CAS-32456-K4K1

Ombudsman's Determination

Applicant	Mr H
Scheme	Teachers' Pension Scheme (**the Scheme**)
Respondent	Teachers' Pensions (**TP**)

Outcome

1. I do not uphold Mr H's complaint and no further action is required.

Complaint summary

2. Mr H has complained that his application for the early payment of his benefits from active status on the grounds of ill health has not been considered in a proper manner. Further, specifically, he says that:-

   2.1. TP did not act in a timely manner.

   2.2. It ignored evidence provided by his GP.

   2.3. It should have given clearer advice to his GP about the information it required.

Background information, including submissions from the parties

3. TP is the administrator of the Scheme. The Department for Education (**DfE**) is the Scheme Manager. The responsibility for decision-making in ill health cases is divided between the two. At the initial application stage, and at the first stage of the Internal Dispute Resolution Procedure (**IDRP**), it is the responsibility of TP to make a decision taking into account a recommendation from the Scheme's medical adviser, OH Assist. If a further appeal is made to stage two of the IDRP, it is the responsibility of DfE to make a decision, again after receiving a recommendation from OH Assist.

4. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

5. The relevant regulations in Mr H's case are the Teachers' Pensions Regulations 2010 (SI2010/990) (as amended) (**the Regulations**), which came into force on 1 September 2010. Extracts from the relevant regulations are provided in Appendix 2.

6. Mr H was born in 1961. His normal pension age (**NPA**) was 60. His first application for ill health retirement (**IHR**) was received by TP on 7 November 2014. His GP completed Part B of a "Medical information form" on 9 December 2014. His case was subsequently referred to TP's medical advisers, OH Assist. OH Assist provided a report, on 16 December 2014, advising that Mr H did not meet the criteria for IHR; that is, he was not permanently incapacitated for teaching.

7. TP wrote to Mr H, on 17 December 2014, explaining that OH Assist had advised that his health would not prevent him from continuing in the teaching profession until NPA. TP said it was unable to accept his application. A copy of the advice from OH Assist was provided for Mr H and he was advised he could appeal.

8. Mr H submitted an appeal on 14 January 2015. In support of his appeal, Mr H provided extracts from a report provided by a consultant psychiatrist, Dr Monteiro. He also provided information relating to the involvement of the College's occupational health department. This included correspondence from an occupational health nurse who had been monitoring Mr H's blood pressure since 2012. Mr H also provided information relating to redeployment, including correspondence with his employer and his union, and documents relating to a grievance against his manager made in 2013. He also provided information relating to the counselling he had received.

9. Mr H's case was referred back to OH Assist for review by another of its medical advisers.

10. OH Assist provided a report, on 2 February 2015, advising that Mr H was not incapacitated for teaching.

11. On 3 February 2015, Mr H was informed that his appeal had been unsuccessful. He was provided with a copy of the OH Assist report. He was also informed that he could submit a further appeal with the DfE.

12. On 5 February 2015, Mr H wrote to the DfE saying he wished to proceed to the next level of appeal. He said he was not suggesting he would never be fit to do some work again but his ability to teach was curtailed. Mr H referred to advice from Dr Monteiro concerning specific treatment and said this was not available to him through the NHS or locally. He said he had taken all the treatment made available to him. Mr H referred to the information provided by his GP in December 2014. He also explained that Dr Monteiro's report was an interim report and he did not know when his final prognosis would be available.

13. OH Assist provided a further report, on 19 February 2015, by a medical adviser who had not previously been involved in Mr H's case. The medical adviser expressed the view that Mr H was not permanently incapacitated for teaching.

14. TP wrote to Mr H, on 26 February 2015, informing him that his appeal had been unsuccessful.

15. On the same day, Mr H submitted a further letter from his GP and asked if this could be included in his appeal. TP received this letter on 4 March 2015. It wrote to Mr H, on 9 March 2015, saying that he had made the two appeals he was entitled to and it could not accept this latest document. TP said Mr H had the right to make a further application for IHR but would have to complete new forms.

16. Mr H completed a new application form on 31 March 2015. His GP completed another "Medical information form" on 25 June 2015. Mr H's case was again referred to OH Assist and it provided a report on 13 July 2015. The medical adviser (who had reviewed Mr H's first application in December 2014) advised that he did not consider Mr H permanently incapacitated for teaching.

17. TP wrote to Mr H, on 14 July 2015, saying it was unable to accept his application and provided a copy of the latest OH Assist report.

18. Mr H's GP wrote to TP on 31 July 2015. She said she wished to take issue with several areas of the OH Assist report. TP asked the OH Assist physician to comment on the GP's letter. He responded on 18 August 2015 and, on 1 September 2015,TP wrote to the GP to provide the response from the OH Assist physician. A copy of this letter was sent to Mr H on 5 October 2015.

