PO-6655

Ombudsman’s Determination

Applicant	Mr L McLachlan
Scheme	Local Government Pension Scheme (**LGPS**)
Respondent(s)	Winchester City Council (**WCC**)

Complaint summary

Mr McLachlan has complained that he has not been awarded tier 1 benefits under regulation 20 of the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007.

Summary of the Ombudsman's Determination and reasons

The complaint should be partly upheld against Winchester City Council because they failed to explain their decision to Mr McLachlan and failed to notify of his option to appeal.

Detailed Determination

Material facts

1. The regulations which applied at the date of WCC's first decision not to award ill health retirement were the Local Government Pension Scheme (Benefits, Membership and Contributions) Regulations 2007 (SI2007/1166) (as amended). Regulation 20 stated,

   "If an employing authority determine …

   (a) to terminate his employment on the grounds that his ill-health or infirmity of mind or body renders him permanently incapable of discharging efficiently the duties of his current employment; and

   (b) that he has a reduced likelihood of undertaking any gainful employment before his normal retirement age,

   they shall agree to his retirement pension coming into payment before his normal retirement age in accordance with this regulation in the circumstances set out in paragraph (2), (3) or (4), as the case may be."

2. The term "permanently incapable" was defined as "more likely than not, be incapable until, at the earliest, his 65th birthday". The term "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".

3. Paragraphs (2), (3) and (4) provided for the member's pension to be enhanced, depending upon the level of his/her incapacity for 'gainful employment', and correspond with the three 'tiers' of benefit as follows:

   Tier 1 (paragraph 2) "no reasonable prospect of his being capable of undertaking any gainful employment before his normal retirement age"

   Tier 2 (paragraph 3) "although he is not capable of undertaking gainful employment within three years of leaving his employment, it is likely that he will be capable of undertaking any gainful employment before his normal retirement age"

   Tier 3 (paragraph 4) "he will be capable of undertaking gainful employment within three years of leaving his employment"

4. Paragraph (5) of regulation 20 stated,

   "Before making a determination under this regulation, an authority must obtain a certificate from an independent registered medical practitioner qualified in occupational health medicine ("IRMP") as to whether in his opinion the member is suffering from a condition that renders him permanently incapable of discharging efficiently the duties of the relevant employment because of ill-health or infirmity of mind or body and, if so, whether as a result of that

condition he has a reduced likelihood of being capable of undertaking any gainful employment before reaching his normal retirement age."

5. Mr McLachlan was employed by WCC as a surveyor. He went on long term sickness absence in April 2011.

6. Mr McLachlan was seen by a consultant occupational physician, Dr Smedley, on 7 July 2011, at WCC's request. Dr Smedley provided WCC with a report. She noted that WCC had asked for a prognosis for a return to work and for ill health retirement.

7. Dr Smedley said Mr McLachlan had ongoing symptoms and a modest impairment in mobility. She said he could walk safely with a stick but could not undertake prolonged walking, lift heavy objects or climb. She thought he would struggle with the full duties of his post; particularly the site visits. Dr Smedley said there would be some scope to rehabilitate Mr McLachlan into a sedentary office role in due course. She said investigation and treatment was still being considered and expressed the view that, with further medical input, Mr McLachlan's symptoms might improve to allow him better function and work ability.

8. With regard to ill health retirement, Dr Smedley said she would not be able to say that Mr McLachlan fulfilled the criteria for any of the three levels of ill health retirement. She said she would not be able to say he was permanently unfit for gainful employment until normal retirement age or for the next three years. She explained that this was primarily because of the scope for further medical input and a reasonably well preserved functional capacity for sitting, standing and walking in a controlled office environment.

9. Dr Smedley said Mr McLachlan might be able to consider a very slow rehabilitation with part time working and office based activities. She noted that Mr McLachlan was apprehensive about this and said she would like to discuss it further with his doctors.

10. On 18 January 2012, Mr McLachlan's union e-mailed WCC saying he had exhausted his sick pay entitlement and remained employed by them on zero pay. The union said it did not appear that Mr McLachlan had been considered for or received any formal decision on ill health retirement. Mr McLachlan wrote to WCC, on 23 January 2012, enclosing a copy of his MRI scan, which he said had been sent to them previously. WCC acknowledged Mr McLachlan's letter by e-mail and said the information had been sent to Dr Smedley and she had been asked to look at the ill health retirement option.

11. On 30 January 2012, Mr McLachlan's GP wrote an open letter. He said Mr McLachlan was suffering from L5 nerve root entrapment and described the medication he was taking. The GP said Mr McLachlan was unable to work for the foreseeable future and he had issued a certificate for three months.

12. Having not received a response to their earlier e-mail, Mr McLachlan's union followed this up on 1 and 23 March 2012. On 20 March 2012, Mr McLachlan's consultant neurosurgeon, Mr Nader-Sepahi, wrote to Dr Smedley at Mr McLachlan's request. He

said Mr McLachlan had presented with the signs and symptoms of L5 nerve root entrapment. Mr Nader-Sepahi described the results of his examination of Mr McLachlan and of an MRI scan. He said he had offered Mr McLachlan an operation and also the option of an injection. Mr Nader-Sepahi said Mr McLachlan had opted for the injection and had reported his lower back pain had settled and he had no more leg pain. He said Mr McLachlan continued to take medication on a regular basis. Mr Nader-Sepahi said, because of the medication and ongoing mild weakness in his left foot, it would not be safe for Mr McLachlan to climb ladders. He said Mr McLachlan had not tried stopping his painkillers to see if he could manage without and did not wish to consider an operation whilst his pain was controlled by the painkillers.

13. In a subsequent letter, Mr McLachlan informed Mr Nader-Sepahi that he had missed his medication on one occasion accidently and had found his leg seized. He explained he had reduced the dosage but found he still needed an extra dose from time to time. He asked Mr Nader-Sepahi to notify Dr Smedley. Mr McLachlan then explained he had declined surgery because of the risk of paralysis and the possibility that it might accelerate the rate at which his spine was degenerating.

