PO-26164

Ombudsman's Determination

Applicant	Mrs S
Scheme	HSBC Bank (UK) Pensions Scheme
Respondent	HSBC Bank Pension Trust (UK) Limited (the **Trustee**)

Outcome

1. I do not uphold Mrs S' complaint and no further action is required by the Trustee.

Complaint summary

2. Mrs S disagrees with the Trustee's decision to reduce her incapacity pension by 50%.

Background information, including submissions from the parties

Background

3. Mrs S injured her back falling from her horse in 1997. She retired on the grounds of incapacity in 1999 and has been in receipt of a pension since then. Mrs S' pension has been subject to periodic review since 1999. In 2017, Mrs S was notified that her pension would be reduced by 50% on the grounds that there had been an improvement in her condition. The pension was reduced gradually over a six month period.

4. The Scheme is currently governed by consolidated Trust Deed and Rules adopted by a deed of variation dated 30 April 2003. Rule 15 of the "General Rules" contains "Provisions relating to Incapacity Pensions – Pre 20.9.01 Retirements". Sub-paragraph (a) of Rule 15 provides:

> "… if a pensioner entitled to a pension under any of the said rule 2 recovers from his illness or disability to any extent before attaining pension age but does not re-enter pensionable service as defined in the relevant special rules the trustee may at any time or times thereafter but not after his attainment of state pension age and subject to preservation requirements suspend reduce or suspend and reduce his pension …"

5. Sub-paragraph (b) allows the Trustee to terminate the suspension or reduction of the pension at any time. Sub-paragraph (c) provides for the Trustee to require a pensioner to provide evidence of continued illness or disability and/or undergo an examination by a qualified medical practitioner named by it. The Trustee "may accept such evidence or a certificate by such practitioner that the pensioner has recovered from his illness or disability to any extent as conclusive evidence of such recovery".

6. In 2017, the Trustee commissioned a functional capability assessment in connection with its review of Mrs S' pension. This was carried out by a chartered physiotherapist, Mr Pearce. A copy of Mr Pearce's full assessment has been provided. A summary of and extracts from the report, together with other medical evidence relating to Mrs S' case, are provided in an appendix.

7. Prior to taking its decision to reduce Mrs S' pension, the Trustee referred Mrs S' case to its occupational health adviser, Dr Stoot. He advised there had been an improvement "to an extent of 2 out of 4" and suggested a review in three years' time.

8. Mrs S appealed the decision to reduce her pension. The Scheme operates a two-stage internal dispute resolution (**IDR**) procedure. At stage two of the procedure, Mrs S submitted a report by an occupational health physician, Dr Vivian (see appendix).

9. Dr Vivian's report was sent to Dr Stoot for comment. He responded on 3 August 2018. The Trustee's Appeals and Discretions Committee (the **Committee**) met to consider Mrs S' appeal. It considered, amongst other things, Dr Vivian's report and Dr Stoot's response. It upheld the decision to reduce Mrs S' pension.

10. In its decision letter, the Committee said it had been provided with all of the relevant medical information relating to Mrs S' case. It also mentioned that comments had been sought from Dr Stoot as to the points raised by Dr Vivian. The Committee noted that Mrs S had been in receipt of her pension for a significant period of time. It said it was required to consider:-

    - Whether it agreed that Mrs S had recovered to any extent between the date of her retirement and the date of the current review; and

    - If it did so agree, whether a 50% reduction in her pension was appropriate.

11. The Committee said it had decided that the medical reports did support the conclusion that Mrs S had recovered to an extent. It said this was on the basis that the information available from 1999 indicated that Mrs S would be unable to work for the foreseeable future; whereas the 2017 functional capability assessment suggested that she would be able to work on a part-time basis. The Committee said it considered it important to point out that it was only required to decide whether Mrs S had recovered "to any extent", which was a low threshold. It was satisfied that a comparison between the limited information from 1999 and the information from the current review indicated that there had been an element of recovery.

12. The Committee said it had then considered whether a 50% reduction to Mrs S' pension was appropriate. It said it recognised that Mrs S' condition did still impair her ability to work but concluded that the 50% reduction was reasonable on the basis that the medical reports indicated that she had the ability to work on a part-time basis.