19. In its response to Mr H's application to The Pensions Ombudsman (**TPO**), TP said he had not yet appealed the second decision to decline his application for IHR. Mr H referred to a letter he had written to TP on 12 October 2015. In this letter, Mr H had said he was unsure whether he had to go through the appeals process again but, if he did, it should accept his letter as instigating that process.

20. TP forwarded a copy of Mr H's letter to OH Assist. On 22 October 2015, TP wrote to Mr H, to provide the response it had received from OH Assist. In particular, OH Assist replied to Mr H's comments that it was unreasonable not to take notice of his GP's letter, that he had received CBT and additional medication since Dr Monteiro's report, and that it was unreasonable to insist on therapy which was not available to him.

21. Mr H's appeal was rejected by TP and in 2016 he brought a complaint (the **original complaint**) about that decision to TPO. This was considered under case reference PO-9369.

22. Mr H's original complaint was considered by a TPO Adjudicator who issued her Opinion on 20 October 2016. The Adjudicator's conclusions were as follows:-

    22.1. TP had received advice from OH Assist in relation to Mr H's application for ill health retirement. It was clear, from the reports, that the OH Assist physicians were aware of and referred to the correct definition of incapacity.

    22.2. The first opinion, given in December 2014, was based on information provided by Mr H's GP in the medical information form. There did not appear to be any key errors or omissions of fact in the OH Assist report. However, there was clearly a difference of opinion between the OH Assist physician and Mr H's GP

as to the likelihood of Mr H recovering sufficiently before his NPA to return to teaching.

22.3. A difference of opinion (even between doctors) was not generally considered sufficient to find that TP should not have relied on the advice from OH Assist in reaching its decision. Mr H's concern that his employer had provided inaccurate information about redeployment was noted. This was referred to in the OH Assist physician's report but the Adjudicator did not consider it impacted on the eventual conclusion.

22.4. The key issue, in assessing Mr H's eligibility for ill health retirement, was the likelihood of his future recovery; rather than the success or otherwise of redeployment discussions.

22.5. Under the Regulations, it is for the applicant to provide such relevant medical evidence as is required to make a decision. In support of his appeal, Mr H had provided extracts from a report provided by Dr Monteiro, a consultant psychiatrist. This report had been commissioned by Mr H's solicitors in connection with a separate claim against his employer. Dr Monteiro expressed the view that Mr H's symptoms met the criteria for a diagnosis of PTSD, Panic Disorder, and Adjustment Disorder with Prolonged Depressive Reaction. He said Mr H would benefit from Eye Movement Desensitisation Reprocessing (**EMDR**), Anxiety Management, and CBT. This report was taken into account by the OH Assist physician when she was asked to review Mr H's case, along with information from the occupational health nurse who had been monitoring Mr H's blood pressure.

22.6. There was a difference of opinion between the OH Assist physician and Mr H's GP. The OH Assist physician expressed the view that, following the treatment recommended by Dr Monteiro, it was likely that Mr H would recover sufficiently to resume teaching; although she accepted that he was unlikely to be able to return to work with the employer.

22.7. TP asked OH Assist for a further review when Mr H submitted his second appeal. Mr H did not submit any additional medical evidence with his appeal, although he did later submit a letter from his GP. The Adjudicator considered it unfortunate that the OH Assist physician referred to Mr H as having 'fallen out' with his line manager because it may have given the impression that he was downplaying Mr H's condition.

22.8. The OH Assist physician said he was unable to validate Dr Monteiro's diagnosis of PTSD without seeing his full report. It was for Mr H to provide medical evidence in support of his application for ill health retirement and it was entirely his decision as to whether he made the full report available. However, it was appropriate for the OH Assist physician to comment on the fact that he had been given limited access to this evidence.

22.9. The OH Assist physician also addressed the concern, expressed by both Mr H and his GP, that some of the treatment options suggested by Dr Monteiro were not available. He suggested there was an alternative which had been shown to be effective. As before, there was a difference of opinion between the OH Assist physician, and Mr H and his GP. But this was not sufficient reason to find that it was maladministration for TP to accept the advice it had received from OH Assist.

22.10. The Adjudicator noted Mr H's comments concerning his attempt to attend another college and the distance he would have to travel to obtain alternative employment. On the first point, she considered it was the case that it was Mr H's likely future health which was key to determining his eligibility for IHR. While his inability to cope with attending another college gave a strong indication that his current health would preclude his return to teaching at present, it did not mean the expectation of future recovery suggested by OH Assist could be said to be invalid. On the second point, the Regulations did not provide for this to be taken into account. Mr H's eligibility for IHR had to be assessed against his ability to return to teaching prior to his NPA regardless of whether appropriate teaching posts were, or would be in the future, available to him locally.

22.11. The Adjudicator noted Mr H's concern that TP had come to a decision on his second appeal without first considering the letter from his GP. However, this letter was submitted after the appeal had been submitted for consideration. There was no indication in Mr H's letter that he wished to submit further evidence from his GP and no reason why TP should have delayed its decision. Having said this, and having reviewed the GP's letter, the Adjudicator did not consider that it would have made any difference to the outcome of Mr H's appeal. The GP had merely reiterated her opinion that Mr H was unlikely to be able to return to a teaching role in any situation prior to his NPA.