14. Dr Smedley wrote to WCC, on 27 April 2012, saying she had carried out a full medical assessment and review of Mr McLachlan's case. She said Mr McLachlan was fit to rehabilitate back into an adjusted role as an Area Surveyor. She expressed the view that he did not meet the criteria for ill health retirement.

15. Dr Smedley said Mr McLachlan had back pain caused by a prolapsed disc. She said the prognosis for this condition was that few patients required an operation and the majority were managed on painkillers. She said clinical guidelines suggested that patients be encouraged to remain as mobile as possible and to return to work, provided it was not of a heavy physical nature. Dr Smedley said Mr McLachlan's job was suitable for someone with his condition; it comprised a mixture of sitting, standing and walking, with no heavy lifting and little requirement for prolonged or repeated bending. She said she had had a long conversation with Mr McLachlan's line manager and understood the nature of his work.

16. Dr Smedley suggested a phased rehabilitation with gradually increasing hours. She suggested activities such as climbing ladders and scaffolding, heaving lifting and carrying, working with a bent posture, and driving for prolonged periods should be restricted. Dr Smedley noted that 50% of Mr McLachlan's work was office based. She said it comprised a mixture of sitting, standing and walking which was not dissimilar to the activities he undertook at home. She noted that Mr McLachlan's activities outside work included local car journeys, walking for up to an hour and transferring small items into a car. Dr Smedley said Mr McLachlan could walk safely with the aid of a stick and she thought it would be safe for him to enter clients' houses and inspect repairs. She concluded,

> "I have had a long discussion with Mr McLachlan today and I am aware that he does not necessarily agree with my opinion. He felt sure that he does not want to come back to work. I have explained that I do not make the final

> decision about ill-health retirement. However, I am not able to say that he meets the criteria at this time, as in my opinion he is not unable to carry out his original role provided appropriate adjustments are made and a rehabilitation is offered."

17. Following receipt of Dr Smedley's report, WCC wrote to Mr McLachlan requesting a meeting to discuss his return to work. They said they were following her advice and could not support his request for ill health retirement. Mr McLachlan suggested his post be deleted and replaced with a training post, thereby making his post redundant. WCC said this had been considered in the past but there was not a business case for doing so. They said they were happy to accommodate all of Dr Smedley's recommended adjustments to his post.

18. Mr McLachlan submitted an appeal under the internal dispute resolution (**IDR**) procedure. WCC sought advice from a consultant occupational physician, Dr Johnson. He provided a report on 24 September 2012. Dr Johnson said he had reviewed Dr Smedley's report and that from Mr Nader-Sepahi. He said the initial issue to consider was whether Mr McLachlan was permanently incapable of continuing his employment; that is, whether his medical condition could be considered permanent and whether his incapacity restricted his continuation of his occupation.

19. Dr Johnson noted that Ms McLachlan had eight years to go to his normal retirement age. He said the clinical report indicated that Mr McLachlan had some residual limitations and referred to mild weakness in his right foot (Mr Nader-Sepahi had said it was the left foot). He noted that Mr McLachlan took strong painkillers and had not tried stopping taking them. Dr Johnson commented that it appeared that the greater part of the predicted limitations to Mr McLachlan's capacity was the result of the ongoing use of painkillers.

20. Dr Johnson noted that Mr McLachlan had been offered surgery but had declined it. He went on to say, in terms of the pension decision, no account could be taken of the possible outcome of future surgery where an individual had taken a reasonable decision not to undergo an operation, particularly where the chances of success were not high. He said it was reasonable to expect the individual to access other forms of reasonable treatment and to follow medical advice with regard to the use of medication.

21. Dr Johnson said he thought it reasonable to accept that the mild weakness in Mr McLachlan's left foot was permanent. He said there was no evidence that Mr McLachlan had attempted to control or reduce his painkillers. He said there was no evidence that Mr McLachlan had accessed a chronic pain service and it would be usual for him to be offered psychological therapy, such as CBT, where the ongoing pain and use of painkillers was not supported by clinical opinion. Dr Johnson expressed the view that Mr McLachlan's condition was not permanent in terms of the degree to which he was affected.

22. Dr Johnson said it appeared that Mr McLachlan might be restricted from some aspects of his job, but it did not appear that these were routine or fully essential. He noted that there had been no attempt to return to work, although a graduated return to work had been suggested by Dr Smedley. Dr Johnson concluded,

> "There is ample evidence to suggest that Mr McLachlan has more treatment options open to him that would be expected to improve his day-to-day capability. Given that the situation as it stands had merited a recommendation for a controlled return to work (which appears to be entirely reasonable from the information available) and that there is considerable hope of further improvement in terms of function either from treatment or through analgesia reduction, there is not persuasive evidence that Mr McLachlan is, in fact, unable to return to his role in the very near future. Indeed the only opinion that has suggested that he might not be so capable was his clinical specialist, who was working with the assumption that the current level of medication was necessary (though he implied it may not be) and with an expectation that the most demanding aspects of the role could not be modified in any way."

23. Dr Johnson said he was unable to conclude that Mr McLachlan met the "basic criterion" of permanent incapacity and he agreed with Dr Smedley's opinion. He then confirmed that he had not previously advised on Mr McLachlan's case and was not representing either WCC or Mr McLachlan.

24. WCC sent Mr McLachlan a copy of Dr Johnson's report with their IDR stage one decision. They noted that Dr Johnson was not of the view that Mr McLachlan was permanently incapacitated and that he agreed with Dr Smedley. WCC said, as a result, they could not support Mr McLachlan's appeal and continued to refuse his request for ill health retirement. They explained he had the right to appeal further.

25. Mr McLachlan's union submitted a stage two appeal and said they were arranging for Mr McLachlan to be assessed by an occupational health specialist.

26. Mr McLachlan was seen by Dr Crane on 7 November 2012. In his report, Dr Crane outlined Mr McLachlan's medical history and the results of his examination. He said Mr McLachlan had developed severe degenerative disc and facet joint disease in his lumbar spine. He acknowledged he was not an expert in orthopaedic surgery but said he thought surgery would be a challenge. He expressed the view that Mr McLachlan had taken an appropriate decision in postponing surgery. Dr Crane noted that Mr McLachlan had obtained some relief from steroid injections but said it would not be possible to continue these on a regular basis.