Mrs S' position

13. Mrs S submits:-

- She has provided medical evidence throughout the review process which counters the Trustee's position. She was informed that only the original medical assessment and the latest assessment were considered.
- Recovery is determined as a return to a normal state of health, mind and strength; whereas improvement is determined as making or becoming better. She has not returned to her normal state of health to any extent. Therefore, the Trustee has not applied the rule correctly.
- She does not agree that the medical evidence supports the conclusions reached. The Trustee has not provided any medical evidence of an improvement in her medical condition.
- The Trustee's decision can be said to be perverse for the following reasons:-
  - Dr Stoot did not refer to any evidence for his assessment that her condition had improved by "2 out of 4".
  - It was merely Mr Pearce's opinion that she was able to manage her condition better. He acknowledged that he was unable to comment as to whether there had been any degree of improvement because it was the first occasion on which he had reviewed her.
  - The assessment that she is able to work for 20 hours per week is based on nothing other than her current ad hoc occasional two hours per week volunteering as a parent helper.
  - The Trustee did not consider any option other than reducing her pension by 50%.
  - There has been no change in her medical condition. It is identical to when ill health retirement was first granted.
- With regard to her ability to sit and stand for prolonged periods, both Dr Mathers in 1998 and Mr Pearce in 2017 reported this as half an hour, alternating between positions. Dr Mathers said she was unable to sit for any length of time. Mr Pearce said she preferred to alternate her sit and stand postures at regular intervals. She is unable to sit or stand without pain for any length of time and prefers to alternate between sitting and standing to try and

reduce the level of pain she experiences. This does not demonstrate a recovery.

- She has explained why she can no longer take pain medication. She now has to rely on her ability to take regular rest breaks. She had to stop taking pain medication after several years with limited results due to side-effects, including stomach problems, dizziness and nausea. The side-effects left her unable to function and bed ridden. Alternative treatments, such as acupuncture, have had no positive effect on her back pain. This is a detrimental change since 1999; not a recovery.

- The voluntary help she provides to the school is on a limited basis. It is a fully flexible arrangement for a maximum of two hours per week, term time only and when she is physically able. It is not every week.

- In 1999, Dr Kelly referred to her role requiring her to walk around and be on her feet. She said this would prove impossible. Dr Kelly also noted that, when her back pain flared up, her mobility was significantly impaired and that this happened approximately twice a month and lasted for up to a week. This is still the case and the criterion which should be applied in her case. The Trustee is manipulating a limited medical report to rewrite her medical past.

- Her comment regarding the negative effect of working on her and her care for her family has been taken out of context. She has learnt over the past 20 years how to adjust her life in order to manage her pain. Having tried several times to increase her activity levels, she has always ended up unable to function independently and housebound by pain. This has always had a detrimental effect on her and her family. This is the same as it was when she retired.

- The impact of increased levels of activity on her pain level and ability to function is the sole reason she is unable to return to work; not the care of her family. Her inability to work has always been based on her medical condition and nothing else. It is not based on prioritising caring for her family. It is incorrect to imply that it is a choice she has made.

- Dr Vivian was in receipt of all her medical records. This put him in a better position to comment on her current abilities than Dr Stoot; whom she has never met.

- With regard to the differences in assessment commented on by Dr Stoot, she had been told to complete the questionnaire by reference to a worst case situation. The physical tests were carried out while her pain levels were bad but tolerable. If it had been a worst case day, she would not have been able to attend the assessment.

- If debilitating pain levels render a person unable to walk unaided, dress themselves, drive or concentrate and they are unable to take pain relief for medical reasons, they would not be able to sustain regular work of 20 hours

per week. This is a medical fact; not just an opinion. No employer would tolerate erratic attendance and unreliable performance due to chronic health issues.

- The reduction in her pension amounts to £463.58 per month and has had a huge impact on her family's finances. This has caused much stress.

The Trustee's position

14. The Trustee submits:-

- It recognises that Mrs S has been in receipt of an incapacity pension for a significant period of time and its decision to reduce her pension was not taken lightly.

- The purpose of the review provision is to enable appropriate adjustments to be made to an incapacity pension in response to changes in the member's condition and circumstances. It is possible for the Trustee to reinstate a pension as well as reducing or suspending it.

- Its comparison of the medical evidence in 2017 with that from 1999 was carried out properly. The decision, that there had been an element of recovery in Mrs S' condition, is justified on the basis of this evidence. There are significant differences between her capabilities in 1999 and her capabilities in 2017. For example:

  In 1999

  - Mrs S took medication for her back pain, which built up during the day.
  - On a good day she was unable to sit for more than 30 minutes.
  - When her pain flared up, her mobility was impaired and she had significantly impaired mobility lasting up to a week. This happened approximately twice a month.
  - She could only drive short distances.

  In 2017

  - Mrs S preferred to alternate her sit and stand postures at regular intervals; for example, half hourly.
  - She was said to be basically able-bodied for most normal, light or ergonomically modified everyday activities and demonstrated functional abilities compatible with attendance at an office-type workplace.
  - She offered voluntary help at a local school for light administration activities one afternoon per week.