22.12. In summary, the Adjudicator did not identify any maladministration in the way in which TP reached the decision not to agree to Mr H's first application for IHR. In her view, this part of his complaint could not be upheld.

22.13. However, Mr H had submitted a further application in March 2015. This application was also declined. Mr H had the option to appeal this decision, but the situation appeared to have become confused because, at the same time, Mr H had applied to TPO in respect of his first application.

22.14. TP was of the view that Mr H had not appealed its second decision. Mr H had referred to his letter of 12 October 2015. In the Adjudicator's view, TP should have taken this letter as an appeal application. TP did obtain further comment from the OH Assist physician who had advised it in July 2015 but it did not ask for a full review, which would have involved another OH Assist physician. Nor did it appear to have reviewed Mr H's application. Its approach had been to simply forward the OH Assist physician's comments to Mr H and his GP.

22.15. In the Adjudicator's view, this amounted to maladministration on the part of TP resulting in injustice to Mr H, inasmuch as his appeal had not been properly considered. Consequently, the Adjudicator considered this much of Mr H's complaint could be upheld.

22.16. The Adjudicator was of the view that, to put matters right, TP should refer Mr H's application back to its medical advisers for a full review. She said that the referral should take place within 14 days of all parties accepting her Opinion. TP should then review its decision to decline Mr H's application and provide its appeal decision within a further 14 days of receipt of the further advice from its medical advisers.

23. On 4 November 2016, TP accepted the Adjudicator's Opinion, a view that was endorsed by DfE on 15 November 2016. TP agreed to accept Mr H's letter of 12 October 2015 as his first appeal against the rejection of his second ill-health application and referred it to the appropriate area of TP for further consideration. It added that if this appeal were to be unsuccessful, Mr H would still have the option of submitting a second appeal to DfE.

24. Following confirmation from Mr H that he also accepted her Opinion, on 6 December 2016, the Adjudicator wrote to Mr H, TP and DfE to confirm that, as all parties had now accepted her Opinion, the original complaint was closed on the basis set out and agreed.

25. It appears that TP had referred Mr H's appeal back to OH Assist for further consideration on 23 November 2016 (this is somewhat confused as TP's response to Mr H's complaint refers throughout to events taking place in 2015 whereas they took place in 2016).

26. OH Assist needed further information which was requested from Mr H on 2 February 2017. Following a further exchange of correspondence between Mr H and TP, the information was received on 24 March 2017 and passed to OH Assist on 28 March 2017.

27. On 10 April 2017, this appeal was considered by a different medical adviser. Mr H's application was rejected and he was informed of this decision by letter on 19 April 2017. A copy of the medical adviser's report was enclosed with the letter and can be found in Appendix 1. The letter also contained his rights to appeal this decision to DfE within six months of the date the letter was received.

28. On 31 July 2017, Mr H submitted his second appeal against the rejection of his IHR application. He said that:-

28.1. His GP had supported his application by completing two application forms and personally writing to TP challenging the decision on his behalf.

28.2. His GP had shown him that EMDR was not available and had written to TP to this effect. He could not understand how TP could now say that EMDR was available when his GP said that it was not at the time of his application.

28.3. He noted that new factors had been introduced which he believed was unfair as he and his GP had taken on board all previous recommendations and fulfilled these as much as possible.

29. On 14 August 2017, this appeal was considered by a different medical adviser who again required further information, which was requested from Mr H on 30 August 2017.

30. TP says that nothing further was heard from Mr H until February 2019, when his GP submitted the further information requested in August 2017. A copy of the relevant sections of the response can be found in Appendix 1.

31. This appeal was again considered by a different medical adviser on 17 April 2019. On 10 May 2019, the medical adviser provided her report to DfE. A copy of her report can be found in Appendix 1.

32. On 16 May 2019, DfE wrote to Mr H regarding his second appeal of 31 July 2017. It said that its medical adviser had considered all the information made available in support of his appeal and also reviewed the information provided as part of his original application and first stage appeal. It said that the medical adviser had not advised that Mr H had become permanently incapable of continuing to work either as a teacher or any other occupation. As a result it did not consider that his appeal had shown that his original application should have been accepted and so it turned down his appeal. It enclosed a copy of the medical adviser's comments for Mr H's information.

33. TP's position:-

33.1. It is the conclusion of both TP and DfE, following advice from its medical advisers, that Mr H does not meet the criteria set out in the Regulations to be granted IHR.

33.2. It is unable to comment on the findings of the approved medical advisers as it is not a medical expert and has no discretion over the advice made to it unless it believes that not all the evidence has been considered or there has been an administrative oversight.