27. Dr Crane noted that Mr McLachlan's job required him to have overall responsibility for the organisation and overseeing of property inspections, evaluations and investigations. He noted that this would mean a considerable amount of site visiting. Dr Crane expressed the view that Mr McLachlan would be unsafe in these activities because of unevenness of terrain and the requirement to climb steps, stairs or

ladders. He also said he would have reservations about Mr McLachlan working in an office because of the risk of tripping. Dr Crane continued,

> "Dr Smedley has provided a view that rehabilitation is possible but that would require significant adjustment to the job so that it was essentially semisedentary and office-based. Unfortunately the degree of adjustment that would need to be made would throw significant burden onto other employees and there would also be considerable administrative rearrangement would be necessary. Furthermore any change that shifted all the site and visiting work to other employees might not be welcomed by them.
>
> Furthermore the assessment requires the occupational physician to determine whether the person is permanently incapable of discharging efficiently the duties of his normal occupation by reason of ill-health. This means that the assessment should be done against the individual substantive role and in this case my view is that Mr McLachlan is permanently incapable of discharging efficiently the duties of his job as property surveyor."

28. Dr Crane then went on to comment on Dr Johnson's report. He said Dr Johnson did not appear to take account of Mr McLachlan's work because he had not mentioned walking on uneven ground or ladders. Dr Crane said he did not think psychological treatment, such as CBT, was a realistic recommendation. He said Mr McLachlan had severe degenerative disease in his spine and there was no evidence that these treatments had any place in providing relief for physical symptoms, such as foot drop. He also thought the recommendation of referral to a pain clinic was unrealistic. Dr Crane said Mr McLachlan was already receiving high doses of analgesic and these would interfere with his ability to work safely and efficiently. He said Dr Johnson had not mentioned Mr McLachlan experienced sleep disturbance.

29. Dr Crane expressed the view that Mr McLachlan had no reasonable prospect of returning to his job (as defined in his job description) or securing alternative gainful employment before his expected retirement age. He noted that Mr McLachlan had said he was entitled to retire at age 60. Dr Crane said he supported Mr McLachlan's application for ill-health retirement and was prepared to sign a certificate at tier 1 level. He did sign a template certificate indicating that there was no reasonable prospect of Mr McLachlan being capable of obtaining gainful employment before age 65 (tier 1).

30. The second stage of the IDR procedure is considered by Hampshire County Council (**HCC**) (the administering authority). HCC acknowledged the stage two application and provided the union with details of the procedure to be followed. Amongst other things, HCC said the grounds of Mr McLachlan's appeal must be explained in full. They said Mr McLachlan's appeal appeared to be on health grounds and, if this was the case, asked that he provide consent for relevant medical evidence to be disclosed to their appeal panel. HCC said the LGPS prohibited decisions being made by employers or at stages one and two of the IDR procedure which would entitle a member to payment of ill health retirement benefits unless a doctor, who was

qualified in occupational health medicine and who had not dealt with the case before, certified that the member was (a) incapable until at least age 65 of doing the job for which they were employed, and (b) unlikely, because of their health, to find other gainful employment.

31. HCC's appeal panel met on 11 February 2013. Mr McLachlan was informed of their decision by letter dated 18 February 2013. HCC said the panel had considered Dr Crane's report and had heard from Mr McLachlan about the impact of his condition on his ability to perform his current duties. They said the panel had also considered Dr Johnson's report and that from Dr Smedley. They noted that Dr Smedley's report "was not a truly independent report".

32. HCC said the panel were concerned that Dr Crane's report was flawed because he had not referred to the statutory criteria for ill health retirement but had made reference to Mr McLachlan's "personal retirement date in accordance with the 85 year rule".[1] With regard to the certificate signed by Dr Crane, HCC said this was compliant with the regulations but the panel did not consider it to be adequate corroboration of the ill health position. They said the panel felt compelled to look beyond Dr Crane's report, and the defect therein, in order to form a view as to whether Mr McLachlan was eligible for ill health retirement.

33. HCC said the panel were of the view that Mr McLachlan was permanently incapable of performing the duties of his role. They went on to say the panel were unable to grant Mr McLachlan's appeal because his appeal sought a finding of entitlement to tier 1 benefits. HCC said the panel had not been satisfied that Mr McLachlan would be unable to undertake any gainful employment (as defined) before normal retirement age (which they said was 65 and not the earlier date). HCC said the panel felt unable to rely on Dr Crane's certificate when his report had relied on retirement at an earlier date. They said the panel's own assessment of the medical evidence was that Mr McLachlan was probably entitled to tier 3 benefits. HCC said the panel could not allow the appeal by substituting an outcome which was neither the basis upon which the appeal had been put nor appropriately certified. They considered there could be no award without a certificate in the terms of the award to be made and, since they did not have a certificate for tier 3 benefits, they could not make that award. HCC also said that the panel took the view that the relevant date for entitlement to benefits would be the date of Mr McLachlan's application (18 January 2012).

34. HCC said the panel's decision was to return the matter to WCC once further unequivocal evidence had been obtained and which addressed the inconsistency between Dr Crane's report and his certificate.

[1] This is a reference to a provision by which members, whose age and length of service add up to 85, may retire before the normal LGPS retirement age of 65.

35. Mr McLachlan contacted Dr Crane and sent him a copy of the appeal panel's decision. He asked if Dr Crane could provide clarification. Dr Crane responded by saying he thought he had completed the ill health retirement form correctly. He pointed out that the form itself referred to age 65.