- She had stated that she would be unable to sustain work in a meaningful regular capacity and that the major obstacle would be the potential negative impact on her care for her family.
- She was not taking any medication to manage her condition.

- Mrs S' disagreement with the decision does not mean that it was incorrect.
- It considered Dr Vivian's report carefully. When faced with conflicting medical opinion, it is for the Trustee to determine what the position is. The objective assessment from the evidence as a whole was that there had been an improvement in Mrs S' condition. This was evidenced by changes in her ability to sit and stand for prolonged periods, a change in medication and her undertaking voluntary work.
- It followed the proper legal principles in exercising its discretion to reduce Mrs S' pension. All relevant information has been taken into account and no irrelevant factors have been considered. Considering the medical reports as a whole, it considers the decision to reduce Mrs S' pension by 50% was reasonable and appropriate.
- The reports indicate that Mrs S is capable of managing her condition such that she could work part-time. In view of this, a 50% reduction was reasonable.
- It provided the following reasons for its decision:
  - In its letter of 23 May 2017, it said: "After due discussion the Committee concluded that although there has been a recovery to an extent, it was not a full recovery because Dr Stoot had advised his rating as 2 out of 4, with 4 being a full recovery. As a result of this the Committee decided to reduce [Mrs S'] pension by 50%".
  - The IDR stage one letter said: "The Committee determined that [Mrs S] had not made a full recovery, but [she] had made some recovery such that a phased return to part-time employment would now be possible when it was not previously. Accordingly, the Committee considered it appropriate to reduce [her] ill-health pension by 50%".
  - The IDR stage two letter said: "the Committee concluded that a reduction of 50% was reasonable in the circumstances and reflected the fact that the medical reports indicated that [Mrs S] had the ability to work on a part-time basis".

15. It disagrees that it should have taken Mrs S' work/life balance into account. The purpose of an incapacity pension is to provide a pension when the member's medical condition prevents them from working. If extraneous factors, such as a member's preference for caring for their family or to have a different work/life balance, were taken into account, it could lead to unintended consequences. For example, it might result in members with the same capacity for work having their pension reduced by

different percentages because one is prepared to work rather than prioritise caring for his/her family.

Adjudicator's Opinion

16. Mrs S' complaint was considered by one of our Adjudicators who concluded that no further action was required by the Trustee. The Adjudicator's findings are summarised below:-

- Trustees and other decision-makers must apply the law and the relevant scheme rules correctly.
- Rule 15(a) provided the Trustee with the power to suspend or reduce or suspend and reduce a member's pension if s/he "recovers from his illness or disability to any extent before attaining pension age".
- Mrs S had suggested that the term "recovers from" meant that her pension should only be reduced or suspended if she had returned to her normal state of health, mind and strength. By this, the Adjudicator took her to mean a return to the state of health she enjoyed before her 1997 accident. However, Rule 15(a) referred to the member having recovered "to any extent". This indicated that the member need not have experienced a full recovery before the Trustee might consider whether or not it would be appropriate to reduce or suspend the pension. In the Adjudicator's view, the Trustee had correctly interpreted the Rule in saying that it was required to determine whether Mrs S had recovered to any extent.
- Determining whether Mrs S had recovered to any extent was a finding of fact; that is, it was a decision based upon an assessment of the facts of the case. Rule 15(c) provided for the Trustee to accept evidence from a qualified medical practitioner "that the pensioner has recovered from his illness or disability to any extent as conclusive evidence of such recovery". The Trustee obtained evidence from Mr Pearce and Dr Stoot; both of whom were qualified medical practitioners.
- Although Rule 15(c) provided for the Trustee to accept the evidence it obtained from a qualified medical practitioner as conclusive, it should not do so blindly. In the Adjudicator's view, the Trustee would still be expected to review the medical evidence in order to determine whether it was appropriate. As a minimum, the Trustee would be expected to satisfy itself that there had been no error or omission of fact on the part of the medical practitioner. It would also need to ask itself whether or not the medical practitioner had addressed the relevant question(s). The Trustee should consider also whether the medical practitioner was qualified to give the opinion s/he had done. For example, it should satisfy itself that the practitioner had not strayed outside his/her area of expertise.

- In the Adjudicator's view, the evidence did indicate that the Trustee had actively reviewed the medical evidence relating to Mrs S' case. It did not simply accept Dr Stoot's advice. In particular, the evidence indicated that the Trustee was prepared to consider the evidence put forward by Mrs S; namely, Dr Vivian's report. It had also asked Dr Stoot to comment on Dr Vivian's report before reviewing Mrs S' appeal.