33.3. Mr H complains that it did not adhere to the timescale set out in the Adjudicator's Opinion, but the referrals to OH Assist and the provision of the appeal decisions had been made within 14 days.

33.4. There is no evidence that it wrote directly to Mr H's GP at any time from 2017 onwards.

33.5. It has dealt with Mr H's request for IHR in accordance with the Regulations and it rejects Mr H's complaint on the basis that it does not agree that he is permanently incapacitated within the terms of the Regulations.

34. Mr H's position

34.1. He is of the opinion that Dr Cryer's report, dated 17 April 2019, says that if he had had the advice from Dr Healy and Dr Cole at the commencement of his application it would have been successful.

34.2. If that is so, he has concerns that his GP simply followed TP's request for further information but that this is being seen as 'after the event' irrespective of the fact his GP's position has remained unchanged throughout.

34.3. Furthermore, if this is viewed as 'after the event' thereby rendering his application incomplete at the time he considers there was undue delay on TP's part which should be taken into account in deciding when the pension should be awarded.

Adjudicator's Opinion

35. Mr H's complaint was considered by one of our Adjudicators who concluded that no further action was required by TP. The Adjudicator's findings are summarised below:-

35.1. Mr H's original complaint was investigated by TPO in 2016. The Adjudicator had considered the agreed outcome of that complaint and the actions taken by TP since then.

35.2. Following the decision in the original complaint, it was agreed that TP should refer Mr H's appeal against its second decision back to OH Assist for a full review. The referral was to take place within 14 days of all parties accepting the decision. TP was to then review its decision to decline Mr H's application and provide its appeal decision within a further 14 days of receipt of the further advice from its medical advisers.

35.3. The fact that the appeal decision was remitted back to TP should not be taken as an indication that the Pensions Ombudsman (**PO**) would have agreed or disagreed with the decision, simply that the Adjudicator at the time concluded that TP had not gone about it in the correct way.

35.4. A member's entitlement to an early retirement pension due to ill health is determined by the applicable scheme rules or regulations. The scheme rules or regulations determine the circumstances in which members are eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

35.5. In this case, in order to be eligible for IHR under regulation 54 and schedule 7, Mr H had to be permanently "unfit by reason of illness or injury and despite appropriate medical treatment to serve as a teacher, organiser or supervisor".

35.6. The issues to be considered included whether the relevant regulations had been correctly applied; whether appropriate evidence had been obtained and considered; and whether the decision was supported by the available relevant evidence.

35.7. Because Mr H had applied for IHR as an active member, he had to meet the criteria for payment at the time his employment ceased in November 2014. The decision reached by TP had to be assessed in the light of the evidence which was, or could have been, available at the time it was made or later comments on Mr H's condition at that time. Any subsequent development in his condition was not relevant to this assessment; unless it could reasonably have been foreseen at the time of the decision, as that would amount to benefit of hindsight. So, a report as to Mr H's current condition would not help determine whether there was any maladministration in the way in which his original application was considered.

35.8. TP was not bound by the opinion expressed by its medical adviser and should come to a properly considered decision of its own. Medical (and other) evidence should be reviewed in order to determine whether it supported the decision made. However, the weight attached to any of the evidence was for TP to decide (including giving some of it little or no weight)[1]. It was open to TP to prefer evidence from its medical advisers; unless there was a cogent reason why it should not or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the medical adviser. The reason would have to be obvious to a lay person. TP would not be expected to challenge a medical opinion.

35.9. Having reviewed the advice provided by the OH Assist physicians, the Adjudicator had seen no evidence of any misunderstanding of the Regulations. Nor was there any evidence of an error or omission of fact on their part.

35.10. The report by Dr McElearney, dated 10 April 2017, showed that he had taken into account the second Medical Application Form completed by Mr H's GP, together with further correspondence from her, Dr Monteiro's report and Occupational Health Correspondence. He accepted that there was no treatment available that would reverse Mr H's anxiety about returning to work with the employer. But the Regulations did not specify that the inability to work was location specific. Dr McElearney considered that further treatments were available which had scope to improve the position such that Mr H could teach

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

or lecture again at a different establishment. He therefore concluded that Mr H did not meet the criteria for IHR.

35.11. Following Mr H's second appeal, his case was again referred to OH Assist. The report by Dr Cryer, dated 17 April 2019, showed that she had considered further information provided by Mr H's GP, a letter from the specialist in psychiatry, Dr Malik, and letters from Professor Healy (Director Psychological Medicine) and Dr Cole (Chartered Clinical Psychologist). Her opinion was that Mr H would not have met the criteria of needing to be permanently unfit for teaching work at the time of his second application for IHR. This was because his prognosis for recovery within the following seven years to NPA was good and further treatment recommended by his psychiatrist had not been tried and if it had been would have increased his chance of recovery to enable him to return to teaching.

35.12. Mr H believed that Dr Cryer's report said that if he had had the advice from Professor Healy and Dr Cole at the commencement of his application it would have been successful.