36. On receipt of the stage two decision, WCC sought an opinion from another occupational health physician, Dr Gillibrand. She wrote to WCC, on 7 June 2013, outlining the actions she had taken thus far and saying she wished to raise some procedural points. Dr Gillibrand referred to Dr Smedley's assessments of Mr McLachlan. She noted that WCC had advised Mr McLachlan that his application for ill health retirement had been refused on the basis of Dr Smedley's opinions. Dr Gillibrand pointed out that Dr Smedley had seen Mr McLachlan on more than one occasion and was not acting as an IRMP, giving a formal opinion on ill health retirement. She said a second doctor should have been asked to advise on that point and went on to outline her understanding of the correct procedure under the LGPS regulations. In particular, Dr Gillibrand said her role, as IRMP, was to give an opinion but it was for WCC to determine the award of ill health retirement. She concluded,

> "In summary therefore, my role is to examine the medical evidence for permanent incapacity, to produce a comprehensive evidence based report which will take account of the medical evidence provided to date, the meeting with Mr McLachlan, and any other evidence from relevant sources. Although I will be providing a certificate in conjunction with the report, Winchester City Council will then need to make a decision on whether to award ill health retirement or not. The employer is entitled to take the views of a number of different parties into account, in this case, the previous occupational health advice given, the report I will provide, and the view of the Appeal Panel.
>
> In light of the fact that an IRMP was not appointed initially and no initial certification produced I am not clear as to why there was a decision to lead to a Stage One Appeal."

37. Dr Gillibrand provided her report on 8 July 2013. She explained she had taken Mr McLachlan's medical history from a consultation with him on 3 July 2013, his GP report, letters from Mr Nader-Sepahi, and previous occupational health correspondence. She provided summaries of the reports she had considered. In her note of her consultation with Mr McLachlan, Dr Gillibrand summarised his description of his duties. She said she had been told that approximately 60% of Mr McLachlan's work was carried out on site and could involve accessing properties through poorly maintained gardens and accessing loft spaces with a ladder. With regard to Mr McLachlan's symptoms, Dr Gillibrand noted (amongst other things) that he could sit for approximately 20 minutes, walk for approximately 25 metres without a stick, and rarely managed a good night's sleep. She noted that his ability to concentrate was much reduced and suggested this might be, in part, due to his medication.

38. Dr Gillibrand quoted regulation 20 (see above). She said there was much published evidence relating to low back pain associated with disc prolapse and referred to guidelines published by the Faculty of Occupational Medicine, the Royal College of General Practitioners, the Clinical Standards Advisory Group and National Institute for Health and Care Excellence. Dr Gillibrand said MRI scans had no predictive value for future back pain and the extent of the disc prolapse did not affect the outcome. She said the main recommendation was to remain active and it was not necessary to be completely free of pain before returning to work. Dr Gillibrand said,

> "I have explained to Mr McLachlan that taking account of the nature of his medical condition (disc prolapse with mechanical back pain) that the same condition can manifest itself in different ways in each individual. Therefore, although subjectively he reports a high level of symptoms and clearly has ongoing pain and persistent foot drop, objectively his tolerances are not measurable scientifically.
>
> The medical evidence would point to the fact that he has a manageable medical condition providing there is a robust approach, following the recognised professional guidelines. The NICE Guidelines for the management of low back pain advocate the use of an intensive combined physical and psychological treatment programme which includes a cognitive behavioural approach and exercise. It advocates approximately 100 hours of a treatment programme over an 8 week period. This course of action has not taken place in Mr McLachlan's case and he has therefore not ha[d] the opportunity for the full range of treatment on offer. This is unfortunate because had there been pursuance of these forms of medical management at a much earlier stage, then I would have expected him to be in a position of being able to manage his condition more effectively. In applying the criteria laid down by the Local Government Pension Scheme Regulations it is expected that a full range of medical treatment would have been tried and this would include the comprehensive pain management and a cognitive behavioural therapy approach."

39. Dr Gillibrand noted that Mr McLachlan had requested pain management but it had not been pursued. She noted that a number of interventions had been tried early on but nothing since Mr McLachlan's second nerve block injection. She said it was unclear why he had not been referred to a specialist pain management clinic and said WCC may wish to take this into account in reaching their decision. Dr Gillibrand said Mr McLachlan had been very compliant with the treatment offered but she felt he had been let down by not having access to the additional services. She expressed the view that, had he been offered the additional services, he could have worked in an adjusted role and may even have been able to return to his current role.

40. Dr Gillibrand said,

> "My remit is to ensure that the medical recommendation regarding ill health retirement and accompanying certification takes full account of the LGPS Regulations 2007, and on this basis it would not be possible to state that Mr McLachlan would be permanently incapable of undertaking his role and that he has a reduced ability to undertake gainful employment before the age of 65. The main reason for coming to this conclusion is that he has not had access to the full range of treatment options available. On the basis of the medical evidence with regard to disc prolapse it would be expected that he would be capable of work. However, for the reasons I have stated above I would accept that without further intensive interventions he would find it very difficult to resume work at the present time."

41. Dr Gillibrand then went on the discuss Mr McLachlan's safety at work. She expressed the view that, had there been a more robust approach taken in managing his condition, she would have expected him to be able to undertake office based work. She said she understood there was a willingness on WCC's part to look at reasonable adjustments. She said,

> "In the medium term, Mr McLachlan may well regain the ability to undertake the more physical aspects of the role, particularly with a more intensive approach to pain management and physiotherapy. With the use of a foot splint, with time this enables individuals with foot drop to lift the foot up, reducing the risk of trips and falls. In view of Mr McLachlan's current age he may still find ladder work difficult but his walking ability should improve … From discussion with Mr McLachlan … the site work … is quite a significant part of the role. However, my understanding … is that consideration could have been made of altering the role, certainly on a temporary basis. There is no documented discussion of more permanent redeployment possibilities because at that time it was expected that with time he would be able to resume his contractual role.
>
> It is recognised that in spite of the stated evidence that there are some individuals who, despite intensive pain management, physiotherapy, and other medical interventions, may remain symptomatic and experience significant levels of disability. However, in order to reach a conclusion that on the balance of probabilities an individual is rendered permanently incapable of discharging efficiently the duties of their employment and have a reduced likelihood of being capable of obtaining gainful employment it would be expected that pursuance of a chronic pain management approach with access to therapy such as Cognitive Behavioural Therapy would have been undertaken. For reasons that are unclear the full range of treatment options have not been made available to Mr McLachlan although it is clear … that he has raised this with his GP …

> It should be noted that failure to return to work is not synonymous with permanent incapacity to carry out the duties of employment. In Mr McLachlan's case I would not consider there is the necessary weight of medical evidence to support the view that attendance at work would cause harm. His subjective opinion is that his functional status is such that he would be unable to work. The objective medical evidence is that with further medical management recovery and rehabilitation back to work would be expected."