- Having reviewed the reports prepared by Mr Pearce and Dr Stoot, the Adjudicator said she had not identified any reason why the Trustee should not have relied on these reports in reaching its decision. She acknowledged that there was clearly a difference of opinion between Mr Pearce and Dr Stoot, on the one hand, and Dr Vivian, on the other. However, a difference of opinion between medical practitioners was not usually sufficient for the Ombudsman to ask a decision-maker to review a decision. The Trustee was not expected to challenge a medical opinion. It was required only to review the medical reports from a lay perspective; as would the Ombudsman. So far as their medical opinions were concerned, the medical practitioners were answerable to their own professional bodies.

- In Mrs S' case, the evidence from Mr Pearce suggested that she had become better able to manage her back pain; rather than there being an underlying change in her condition. Rule 15(a) referred to the pensioner having recovered from his/her "illness or disability". The reference to "disability" suggested that the Trustee should consider not only whether the pensioner had recovered from the condition in question but also whether there had been a change in the effect that condition had on the pensioner's capacity to work.

- The Trustee had compared Mrs S' reported capacity to undertake activities, such as sitting, standing and driving, in 1999 and 2017. In the Adjudicator's view, this was the correct approach for the Trustee to take. It concluded that Mrs S was capable of undertaking more activity in 2017 than she had been in 1999. This decision was supported by the evidence which was available to the Trustee at the time of its decision. In the Adjudicator's view, it could not be described as unreasonable or irrational.

- Once the question of Mrs S' recovery had been decided, the Trustee then had to consider whether to reduce or suspend her pension. This involved the exercise of a discretion. Rule 15(a) provided that the Trustee "may" reduce or suspend a pension; that is, it was not obliged to do so. The Trustee, therefore, had to come to a decision as to whether it was appropriate to exercise its discretion to reduce or suspend Mrs S' pension. In exercising its discretion, the Trustee could be expected to follow certain well-established principles. It must:-

  - Consider all relevant matters and ignore any irrelevant ones;

  - Ask the correct questions;

- Interpret the law and the Scheme Rules correctly; and
- Not come to a perverse decision.

- In this context, a perverse decision was one which no reasonable person could have reached on the facts of the case. There was often a range of decisions which would not be considered to be perverse. Where a decision related to the exercise of discretion, the Ombudsman may only consider whether the decision had been made in a proper manner; that is, in accordance with the above principles. He did not have to agree with the decision and he could not intervene simply because he thought the decision-maker could have reached a different decision.

- One of the specific obligations on the Trustee was to consider all relevant information which was available to it. In Mrs S' case, the Trustee had to consider that the evidence indicated that she would be capable of some part-time work. The evidence it received from Mr Pearce indicated that Mrs S would be capable of working for 20 hours per week, following a phased return to work over 12 weeks. This would equate to working for roughly 50% of normal working hours. The Adjudicator noted that Dr Stoot had referred to an improvement of "2 out of 4". The Trustee had stated that "4" would equate to a full recovery. On that basis, Dr Stoot could have been taken to mean that Mrs S had made a 50% recovery.

- The Adjudicator noted that Mr Pearce had referred to Mrs S' ability to work part-time was likely to be at the detriment of her ability to care for her family. His assessment of 20 hours per week appeared to be the maximum Mrs S was likely to achieve. Dr Stoot had said Mrs S' capacity to work needed to be "viewed within the context of the required activities of daily living, including her family responsibilities". The Trustee had argued that it was not required to consider this aspect of Mrs S' case. It had put forward the scenario of two members with the same capacity for work but only one of whom had family commitments. It had suggested the members might end up with different reductions to their pensions.

- The Adjudicator acknowledged that it could be argued that Mrs S' capacity to continue to care for her family was not a relevant matter in considering whether or not to reduce her pension. Arguably, Mrs S was in receipt of a pension to compensate for the fact that she was unable to work as a result of her condition. If she was able to work to some extent, then the rationale for paying her pension had changed. The Adjudicator also acknowledged that members should be treated fairly and equably. She commented that family commitments were not the only factors driving a healthy work/life balance. The Adjudicator noted Dr Stoot's reference to "activities of daily living" which would apply to all members and which would affect their quality of life.

- Had the Trustee decided to take account of the impact that working for 20 hours per week was likely to have on the quality of Mrs S' life, the Adjudicator was of the view that it would not have been criticised for that. Having said that, the Trustee's decision to base its reduction of Mrs S' pension on the numerical ratio of her maximum capacity for work to an average full-time position could not be said to be perverse. It was within the range of possible decisions which could have been reached on the facts of the case.