35.13. Dr Cryer said that there were reasons to believe, at the time of Mr H's IHR application in July 2015, he had a good prognosis for returning to some form of teaching work again, although it was unlikely to be at the same place of employment. This was because he had not had sufficient treatment for his symptoms of PTSD or severe work-related anxiety to be able to confirm that he met the criteria for permanent incapacity from teaching. While Dr Cryer acknowledged that Mr H's GP had reported that she felt Mr H was unfit for teaching work again, Dr Cryer considered that although this might be the case in March 2019, as Mr H had by then tried reasonable treatments, at the time he applied for IHR this would not have been her opinion.

35.14. The position could not be considered with the benefit of hindsight. Dr Cryer's opinion was clearly that at the time of Mr H's application for IHR the evidence presented indicated that he had a good chance of recovery to the extent that he could return to teaching, albeit at a different location before his NPA

35.15. The Adjudicator acknowledged that Mr H was still experiencing issues with his health. But, in and of itself, that did not invalidate the opinions expressed by the OH Assist physicians at that time.

35.16. The Adjudicator also recognised that Mr H did not agree with the views expressed by the OH Assist physicians and acknowledged that there was a difference of opinion between TP's medical advisers and Mr H's GP. But that was insufficient for the PO to find that TP's decision had not been properly made. He did not believe that there were grounds for finding that TP should not have accepted the advice it received from its medical advisers.

35.17. Mr H had also complained about the length of time TP took to consider his second application for IHR and appeals between 2015 and 2017 following his original complaint.

35.18. The Adjudicator who considered his original complaint had directed that TP should remit his appeal back to OH Assist within 14 days of the acceptance, by all parties, of her Opinion. She had confirmed to all parties that her Opinion had been accepted on 6 December 2016, so to comply TP would have had to have referred the case back to OH Assist by 20 December 2016. However, the evidence showed that it had done so on 23 November 2016 as it and DfE had already confirmed their agreement. In the Adjudicator's view TP had therefore initially complied with the directions.

35.19. A scheme's IDRP must ensure that decisions are reached, and notified to applicants, within a "reasonable period". The Pensions Regulator's code of practice provided that the relevant decision-maker was expected to determine disputes within four calendar months of receiving the application. The four-month period applied separately to each determination stage. While the Adjudicator acknowledged that TP's and DfE's stage 1 and 2 IDRP responses had taken more than four months, he considered that much of the delay was as a result of OH Assist requesting further information and that there had been communication between TP, DfE and Mr H. The most significant delay was from 30 August 2017 to February 2019, as a consequence of the lengthy waiting list for EMDR treatment, as Mr H had acknowledged. As such, the Adjudicator was satisfied that the time taken by TP and DfE was reasonable when considering Mr H's application.

36. TP accepted the Adjudicator's Opinion but Mr H did not and the complaint was passed to me to consider. Mr H provided his further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the following additional points Mr H has raised:-

36.1. He believes the main issue is that at the time of the initial application Dr Cryer was of the opinion he may have been able to return to work with appropriate treatment. This is clearly at odds with the opinion of his GP and others who saw him many times over the period of time in question.

36.2. The fact that TP wrote to him saying in effect "To give your case the best possible chance of success you should get the additional treatment" resulted in his GP immediately requesting this for him, culminating in Dr Coles' report. There was of course some delay for the treatment but this was due to the long NHS waiting list.

36.3. It is obvious that, in March 2019, Dr Cryer's opinion was much closer, if not the same, as that of the opinion always stated by his GP and others. Hence, he thinks it would be reasonable for TP to accept his doctors' evidence supported by Dr Cryer's ultimate prognosis of March 2019. He believes the evidence is

overwhelming that it would be impossible for him to be put in a teaching environment again.

36.4. Because TP asked for this additional treatment, it should be considered alongside all the original evidence provided. If the additional treatment was not to be included in the decision, then why did TP request it?

36.5. The other alternative for TP would be to accept the position of IHR at the conclusion of treatment around March 2019.

36.6. He is concerned that his pension is made up of both employer and his own personal contributions. He believes that TP looks for reasons not to award IHR rather than be impartial.

Ombudsman's decision

37. I will start by reiterating a point that the Adjudicator made in his Opinion, which is that Mr H's claim has to be assessed in the light of the evidence which was, or could have been, available at the time his employment ceased in November 2014, or later comments on his condition at that time. Any subsequent development in his condition is not relevant.

38. Mr H says that Dr Cryer's opinion, in March 2019, was much closer, if not the same, as that of the opinion given by his GP and other treating medical practitioners. He therefore thinks that TP should accept his doctors' evidence as this is supported by Dr Cryer's prognosis of March 2019.

39. Mr H also says that the additional treatment should be considered alongside the original evidence provided and questions why it was requested if TP was not going to consider it.