42. Dr Gillibrand said she would not support the view that Mr McLachlan was permanently incapable of working. She acknowledged that his role would require temporary modification to exclude climbing and ladder work. She recommended referral to a comprehensive pain management programme which she said was known to be available in his local area. Dr Gillibrand also said that she was not of the opinion that Mr McLachlan had a reduced likelihood of obtaining gainful employment before his normal retirement age. She then reiterated the point that WCC were not bound to follow her opinion and could take other opinions into account.

43. Mr McLachlan was provided with a copy of Dr Gillibrand's report. He wrote to her raising a number of points. Mr McLachlan said Dr Gillibrand:

- Had not mentioned the degeneration at the top of his spine noted by Dr Crane,
- Did not explain that he could not drive because of certain medication he was taking,
- Had not mentioned that his limp would be permanent and getting out of a car was difficult,
- Had not noted that he could only sit at a desk for half an hour and would be forced to lie down if he tried to go for longer than this.

44. Mr McLachlan also mentioned that he had requested redundancy but had been refused by WCC.

45. WCC wrote to Mr McLachlan, on 8 August 2013, asking him to attend a meeting to discuss arrangements for a return to work. They said they had received Dr Gillibrand's report and she agreed with Dr Smedley that his case was not suitable for tier 1, 2 or 3 retirement.

46. Mr McLachlan's union wrote to WCC saying that they had failed to comply with the IDR stage 2 procedure. The union said WCC had been required to address the specific issue of the inconsistency between Dr Crane's report and his certificate. They said WCC had instead sought a further opinion from Dr Gillibrand. The union said Dr Gillibrand's view was contrary to the decision of HCC's appeal panel who had determined that Mr McLachlan was permanently incapable of performing the duties of his role.

Summary of Mr McLachlan's position

47. Mr McLachlan argues:

- WCC failed to apply the LGPS regulations properly. In particular, they failed to refer the matter to an IRMP in the first instance. Dr Smedley could not qualify as an IRMP because she had previously advised on his case.
- WCC failed to come to their own decision on his eligibility for ill health retirement. Instead they relied solely on the advice from their own occupational health advisers and failed to give due consideration to the criteria set out in regulation 20.
- Regulation 20(1) gives WCC discretionary power to determine whether a member satisfies the qualifying conditions for ill health retirement. WCC failed to exercise this power in accordance with the principles set out in *Edge v Pensions Ombudsman* [1999] EWCA Civ 2013.
- WCC failed to reach a decision promptly. He applied for ill health retirement on 18 January 2012 but did not receive the initial decision until May 2012. He appealed in June 2012 but did not receive a decision until October 2012. The IDR second stage decision was issued in February 2013 but he did not receive WCC's decision to decline his application for ill health retirement until August 2013.
- WCC failed to give satisfactory reasons for their decision (see *The Trustees of the Saffil Pension Scheme v Curzon* [2005] EWHC 293 (Ch)). They have only referred to the advice from Drs Smedley, Johnson and Gillibrand. In the light of Dr Crane's opinion and the decision from HCC's appeal panel, WCC's decision is perverse in that it is a decision no reasonable employer could reach.
- WCC failed to make a decision in good faith (see *Mihlenstedt v Barclays Bank International Limited* [1989] PLR 91).
- WCC failed to take account of Mr Nader-Sepahi's report of March 2012, Mr McLachlan's response or the letter from his GP. Nor did WCC take Dr Crane's report into account. He sent them a copy of Dr Crane's response to his request for clarification and they ignored this. They did not attempt to contact Dr Crane themselves.
- Dr Crane's report could have been clearer but it is without question that he completed a certificate recommending payment of a tier 1 pension. He did so in the knowledge that this required an assessment of Mr McLachlan's work prospects up to age 65.
- Dr Johnson's report was "a report on a report" because he did not examine him.

- WCC have attributed delay in the process to seeking expert advice. He trawled the internet and contacted three or four doctors himself. He was told they were busy but could see him in two to three weeks if he was willing to fit in with their availability.

- It was not a contradiction to apply for voluntary redundancy and express the wish to work until age 65. His intention had been to retire at age 60 and then work part-time (three days per week) for WCC until age 65.

- He has suffered financial loss. He has had to sell his house and is now having to rent. He is still supporting one of his sons through university. He has also suffered distress and inconvenience. He had hoped to be able to work until age 65 and was expecting to leave with a small award for his long service. Instead he found himself applying for ill health retirement and being obstructed in this rather than supported. The protracted nature of his case has put a great deal of strain on him and his family.

- He would like the Ombudsman to determine that he is entitled to a tier 3 pension backdated to 18 January 2012, together with compensation for distress and inconvenience.

Summary of WCC's position

48. WCC submit:

- Mr McLachlan's second stage IDR appeal was in respect of tier 1 ill health retirement. He was unsuccessful in this and the panel was unable to find in his favour.

- At no stage during the appeal process did Mr McLachlan submit that any previous occupational health consultant's reports obtained by WCC were invalid for procedural reasons. The first time that it was suggested that Dr Smedley's reports were not in accordance with the LGPS regulations was in Mr McLachlan's application to the Ombudsman. It is questionable whether the Ombudsman would be able to make a finding on this matter if it has not previously been raised with WCC or on appeal to HCC's appeal panel. In any event, any procedural irregularities would not affect the outcome.

- Dr Smedley was completely independent and was not Mr McLachlan's GP. She advised solely on the condition for which Mr McLachlan was absent from work. Normally, WCC would ask a consultant to indicate whether an employee was likely to meet the ill health retirement criteria and, if it is indicated that they would, then ask an IRMP for an opinion. In Mr McLachlan's case, Dr Smedley indicated that he would not meet the ill health retirement criteria.