17. Mrs S did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mrs S 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 Mrs S for completeness.

Ombudsman's decision

18. Rule 15 requires the Trustee to undertake two actions:-

    - To determine whether or not Mrs S has recovered from her illness or disability to any extent; and

    - To decide whether or not to suspend or reduce her pension.

19. The first of these is a finding of fact. The second is a discretionary power.

20. Rule 15 allows the Trustee to require a pensioner to provide evidence of continued illness or disability and/or to undergo an examination by a qualified medical practitioner. In Mrs S' case, the Trustee arranged for her to attend a functional capability assessment by Mr Pearce, a specialist physiotherapist. It also sought advice from Dr Stoot, a consultant occupational physician. These were appropriate sources of the type of evidence which the Trustee required in order to determine whether Mrs S had recovered to any extent.

21. Mrs S disagrees with the conclusions drawn by Mr Pearce and Dr Stoot. So far as their medical opinions are concerned, it is the case that neither Mr Pearce nor Dr Stoot come within my jurisdiction. They are accountable to their own professional bodies. The question for me is whether there was any reason why the Trustee should not have relied on either report in coming to a decision. The kind of reasons I have in mind are errors or omissions of fact or a misunderstanding of what they were being asked to assess.

22. Mr Pearce came to the conclusion that Mrs S would be able to work for up to 20 hours per week, following a phased return to work. This was based on his face-to-face assessment of Mrs S' capabilities and the results of certain tests she underwent on her visit to him. Mrs S disagrees with Mr Pearce's conclusions but she has not pointed to any error of fact on his part. For example, Mr Pearce referred to Mrs S volunteering at a school for one afternoon per week, which is not inconsistent with her own report of two hours per week during term time. Mr Pearce commented on the fact

that Mrs S was not taking pain medication. Mrs S has explained that she had adverse reactions to the pain medication she had been offered. This was noted by Mr Pearce.

23. Having reviewed Mr Pearce's report, Dr Stoot advised the Trustee that there had been an improvement in Mrs S' capacity for work. Mrs S disagrees that there has been any improvement in her condition. In particular, she points out that she had been assessed as unable to sit for more than half an hour in 1999 and this was the same in 2017.

24. Mrs S argues that Dr Stoot failed to refer to any evidence in support of his conclusion. Dr Stoot came to his conclusion on the basis that, in 1999 and 2013, Mrs S had been considered unfit for work and she was now considered capable of working with appropriate adjustments. His advice is not inconsistent with the available evidence. For example, in 1998, Dr Mathers had said Mrs S had difficulty driving and was restricted to local journeys of approximately 10 to 15 minutes; in 2017, Mr Pearce reported that Mrs S managed to drive most days for up to 10 to 15 minutes and could travel as a passenger for up to an hour.

25. Mrs S provided the Trustee with an alternative opinion from Dr Vivian. Again, Dr Vivian did not point to any factual error on the part of Mr Pearce or Dr Stoot; rather, he disagreed with their interpretation of the facts. The Trustee considered Dr Vivian's advice but gave greater weight to the advice it received from Mr Pearce and Dr Stoot. The weight which is attached to any of the evidence is for the Trustee to determine, including giving some of it little or no weight[1]. In the absence of any factual error or misunderstanding by Mr Pearce or Dr Stoot, it was open to the Trustee to prefer their advice. I do not find that it was maladministration for it to have done so.

26. Having determined that Mrs S had recovered from her disability to an extent, it was then for the Trustee to decide whether and to what extent it should exercise its discretion to suspend or reduce her pension. Because this is a discretionary power vested in the Trustee, the extent to which I may interfere in its decision is limited. I may not exercise the discretion myself and it is irrelevant whether I would have come to the same decision. I will confine myself to considering whether the Trustee followed the principles described by my Adjudicator.

27. I find that the Trustee did take all relevant matters into account, including evidence from Mrs S and Dr Vivian. There is no evidence that it took any irrelevant matters into account. I find that it asked the right question based on a correct interpretation of the Scheme Rules; namely, whether it would be appropriate to reduce or suspend Mrs S' pension. It then remains for me to consider whether the Trustee's decision could be said to be perverse. The benchmark for a perverse decision is set high; as might be expected. It is a decision which no other body, faced with the same set of facts and properly advising itself, could reach.

28. Mrs S has argued that the Trustee's decision to reduce her pension by 50% should be considered perverse. However, the reasons which she has put forward really go to

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

the question of whether she has recovered to any extent. I have already dealt with this. On the basis that the Trustee had determined that Mrs S had recovered to the extent that she might now undertake part-time work of up to 20 hours per week, its decision cannot be said to be perverse. It falls within the range of possible decisions which might be made on the facts of her case.