40. But Dr Cryer was not assessing the position at March 2019; she was considering the position as it was in November 2014 and in looking at that she said:

> "My opinion is that [Mr H] would not have met the criteria of needing to be permanently unfit for teaching work when he applied in July 2015 (the date of his second application). This is for two reasons:
>
> - His prognosis for recovery sufficiently to return to teaching work within the following 7 years until normal retirement age was good.
> - Further treatment recommended by his psychiatrist had not been tried and if it had would have increased his chance of recovery sufficiently to enable him to return to some form of teaching work again."

41. Her conclusion was that Mr H did not meet the criteria for being permanently incapacitated for teaching as defined by the Regulations when he applied in 2015.

42. Mr H says that the main issue is that Dr Cryer believes at the time of his initial application he may have been able to return to work with appropriate treatment and that this is at odds with the opinion of his GP. But, as the Adjudicator pointed out, the weight which is attached to any of the evidence is for TP to decide, including giving some of it little or no weight. It is open to TP to prefer evidence from its medical advisers.

43. Mr H of course remains entitled to a pension from his membership of the Scheme and, as he is now past NPA he will be able to draw that immediately with no actuarial reduction.

44. I do not uphold Mr H's complaint.

Anthony Arter CBE

Deputy Pensions Ombudsman
23 March 2023

Appendix 1

Medical Evidence

OH Assist (Dr McElearney) report dated 10 April 2017

"As per the Ombudsman's instructions I have reconsidered this case in its entirety…

This the (sic) medical evidence I have considered consists of

- The Medical application form completed by his GP Dr Hindle dated 25/06/2017
- Further correspondence from the GP dated 25th Feb 2015 and 31/07/2015 and
- The Independent Consultant Psychiatrist's report from Dr TB Montiero (sic) dated 22/09/2014.
- OH Correspondence (L Williams) dated 14/03/2014 and 05/01/2015

The relevant regulations are the Teachers' Pensions Regulations 2010 (as amended)

The Scheme Criteria are:

Incapacity for teaching.

This is defined as being unfit by reason of illness or injury and despite appropriate medical treatment to serve as a teacher (either full or part-time, at their existing establishment or elsewhere) and likely to remain so up to normal retirement age.

Enhanced Benefit

This is defined as the ability to carry out any work is impaired by more than 90%, and is likely permanently to be so, up to normal retirement age.

My Advice:

[Mr H] was employed as a lecturer in Motor Engineering in an (sic) Further Education College. From the GP, OH and Psychiatrists reports [Mr H] was subjected to a range of behaviours that triggered the onset of work related stress.

As time passed and further events occurred, this became a more significant problem ending in the development of Post Traumatic Stress Disorder, Panic Disorder and Adjustment Disorder.

Again from the submitted reports, the employer did not address the precipitating and maintaining factors in spite of appearing to be aware of them. This worsened the problem.

[Mr H] was treated by his GP and sought assistance locally for psychological care. He had CBT and Counselling and was put on an antidepressant, Citalopram 20 mgs.

His GP did not make referral to a psychiatrist, that occurred when he commenced legal action and his solicitors instructed Dr Monteiro who undertook a one off assessment and report dated 22/09/2014.

There is a consistency in the medical evidence. [Mr H] was exposed to behaviours at work by his manager which precipitated stress initially and later PTSD, anxiety and Panic Disorder. These behaviours and this employer were the stimulus.

The breakdown in the relationship is such that [Mr H] could never go back to teach at that establishment, and no treatment will change that position. He has developed high blood pressure requiring medication, and he seems to be stable on medication.

The two questions I have to address are:

Is [Mr H] permanently incapacitated to teach? And

Is [Mr H]'s capacity for any other work impaired by 90%?

What is clear is that he has developed PTSD, Anxiety and an adjustment disorder because of what he perceives has happened to him in that workplace. There is no treatment to can (sic) reverse that and which would safely allow him to return there.

However, fitness to teach is not just about teaching in one location, its (sic) about his capacity to teach / lecture in this case at any location.

Dr Hindle wrote that [Mr H], using the skills acquired in CBT, was unable to enter the building of the nearest alternative employer to the one where his problems began.

Dr Hindle maintains that he has completed all of the treatments available to him and infers that this now shows that he is permanently incapacitated to teach.

However, the nhsdirect-Wales website still advises that PTSD is a treatable condition and that trauma focused CBT and Eye Movement Desensitisation and Reprocessing are effective treatments.

It also recommends that Paroxetine and Mirtazepine are effective antidepressants in its treatment. The evidence that has been presented is that [Mr H] has only ever been on Citalopram.

I note that these treatments were recommended by the Independent Psychiatrist and that he deferred offering a prognosis in the case until they had been tried.

So, whilst these treatments would never have the effect of getting him back to lecture in his previous employer's FE College I cannot advise that he has completed the treatments appropriate for his condition.

[Mr H] does not have a pre existing psychiatric condition nor evidence of any other medical prognostic factor that would suggest he would not respond to this treatment.