- Mr McLachlan was afforded the right to appeal and advice was provided by Dr Johnson in accordance with the regulations.

- Mr McLachlan appealed claiming he was entitled to tier 1 benefits; there was no claim in respect of tier 3 benefits. HCC's appeal panel concluded there was no case for tier 1 retirement and concluded they were unable to find in Mr McLachlan's favour.

- Following the stage two appeal, Mr McLachlan did not provide any further medical advice and no further information was provided by Dr Crane.

- Dr Gillibrand carried out what she described as an in-depth review of Mr McLachlan's case.

- WCC noted Dr Gillibrand's advice that they should take account of previous occupational health advice, her report, and the view of the appeal panel. They did so and concluded that Mr McLachlan was not suitable for tier 3 retirement.

- The only report which supported Mr McLachlan's claim for ill health retirement was that provided Dr Crane at the request of the union. His report was found to be flawed and those flaws were not corrected at any stage. The most in-depth report was provided by Dr Gillibrand who came to the matter afresh.

- WCC considered all available relevant information, including Dr Crane's report. It was reasonable for them to conclude that Mr McLachlan was not suitable for tier 3 ill health retirement.

- If Dr Smedley's advice were to be disregarded, it would be reasonable for WCC to come to the conclusion they did on the basis of the reports from Drs Johnson, Crane and Gillibrand.

- WCC followed a fair decision making process and acted in good faith. There was clear reference to the detailed experts' reports in each decision made by WCC. WCC was entitled to rely on the reasoning provided by the experts.

- There was delay during the process. This was in part due to the complexities of the case and the need to obtain expert advice. This relied on the availability of those experts.

- Mr McLachlan was the cause of considerable delay. His second stage IDR appeal was made in respect of tier 1 retirement and accompanied by expert evidence which was not properly certified. He subsequently requested tier 3 retirement on the basis of the appeal panel's recommendations. He also waited 14 months before lodging a complaint with the Pensions Ombudsman Service.

- Mr McLachlan's case can be distinguished from the *Saffil* case because WCC had three very clear reports confirming that he was not suitable for tier 1 or tier 3 ill health retirement.

- WCC did not come to a perverse decision. Their decision was supported by three opinions which contradicted Dr Crane's.
- WCC believe they have set out their reasons for their decision by sending Mr McLachlan a copy of Dr Gillibrand's report and offering to meet with him to discuss it. Mr McLachlan did not take up the offer of a meeting and neither he nor his representative raised any issue concerning the providing of sufficiently detailed reasons for preferring Dr Gillibrand's report. They note that the appeal panel did not accept Dr Crane's opinion and referred the matter back to WCC.
- Mr McLachlan says he had hoped to remain in work until age 65 and yet he applied for redundancy on two separate occasions.
- Mr McLachlan has not submitted a schedule of loss or expert evidence in support of his claim for compensation for distress and inconvenience. There is no way of determining such an award. It would not be reasonable to award damages given the extent to which WCC have gone to try and resolve the matter.

Conclusions

49. In order for Mr McLachlan to take ill health retirement under regulation 20, WCC would have to decide to terminate his employment on the grounds that (a) his ill health rendered him permanently incapable of discharging efficiently the duties of his employment with them; and (b) that he has a reduced likelihood of undertaking any gainful employment before his normal retirement age. For the purposes of regulation 20, normal retirement age means age 65.

50. This is the first decision WCC are required to make. It is only once this has been decided that they are then required to consider which of the three possible tiers of benefit Mr McLachlan should receive. It is not the case that a member applies for tier 1 or tier 3 ill health retirement. Faced with an employee who may potentially qualify for ill health retirement under regulation 20, WCC need first to make a decision under regulation 20(1). Before they do so, they are required, under regulation 20(5), to seek an opinion from an IRMP.

51. WCC have explained that they would usually refer a member to an occupational health adviser to give an opinion as to whether he/she is likely to qualify for ill health retirement. Only if the member is likely to qualify do they then refer them to an IRMP. However, determining whether the member is likely to qualify for ill health retirement is, in effect, making a decision under regulation 20(1). On the basis of Dr Smedley's report(s), WCC determined not to terminate Mr McLachlan's employment on the grounds that his condition rendered him permanently incapable of discharging efficiently the duties of his role. Before making that decision, they should have sought an opinion from an IRMP. Whilst there is no reason to doubt Dr Smedley's independence, she could not qualify as an IRMP because she had previously advised

on Mr McLachlan's case. This is a matter of fact. Failure to make a decision in accordance with the LGPS regulations does amount to maladministration.

52. WCC argue that I cannot consider this point because Mr McLachlan did not raise it during the IDR process. It is true that neither Mr McLachlan nor his union specifically raised the matter. I note that WCC were made aware of it by Dr Gillibrand prior to her giving her opinion. So, it would not be strictly true to say that WCC were not made aware of this flaw in their decision making process prior to Mr McLachlan's application to the Pensions Ombudsman Service. In any event, it does not fundamentally change the nature of Mr McLachlan's complaint;, that WCC failed to consider his eligibility for ill health retirement in the proper manner.

53. In and of itself, the failure to seek an IRMP's opinion (that is, an opinion from a doctor who meets the LGPS requirements rather than one who does not) before deciding not to award ill health retirement may not have resulted in injustice to Mr McLachlan. If the decision was later shown to be appropriate, he would be in the position he should be regardless of the maladministration. It is necessary, therefore, to consider whether the maladministration was addressed during the appeal/IDR process.

54. At stage one of Mr McLachlan's appeal, WCC sought an opinion from Dr Johnson, who did qualify as an IRMP. Dr Johnson did not examine Mr McLachlan but he did confirm that he had reviewed both the reports from Dr Smedley and that from Mr Nader-Sepahi. It is largely a matter for the doctor's own professional judgment as to whether he examines the member concerned. If there are ambiguities in the reports the doctor is relying on or he says there is insufficient information in them for him to give an opinion, there may be a case for asking him to see the member. That does not appear to be the case here. I note that Dr Smedley had seen Mr McLachlan at the time she prepared the report Dr Johnson reviewed.