29. I do not uphold Mrs S' complaint.

Anthony Arter

Pensions Ombudsman
20 November 2019

Appendix

Medical evidence

Dr Mathers, GP, 12 June 1998

30. Dr Mathers reported that Mrs S had been reviewed by a consultant orthopaedic surgeon, who had advised that the compression fracture she had sustained in her fall had healed but that there was some displacement. He said Mrs S had been referred to a pain clinic. Dr Mathers said Mrs S was using co-codamol as a simple analgesic and used ibuprofen periodically.

31. Dr Mathers said Mrs S had been given exercises to do by a physiotherapist but found these difficult to perform when experiencing a flare-up of her back pain.

32. Dr Mathers said Mrs S reported experiencing a constant dull backache which built up during the day. He said the pain was at its maximum on the right, radiating to Mrs S' right buttock, and she experienced 'pins and needles' in this area. He said Mrs S also experienced periodic stabbing pain and the area was tender to the touch. Dr Mathers said Mrs S was unable to sit for any length of time; half an hour on a good day. He also said she was unable to stand or lie for any length of time. He said Mrs S experienced flare-up approximately twice a month lasting up to a week. Dr Mathers said Mrs S had difficulty driving; particularly getting in and out of the car, twisting to see behind and leaning forward. He said she was restricted to local journeys of approximately 10 to 15 minutes.

33. Dr Mathers expressed the view that Mrs S would not be able to perform her current duties or those of a suggested alternative role because they involved sitting for considerable periods of time, lifting and bending. He said the treatment options were for Mrs S to continue with exercises to strengthen her back and medication. Dr Mathers said it was hoped that, with the passage of time, Mrs S would experience a reduction in discomfort and improved mobility. He suggested a review in two to three years.

Dr Kelly, occupational health physician, undated

34. Dr Kelly noted that Mrs S had been referred for x-ray and a specialist's opinion. She noted that Mrs S had been advised that surgery was not possible and that she would have to adjust to living with a permanent disability. She said Mrs S had been referred to a pain clinic.

35. Dr Kelly said Mrs S experienced a constant dull backache, which built up during the day and for which Mrs S took medication. She said Mrs S was unable to sit for longer than half an hour and found it difficult to stand for any length of time. Dr Kelly said Mrs S' job entailed walking around and being on her feet, which would prove impossible. She said, when Mrs S' pain flared up, her mobility was significantly impaired and this happened approximately twice a month for up to a week. Dr Kelly said driving was restricted to local journeys. She concluded by saying an

occupational health physician had said that there would be no significant recovery for two to three years.

Mr Pearce, specialist functional assessor, 7 February 2017

36. In his report, Mr Pearce said he had been asked to assess:-

- Mrs S' current status, including diagnosis and clinical findings;
- Residual clinical difficulties or vulnerabilities;
- Current treatment, medication, physiotherapy, specialist review, etc.;
- Functional impact of any physical problems, including the impact of any difficulties on Mrs S' activities of daily living;
- Employment status;
- Prognosis;
- Capability for work and to include what type of work, hours, etc.;
- His opinion on the degree of improvement, if any.

37. Mr Pearce said Mrs S had clinical signs of a low back impairment with much reduced function. He said Mrs S reported significantly less than normal tolerances to sustained postures and preferred to alternate sit and stand postures regularly. He noted that Mrs S' body dexterity was reduced and she used adaptive behaviour, such as use of long-handled tools or a grabber and squatting. Mr Pearce said Mrs S had reported that her symptoms were least restrictive in the morning and gradually worsened over the day. He said:

> "Nevertheless, with the reported good pacing of activity and by avoiding aggravating activities, [Mrs S] stated that she has learned to manage the back problem better and functions basically on a daily basis, and in fact is an effective carer for her young family (and for her husband who was recently taken ill …)."

38. Mr Pearce said Mrs S had reported that she was not employed in any capacity but offered occasional voluntary help at a local school for "light admin type activities". He said Mrs S had stated that she would not be able to tolerate working in a meaningful capacity because it would impair her ability to perform caring duties for her family. He said:

> "Based on the history of ADLs and today's FCA performance [Mrs S] is basically able-bodied for most normal, light or ergonomically modified everyday activities, and demonstrated functional abilities today that were compatible with attendance at an office type workplace for such duties."