Thus I have to advise that there remains scope with this treatment for him to improve such that he could teach / lecture again at a different establishment. His attempt to return to a different location has taken place in advance of this further treatment and is not evidence of permanent incapacity to teach in itself.

In regards the second question, his capacity for other work, [Mr H]'s anxiety is situation specific and he is likely to be capable of alternative employment in advance of the treatment that would be likely to return his capacity to teach at a later date.

He meets neither criteria."

Letter from Dr Malik to Mr H's GP, Dr Hindle, to TP dated 20 November 2017

"Presenting complaints:

[Mr H] said as of now he is feeling much better within himself. In the past he has suffered severe anxiety with panic attacks related to harassment and bullying he had suffered during his work as a lecturer at the local college. He said, even today, everything reminds him about the traumatic experiences at the college which triggers panic attacks and anxiety. For example, recently he saw a college minibus moving behind his car whilst he was driving. He had to move to the side and stop to let the minibus drive away and to stop the panic attack escalate further.

He said he avoided watching TV if the programme was about any college as it may trigger anxiety flashbacks and panic attacks.

He said he received CBT and Citalopram that had helped him with his anxiety and panic attacks which were severe between 2011 and 2014 when he was declared unfit to work by the Occupational Health Department at his college. However, the Medical Advisor of the Minister of Education, has insisted that he is fit to work and should work in a different college as a lecturer. As a result of the instruction from the Medical Advisor he found a job in a different college but, according to him, he could not leave the car park because of a severe panic attack and flashback he experienced at that time.

…

He told me that he is now doing a different job as a builder and is not able to do his work as a lecturer any more as a result of what he suffered whilst with his previous employer.

…

His past psychiatric history, until 2011 there were (sic) no previous engagement with the mental health team. It was not until after his diagnosis of PTSD that he received counselling, CBT and also treated with Citalopram. He had a private psychiatric assessment in Manchester in 2016 when he was diagnosed with the PTSD.

…

He has no physical health problems and takes no medication at this time.

Mental State Examination:

He is a 55 year old gentleman who is well kempt, relaxed, has a good rapport with eye contact maintained. His speech is normal in content, rational and comprehensible. Mood was euthymic. He is not psychotic. He is insightful, cognition grossly intact. There is no risk to self or to others.

Impression: Work related anxiety and PTSD related to the harassment and bullying he suffered during his previous employment at the college.

Plan:

1. No need for any psychiatric medication at present.

Letter from Dr Cole, Chartered Clinical Psychologist, to Dr Hindle dated 4 February 2019

" Further to my letter dated 20 December 2017 I am writing to let you know that [Mr H] has attended five appointments which included two sessions of EMDR for trauma related to his experiences at work. I have not read previous reports relating to this case but [Mr H] has informed me that EMDR had been recommended by the pension services prior to making a decision on early retirement funds.

During the review assessment on (sic) [Mr H] explained that he would not be able to return to work as a lecturer as he remains very distressed about the prospect about being around students or his previous place of employment even though the person responsible for the bullying has now left. Dreams involving the protagonist are no longer related to actual events at the college although the individual does appear in other dreams. If a trigger occurs such as to (sic) seeing a can used by college, [Mr H] can experience symptoms of anxiety such as increased heart rate. He has learned a number of anxiety management strategies through the third sector such as CBT which he is able to use to reduce these symptoms. He does not report being constantly on guard, and his current presentation would not meet criteria for Post Traumatic Stress Disorders DSM-5 as the events prior to leaving work did not signify 'death or threatened death or actual or threatened serious injury'. [Mr H] has spent his last year writing a book at home.

It was decided to offer short EMDR interventions to see if there was any remaining distress related to his experiences. At the outset he reported 5/10 subjective units of distress which suggested that he was not in a serious anxiety state and although his distress increased slightly as he recalled details of the day, ultimately the SUDS reduced. We concluded that some of his thoughts about work could be related to unrealistic high standards as we concluded that most individuals would be somewhat overwhelmed when faced with writing up a new course at short notice.

In conclusion, trauma symptoms related to the work situation have improved overtime although [Mr H] remains fearful of returning to work in a college setting. As stated

previously, one option would be to try graded exposure to increase tolerance of returning to a work environment, if the desire to work remained. As his current symptoms profile would not generally be considered sufficiently severe to meet criteria for secondary care, he might wish to consider approaching primary care for this type of intervention.

[Mr H] as now been discharged from psychology."

Letter from Dr Hindle, to TP dated 20 February 2019

"Following your letter to my patient of 30th August 2017 in which you rejected his appeal to receive early payment of his Teachers' Pension on medical grounds, I have endeavoured to help him with the treatment routes suggested by your medical adviser.

Please find enclosed copies of correspondence indicating that

1. [Mr H] was referred to the local consultant psychiatrist for consideration of whether he should be medicated with mirtazapine or paroxetine as indicated by your medical adviser. You were already aware that both the psychiatrist and I were of the opinion that [Mr H] had made a good recovery from his more general depression and anxiety while taking citalopram.