55. Dr Johnson does not quote the LGPS regulation anywhere in his report. He did, however, say he was required to consider whether Mr McLachlan was "permanently incapable of continuing in [his] employment as a result of illness or injury". This is not straying too far from the actual wording of the regulation. Dr Johnson clearly had the correct eligibility criterion in mind when reviewing Mr McLachlan's case.

56. Dr Johnson noted that Mr McLachlan had some residual limitations. He referred to mild weakness in Mr McLachlan's right foot. Mr Nader-Sepahi had said it was the left foot and later in his report Dr Johnson refers to the left foot. This error is unlikely to have had any impact on the overall outcome of his review. Dr Johnson noted that Mr McLachlan continued to take strong painkillers and had not tried stopping them. These observations accord with the information provided by Mr Nader-Sepahi. Mr McLachlan had explained why he was reluctant to stop his medication, but Dr Johnson's observation was factually correct.

57. Dr Johnson noted that Mr McLachlan had declined surgery and he said no account should be taken of a possible outcome of such surgery where the individual had taken a reasonable decision to decline the option. He then went on to say it would be

reasonable, however, to expect the individual to access other forms of reasonable treatment and to follow medical advice with regard to medication. Dr Johnson noted that Mr McLachlan had not accessed a chronic pain service or tried to reduce his painkillers.

58. Dr Johnson accepted that there were aspects of Mr McLachlan's role which he was currently unable to do. He thought these were not routine or essential aspects of the role. Dr Smedley had described Mr McLachlan's role as 50% office based, which she thought suitable for someone with his condition because it comprised a mixture of sitting, standing and walking. Dr Johnson does not appear to have seen a job description and, consequently, was relying on Dr Smedley's description of Mr McLachlan's role. However, it is clear from Dr Smedley's report that she had given some thought to the role and had discussed it in some detail with Mr McLachlan's line manager.

59. Regulation 20 refers to the member being permanently unable to discharge efficiently the duties of their employment. It was accepted by both Dr Smedley and Dr Johnson that Mr McLachlan was, at the time, unable to perform all of the duties of his employment. It is not clear, however, whether they considered the restrictions to be permanent. Dr Smedley had suggested a phased return to work but this was on the basis that Mr McLachlan's duties would be adjusted to accommodate the restrictions imposed by his condition. WCC had said that they were happy to make the suggested adjustments.

60. It is not immediately clear from the wording of regulation 20 whether it is intended that the member be permanently incapable of discharging all or some of their duties. Nor is it clear to what extent the efficiency of the member in discharging their duties should be affected in order to qualify for ill health retirement. It is a well-established principle that, in the absence of a specific definition, words are to be given their ordinary everyday meanings and any interpretation should be practical and purposive. The courts have also been willing to consider the overall purpose of the scheme as an aid to interpretation. Here, regulation 20 provides for the payment of a pension when the member is no longer able to work (to varying degrees). In other words, it provides for a replacement income when ill health prevents the member from continuing in their employment.

61. In Mr McLachlan's case, WCC were willing and able to make adjustments to his role to accommodate his condition. He would have been able to continue to earn at his previous level. In such circumstances, the fact that Mr McLachlan was unable to undertake certain aspects of his role would not appear to be sufficient to meet the requirements of regulation 20. I acknowledge that Mr McLachlan disagrees with the view that he could undertake any of his former duties and I will come to that later. As a general principle, the approach taken by Dr Smedley and Dr Johnson, in taking account of the adjustments agreed by WCC, in assessing Mr McLachlan's incapacity for discharging his duties does not represent a misinterpretation of regulation 20.

62. Dr Johnson expressed the view that Mr McLachlan was not permanently incapable of discharging efficiently the duties of his employment with WCC. He came to this view on the grounds that, whilst Mr McLachlan was currently unable to undertake certain duties (for example, climbing ladders), a graduated return to work had been suggested. He said the treatment options (access to a chronic pain service) available to Mr McLachlan would be expected to improve his day-to-day capability. Dr Johnson said he could not conclude that Mr McLachlan met the basic criterion of permanent incapacity.

63. WCC declined to support Mr McLachlan's application for ill health retirement on the basis of Dr Johnson's report. It is open to WCC to accept the advice of the IRMP unless there is a cogent reason why they should not. For example, an error or omission of fact or a misinterpretation of the relevant regulations by the IRMP. As discussed above, that does not appear to be the case here. The weight that WCC attach to any of the evidence is for them to decide. Mr McLachlan argues that WCC failed to come to their own decision. WCC's letter notifying Mr McLachlan of their decision to refuse his request for ill health retirement refers only to the reports from Drs Smedley and Johnson. On balance, I do not think this is sufficient to find that WCC failed to make a decision (as opposed to deciding to accept Dr Johnson's advice). They could perhaps have explained why they preferred these reports/opinions to those from Mr Nader-Sepahi and Mr McLachlan's GP. I note, however, that Mr Nader-Sepahi had not expressed an opinion as to Mr McLachlan's future capacity to discharge his duties.

64. WCC's decision to accept Dr Johnson's report and decline Mr McLachlan's application for ill health retirement does not amount to maladministration. It cannot be described as a perverse decision; that is, a decision which no other employer, faced with the same circumstances and properly advising itself, could come to. The approach WCC took at stage one of Mr McLachlan's appeal addressed the earlier flaws in their decision making process.

65. At stage two of the appeal, Mr McLachlan submitted a report from Dr Crane. He was of the view that it would be unsafe for Mr McLachlan to undertake site visits and that a return to work would require a significant adjustment to the role. Dr Crane expressed the view that the rearrangement of duties would be unwelcome to other staff. This is irrelevant. He then said assessment should be by reference to Mr McLachlan's substantive role. I take him to mean that the fact that WCC were willing to accommodate adjustments should be ignored. For the reasons given earlier, I do not consider this to be the case. Dr Crane signed a template certificate indicating that he thought Mr McLachlan met the criteria for tier 1 benefits.

66. I note that both Dr Smedley and Dr Crane refer to Mr McLachlan's capacity for "obtaining" gainful employment. By the time of Mr McLachlan's application, regulation 20 had been amended to say "undertaking" rather than obtaining. However, I do not consider this error to have affected the outcome of Mr McLachlan's case.

