physician.
- The assessment required a prognosis for working capability to normal retirement age.
- The process required an objective assessment based on the facts of the case. A face-to-face assessment was not required. Medical assessments were based on the patient's overall history and not on how they felt on the day of examination. Clinical examination alone was not usually helpful and test/investigation results were generally the most useful sources of fact.

- Ms N presented with typical symptoms of CFS and fibromyalgia. These were not diseases, because there was no identifiable underlying pathology, but were conditions where the patient described troubling symptoms.

- Ms N gave a clear history of troubling fatigue from when she was a teenager. She had generally coped well with normal life despite episodes of troubling fatigue and symptoms of depression. When troubled by stress, Ms N was more likely to seek medical help with symptoms of fatigue and pain due to increased central sensitivity to symptoms.

- In his view, Ms N's symptoms were all problems of central sensitivity; apart from those linked to infections. The expectation would have been for a full recovery over time as before. Where such a recovery does not occur, it was important to look for barriers to recovery.

- One such barrier was sequential stressors, where full recovery had not been achieved before the next stressor was experienced. Prolonged stress could lead to suppressed immunity and increased anxiety. Suppressed immunity could lead to an increase in minor infections which a patient with increased central sensitivity was likely to be more aware of.

- Ms N had experienced a sequence of stressors. Dr Williams listed these, including Ms N's difficulty with the approach Redbridge had taken to her work. He commented that, had Redbridge been more supportive, Ms N may have settled down and made a full recovery in terms of returning to work. He noted, however, that Ms N's view of a supportive employer was not the same as Redbridge's. Dr Williams noted, in particular, Ms N's wish to be paid her full pay whilst working fewer hours and being allowed more time off than was provided for in Redbridge's policy.

- Dr Williams noted that Redbridge had expected Ms N to return to an audit role and relinquish some of her fraud work. He said Ms N had been reluctant to do this and that she felt she was not appropriately trained. He said he had no evidence in relation to the training needed or why Redbridge appeared to ignore this. Dr Williams suggested that it indicated that Ms N's adjustment disorder was worsened by her perception of Redbridge's attitude.

- From 2011 onwards, Ms N developed increasingly troubling symptoms of fatigue and pain. She identified the underlying problem as her increasingly dysfunctional relationship with Redbridge. Had Ms N been able to find an alternative role with another employer, the expectation would have been for a full recovery.

- Therapeutic intervention was a controversial area. CBT was almost universally recommended and Ms N had been receiving CBT. However, she may have received other input which prevented her from fully engaging with CBT.

- Pacing was often recommended; either as a treatment on its own or as a pre-cursor to graded exercise therapy (**GET**). GET was a process for progression after the patient had found a pacing level they could cope with. Ms N had not engaged with GET.

- Ms N had persisted with the Perrin technique, together with a variety of additional therapies. There was no clear scientific evidence to support any of them. There could be significant psychological harm in undertaking treatments of no value in cases of CFS. Relying excessively on the support of practitioners, family or friends had been shown to negatively affect recovery. There had been no discussion about Ms N stopping the Perrin technique. She had been receiving this treatment since 2011 and, over that time, her condition had worsened.

- Pain was clearly a major part of Ms N's presentation; in the form of fibromyalgia. There was good evidence that fibromyalgia was a condition of central pain sensitisation and central pain processing. There was good evidence that certain medication could have harmful effects. There were medications which had an evidence base for benefit. Ms N had tried one of these but at a high dose, which was likely to have side-effects in relation to cognitive function. There was a specific medication of benefit in fibromyalgia, which Ms N had not tried. With suitable adjustment to her medication, he would expect a significant improvement in Ms N's symptoms.

- Ms N described being troubled with migraine. This was known to be stress related, so a significant improvement would be expected when her stress was resolved. Migraine was also known to improve with age. Ms N was not taken any specific medication for migraine and there were a number of approaches known to substantially improve symptoms.

- The approach to considering an application for early payment of deferred benefits and for ill health retirement was much the same. An applicant had to be considered permanently unfit for their current or former role.

- Ms N's difficulties with her work were tied up with a progressive breakdown in her relationship with Redbridge. This was not a relevant factor. The question was whether or not Ms N could work in her former role and this did not include her relationship with specific individuals.

- Ms N described major disabling symptoms but was able to drive a significant distance, travel on a bus and work in retail. Ms N must appear to be functioning well when at work in order to perform her role with John Lewis. She must have reasonable cognitive function in order to drive a car and operate a till.

- There was a difference between Ms N's current work and her fraud work but this was not the role she was employed in. Audit work did not involve same the

tense interaction between individuals as with fraud work; it was a measured process involving paper and IT processes. It would require good cognition.

- Sitting for long periods might exacerbate Ms N's symptoms. As there was no pathological process underpinning her symptoms, sitting would not cause her harm. Ms N could clearly sit at times during the day and a role which was mostly sedentary would not harm her. She might feel stiff but people coped with this by moving regularly, standing, stretching and walking about. There was no reason why Ms N could not work in this fashion when undertaking audit work.

- Ms N had said she only worked shifts of around five and a half hours. However, she also coped with significant commuting each day. Her total hours, including commuting, represented around seven and a half hours each day she worked. The fact that Ms N could commute was relevant to considering her overall capacity for work. Ms N could physically work effectively for a full working day four days a week. She described her work as physically challenging and a more sedentary role would not be so physically challenging.

- It was important to recognise that a significant aspect of Ms N's ongoing symptoms was her dispute with Redbridge and the prospect of significant financial gain. Once this was resolved, a substantial improvement in her symptoms could be expected.

76. Dr Williams concluded:

"In my experience, an employee who is currently able to work four full days a week, and who would be expected to improve significantly with appropriate adjustments to her medication should cope four days a week in a more mentally challenging role. Furthermore, once the stress of the dispute with Redbridge has been resolved, she should improve to the point where she can manage five days a week in her former role. On balance of probabilities, I would therefore expect her to be capable of her former role of Senior Internal Auditor once all these issues have been resolved and her treatment has been optimised. It may well take a couple of years for this process to be complete, however she is currently aged 48 and has a couple of decades to go before normal retirement age. I note that Dr Perrin disagrees with this view, however his opinion given in 2015 was clearly incorrect and not borne out by subsequent events. His opinion given in 2017 is not supported by any factual evidence, whereas her past history would suggest she will cope much better.

Overall, in my opinion she not therefore permanently unable to work in her current role."