39. Mr Pearce noted that Mrs S had stated that, if she were to work, this would be at the expense of her domestic responsibilities because she could not manage both. He said, unless Mrs S received successful spinal surgery, which had been discounted at this stage, she was likely to remain at her current functional level for the foreseeable future. Mr Pearce concluded:

> "In conclusion, [Mrs S] reports a significant back problem which results in symptoms and a restriction of her functional activities, and her condition is unlikely to be compatible with sustained, reliable full time employment in a meaningful capacity. In my view [Mrs S] would however currently qualify (from the physical demands perspective) for part-time (20 hours per week, e.g., for mornings) modified work …"

40. Mr Pearce provided details of his interview with Mrs S. He reported that Mrs S had said that the major issue was the low back pain which had been ongoing since fracturing her lumbar vertebra. Mr Pearce reported that Mrs S had said she had learned to cope with the issue better but her level of disability had remained at around the same level for at least seven years. He said Mrs S had reported a slight worsening after her last childbirth. Mr Pearce said Mrs S had reported being able to perform most normal everyday activities but had to plan and pace her activities. Mrs S had estimated her abilities as 20% of her pre-accident fitness.

41. Mr Pearce noted that Mrs S reported a near constant ache with periodic worsening and worsening during the day. He said her acute days were associated with spasms in her back, which she walked off slowly. He noted Mrs S had not had any recent housebound days and managed to drive on most days. Mr Pearce said Mrs S was not taking any routine medication for the pain and noted that she had reported being intolerant of codeine and other pain medication. He noted that a TENS machine had made Mrs S nauseous.

42. Mr Pearce said Mrs S had reported managing her ADL/personal care independently and that she was able to perform light household chores and shopping; carrying small light bags one at a time. He said she did not garden but did walk to the school and with her dog. He said Mrs S was able to drive for up to 10 to 15 minutes in an automatic car and could travel as a passenger for up to an hour.

43. In response to the request for an opinion on the degree of improvement, Mr Pearce said it was difficult to comment because this was the first time he had reviewed Mrs S.

Dr Stoot, occupational health physician, 8 March 2017

44. Dr Stoot said the functional capability assessment indicated that Mrs S was capable of work with adjustments. He expressed the view that there had been an improvement in Mrs S' condition of "2 out of 4" and suggested a review in three years.

45. Dr Stoot noted that Mrs S had last been reviewed in 2013 and, at that time, it was considered that there had been no improvement. He said Mrs S continued to

demonstrate the clinical signs of low back impairment; particularly, an inability to sustain a static posture. He noted that Mrs S needed to change her posture every half hour and there was a loss of body dexterity. Dr Stoot said:

> "Overall the examining Clinician believes that she is able-bodied for most activities of daily living provided care is take with regard to ergonomic arrangements.
>
> … This assessment indicated that she in fact capable of undertaking work and specific recommendations are given in that regard. This therefore does represent a change from being unfit for work to now being fit for some work. Equally though it does need to be recognised that she does have some residual disability.
>
> … It is apparent that this lady has improved to an extent and that she could now be considered for work with appropriate adjustments in place …"

Mr Pearce, 24 November 2017

46. Mr Pearce said, were it not for reported family commitments, Mrs S could typically be at an office-type workplace or work from home, other than for occasional acute days. He noted that Mrs S had reported that she was not generally housebound, could drive and did not take pain medication. Mr Pearce referred to Mrs S' voluntary work on one afternoon per week and that she walked to the school and with her dog. He said she was confident in her ability to be safely at a workplace, at least in part. Mr Pearce said:

> "[Mrs S] stated she would be unable to sustain work in a meaningful regular capacity, and the major obstacle would be the potential negative impact on her and care for her family due to the reduced tolerance to function, i.e. work would reportedly likely reduce her capacity for her other daily functioning, or similarly, [Mrs S] said that if she were working this would be at the expense of her domestic responsibilities , and said that she could not manage to do both, i.e., it was "one or the other".
>
> I do not personally disagree with [Mrs S'] comments here, but this also indicates that if she did not have family commitments, she could likely 'be at a workplace' which is what the functional daily profile produced via the FCA also indicates. Therefore, the primary obstacle to work may perhaps be regarded as family or domestic commitments or responsibilities, not lack of 'functional abilities'. However, the FCA report is clearly not concluding that [Mrs S] is employable (although she currently manages voluntary work)."

Dr Vivian, occupational health physician, 8 May 2018

47. Dr Vivian said he had undertaken a paper review. In his report, he set out a summary of the medical reports dating from 1997 to 2017, including those obtained in connection with previous reviews.