67. The second stage of the appeal was undertaken by HCC. Their appeal panel came to the view that Dr Crane's report indicated that Mr McLachlan was likely to meet the criteria for a tier 3 award. They said they could not uphold his appeal on that basis because Dr Crane had referred to a retirement age of 60, Mr McLachlan had not brought his appeal on that basis and they did not have a tier 3 certificate.

68. The decision as to whether Mr McLachlan met the criteria for ill health retirement under regulation 20 was/is for WCC to make. If the appeal panel were of the view that WCC's decision had not been reached in a proper manner, the correct course of action was for them to remit the decision to WCC for review. This is the approach taken by the Ombudsman and the courts. It was not for the appeal panel to review the medical evidence in order to reach a substitute decision of their own. The fact that Mr McLachlan had not brought his appeal on the basis that he qualified for a tier 3 benefit was not relevant. As I have said, the member does not have to apply for a specific tier of benefit. Nor was it relevant that they did not have a 'tier 3 certificate'. Even if they had such a certificate, it would not be for them to substitute their decision as to Mr McLachlan's eligibility for benefit for WCC's. In any event, the appeal panel remitted the decision for reconsideration by WCC.

69. Mr McLachlan's union took the view that WCC should only have addressed the inconsistency between Dr Crane's report and the certificate he provided relating to the normal retirement age. They did not consider it appropriate for WCC to seek an opinion from Dr Gillibrand. Given that the appeal panel had referred the matter back to WCC to reconsider, it was open to them to seek further advice. They were not in any way bound by the view taken by the panel that Mr McLachlan should receive a tier 3 award. The decision remained one for WCC to make and they were free to seek such further advice as they felt they needed in order to make that decision.

70. It is clear from Dr Gillibrand's report that she understood the eligibility test to apply and that she had obtained appropriate information about Mr McLachlan's health and his role. Dr Gillibrand noted that Mr McLachlan had not been given access to a pain management course. She said the criteria laid down by the LGPS regulations expected a full range of medical treatment to have been tried. This is not the case. There is no requirement for the member to have tried a full range of treatment in order to qualify for ill health retirement under regulation 20. Where there are further treatment options available, the IRMP should be asked to give an opinion on the likely efficacy of that treatment. In fact, Dr Gillibrand went on to do this. She acknowledged that, without further treatment, Mr McLachlan would find it difficult to resume his role. However, she concluded that, with further medical management, a return to work could be expected.

71. There is clearly a difference of opinion between Dr Gillibrand and Dr Crane. As I noted earlier, Mr McLachlan disagrees with the view that he could be expected to return to work. However, a difference of opinion is not sufficient for me to find that it was not appropriate for WCC to rely on/accept an IRMP's opinion. Dr Gillibrand's report does not contain any errors or omissions of fact and, apart from her comment

concerning a requirement for the member to have tried a full range of treatments, she did not misinterpret the LGPS regulations. I note that she too referred to obtaining (rather than undertaking) gainful employment but this is unlikely to have had any effect on the outcome of her review. It was open to WCC to accept the advice they received from Dr Gillibrand and it did not amount to maladministration for them to base their decision on her report.

72. Having said this, WCC then failed to explain their decision to Mr McLachlan. Their letter simply notified Mr McLachlan that Dr Gillibrand had agreed with Dr Smedley and asked him to attend a meeting to discuss his return to work. Mr McLachlan was also not told of his option to appeal this decision. WCC argue that sending Mr McLachlan a copy of Dr Gillibrand's report and offering to meet with him should have been sufficient. I disagree. As a minimum, WCC should have explained why they attached greater weight to the opinion offered by Dr Gillibrand to that of Dr Crane. They must have had a reason for preferring the advice from Dr Gillibrand to the opinion offered by Dr Crane. It should, therefore, be a relatively simple task for them to explain this to Mr McLachlan (and should take up no more of their time than they have spent arguing why they should not be required to do so). Simply sending Dr Gillibrand's report to Mr McLachlan would not, for example, help him to understand why the medical evidence he had put forward had not been accepted. It leaves Mr McLachlan (and/or his union representative) having to try and discern from Dr Gillibrand's report what WCC's reasoning might be. This is unsatisfactory. WCC's failure to explain the decision to Mr McLachlan amounts to maladministration. Mr McLachlan suffered injustice inasmuch as he was not in position to understand why WCC had reached the decision they had and either accept it or prepare an appeal. To this extent, his complaint can be upheld.

73. Mr McLachlan has submitted a claim for direct financial loss as a result of maladministration by WCC. He has explained that he has needed to sell his house and is finding it difficult to support his son through university. The evidence does not indicate that the decision reached by WCC was incorrect/perverse. So far as the decision not to award ill health retirement is concerned, Mr McLachlan is in the position he would have been in had no maladministration occurred. The evidence does not support a finding of direct financial loss.

74. Mr McLachlan has also complained that there was undue delay in dealing with his application. The evidence indicates that WCC were slow to act on his application and there were delays while the case was with the medical advisers. Mr McLachlan has pointed out that he was able to find doctors willing to consider his case within two to three weeks. However, it is not quite as simple as that. The IRMP must meet the requirements of the LGPS regulations; one of which is that he/she is approved by the relevant administering authority. WCC do not have a completely free hand in which doctors they consult.

75. On balance, I consider the failure by WCC to explain their decision and to notify Mr McLachlan of his right to appeal, together with the delays during the process will have caused distress and inconvenience for Mr McLachlan. However, I do not find that it amounts to distress of a magnitude which would justify a monetary award. Nevertheless, WCC do need to provide redress for their maladministration by providing Mr McLachlan with a more comprehensive explanation for their decision and allowing him the opportunity to appeal it.

Directions

76. Within 28 days of the date of my final determination, WCC will provide Mr McLachlan with a detailed written account of their reasoning and provide him with the opportunity to appeal their decision not to award ill health retirement.

Anthony Arter

Pensions Ombudsman
14 October 2015