48. Dr Vivian said that the "nub of this case is whether there has been an improvement in [Mrs S'] condition, allowing a return to part-time work". He then set out why he disagreed with the opinions expressed by Mr Pearce and Dr Stoot. With regard to Dr Stoot's opinion, Dr Vivian said he had formed the opinion that Mrs S was fit with limitations and viewed this as a change. He said Dr Stoot had not explained what change he had seen. He expressed the view that the functional capability assessment had not demonstrated a significantly different position to that outlined in previous medical reports. With regard to Mr Pearce's report, Dr Vivian said:-

    - He had not answered the question of degree of improvement.
    - He had said Mrs S would need to alter her position regularly at work but had not made a convincing case that she could provide regular and efficient service.
    - He had failed to consider the fluctuations in Mrs S' symptoms during the day and between days or the flexibility of her current voluntary work.
    - He had proposed a 12-week return to work plan but did not provide a justification as to how Mrs S would cope with this.
    - His opinion could equally well have been expressed at the start of Mrs S' incapacity as now. This did not amount to a change.
    - His opinion did not reflect the facts of the case.
    - He did not provide any research evidence to justify his opinion and his assumptions were unrealistic.
    - He had expressed surprise that Mrs S was not on pain medication but she had provided an explanation for this; namely, she experienced side-effects which were more intrusive than the pain.
    - He appeared to be unaware of the limitations of pain medication.

49. Dr Vivian said Mrs S demonstrated an ability to carry out daily activities and there was extensive evidence of her having to modify and pace her activities with no suggestion of significant improvement over time. He expressed the view that the functional capability assessment had not demonstrated an improvement in Mrs S' ability. He also expressed the view that functional capability assessments were generally held to be unreliable and cited a 2003 book. Dr Vivian said he did not recommend individuals undergo functional capability assessments.

50. Dr Vivian said it was not clear what the cause of Mrs S' pain was; that is, whether it was physical or a combination of physical and psychological. He expressed the view that all the medical interventions for back pain were broadly ineffective, including surgery, injections, medication, hands-on manipulation and acupuncture. He said it was no surprise, therefore, that Mrs S had seen no improvement. Dr Vivian said up to 10% of individuals with a wedge fracture would experience long-term pain with no

realistic chance of improvement after two years. He also said there were few if any benefits to be derived from attending a pain management programme.

51. Dr Vivian concluded:

> "[Mrs S] … sustained a wedge fracture of her lumbar spine when she was thrown off a horse in 1997 …
>
> In January 2017, she underwent a functional capacity evaluation. The physio assessor formed the opinion that she could return to part-time work after a 12-week phased return. He did not state that her condition had improved. I do not agree with his interpretation of the facts, and do not believe his opinion regarding work is reliable.
>
> In March 2017, Dr Stoot formed the opinion that a significant change had occurred. In my opinion, his reasoning is flawed: what has actually taken place is that a professional has provided a different interpretation of the facts. There is no evidence of significant change, and I do not agree that she is fit to work in any meaningful capacity. Given the passage of time, this is a permanent restriction."

52. Dr Vivian said he was willing to respond to respond to any observations Mr Pearce and Dr Stoot might have. He then referred to a recent court case which had found that police officers were entitled to a degree of finality in respect of their entitlement to pensions. Dr Vivian suggested that the same should apply to other pensioners.

Dr Stoot, 3 August 2018

53. Dr Stoot expressed the view that Dr Vivian's report did not provide any new medical evidence; rather, it was a critique of the assessment process and the opinions derived from this.

54. Dr Stoot acknowledged that Mrs S had an ongoing disability as a result of chronic low back pain following her spinal fracture. He said the functional capability assessment had been carried out by a specialist who was more qualified to perform such an assessment than an occupational health physician. Dr Stoot said he would, therefore, defer to the specialist's opinion.

55. Dr Stoot noted that, in 1999, Mrs S was found to be unfit for work for the foreseeable future; whereas the functional capability assessment had found her able to do part-time work. He expressed the view that this was a significant change in Mrs S' functional capability. Dr Stoot noted that there was limited information from the time of Mrs S' retirement and that this made forming an opinion difficult. He said it was interesting to note that Mrs S had said that she would be able to work if it were not for her domestic responsibilities. He also noted there had been changes in Mrs S' function when distracted.

56. Dr Stoot said he would not be willing to change his opinion at that stage. He concluded:

> “My view overall is that we have an unfortunate situation of an individual who has developed chronic pain as a result of a spinal fracture. She is capable of limited work but that would need to be viewed within the context of the required activities of daily living, including her family responsibilities.
>
> Therefore, in terms of reviewing this case I would recommend that the Discretions Committee considers this conflict. That is not something I can advise on, rather it is for the Committee to determine what level of influence this should have on the review process.”