2. It was the psychiatrist's further opinion that there was no additional benefit to be had from taking different antidepressants because [Mr H] had recovered from the anxiety and depression that were affecting his activities of daily living and now had only a very situation specific anxiety related to work and the harassment and bullying he suffered.

3. [Mr H] has had a course of EMDR delivered by the psychologist and it was her opinion that this treatment was not helpful to [Mr H].

4. The psychologist did suggest that [Mr H] might try a graded exposure to work under the care of the primary care mental health worker. However this approach was the first one tried over many months when he was first unable to work, without success in enabling him to return to work. [Mr H] paid for this intervention privately in the hope of being able to return to work in 2014/5. I have discussed a further referral with our primary care mental health worker in the surgery and she does not feel that she could be of any more help.

As his general practitioner, I feel we have now exhausted all the possible routes of help for [Mr H]. I would be grateful that you reconsider your decision not to award his pension early on medical grounds."

OH Assist (Dr Cryer) report dated 17 April 2019

"Regulations Applicable:

The relevant regulations are the Teachers' Pensions Regulations 2010 (taking account of amendments made from 1 April 2015)

Scheme Criteria:

Incapacity for teaching.

'Incapacitated' is defined as being "unfit by reason of illness or injury and despite appropriate medical treatment to serve as a teacher, organiser or supervisor."

'Incapacitated permanently' is not defined in the 2010 regulations but is taken to mean incapacitated in either a full or part-time capacity at their existing establishment or in any teaching post elsewhere and that is likely to remain the case up to the person's normal pension age.

Total Incapacity

This is defined as the ability to carry out any work is impaired by more than 90%, and is likely permanently to be so, up to normal retirement age.

This is taken to be the case where a person is permanently incapacitated and that this is more likely than not to remain the case up to the person's normal pension age

Questions to be answered:

1. Was the person incapacitated (i.e. unfit to teach) at the date of leaving pensionable service? **Yes**
2. Is there a link between the illness at the date of leaving pensionable service and at the date of application? **Yes**
3. Is the person permanently unfit to teach at the date of application? **No**
4. Is the person permanently incapable of any gainful employment (total incapacity) at the date of application? **No**

…

The Medical evidence considered:

I have considered the evidence previously provided for both the 2014 and 2015 applications and appeals. In addition, /I have considered the following new evidence submitted:

- A letter from his GP, Dr Hindle, dated 20.2.19.
- Letter from Dr Hindle to psychiatric services dated 12.9.17.
- A letter from the Specialist in psychiatry Dr Malik dated 20.11.17.
- Letter from Professor Healy, Director psychological Medicine dated 3.10.17.
- Letter from Dr Cole, Chartered Clinical Psychologist dated 4.2.19.

I confirm that I have not previously been involved in or advised on this case before and am providing independent and impartial advice.

Rationale:

At the time [Mr H] applied for IHR in 2015 he would have been 53 years old and had about 7 years until his normal retirement age.

At the time of his initial application he had been suffering from severe anxiety related to work events for at least a couple of years. He had been on long term sick leave since January 2014 as a result.

The psychiatrist Dr Moneiro (sic) employed for a medico-legal report in 2014 had felt that his diagnoses were Post Traumatic Stress Disorder (PTSD) and Panic disorder. He recommended in 2014 that [Mr H] be treated with anxiety management and EMDR therapy. The latter is a specific therapy for PTSD symptoms and is often successful. This psychiatrist commented that he would be unable to predict his prognosis (future health likelihood0 until he had tried these treatments.

My opinion is that [Mr H] would not have met the criteria of needing to be permanently unfit for teaching work when he applied in July 2015. This is for two reasons:

- His prognosis for recovery sufficiently to return to teaching work within the following 7 years until normal retirement age was good.
- Further treatment recommended by his psychiatrist had not been tried and if it had would have increased his chance of recovery sufficiently to enable him to return to some form of teaching work again.

Reasoning with regards to prognosis for recovery: My impression gained from reviewing the evidence is that [Mr H] had a good prognosis for returning to some form of teaching work again. It was unlikely to [be] at the same place of employment, but the geographical availability of work is not a factor for consideration for this pension scheme. My reasoning for this view is that he had good mental health previously and no additional stressors contributing to his illness. For example, typical predictors of poor prognosis are previous poor mental health, personal stress, bereavement, physical illness, unhappy childhood, or alcohol problems. He did not appear to have any of these factors. He would have had a good chance of recovery either with no treatment naturally or with the further recommended treatment of EMDR.

Reasoning with regards to further treatment possible: At the time of the initial ill health retirement application in July 2015, [Mr H] had not had sufficient treatment for his symptoms of PTSD or severe work-related anxiety to be able to confirm that he met the criteria for permanent incapacity from teaching. He had tried one type of antidepressant medication, counselling, CBT and anxiety management. He had not tried the EMDR treatment recommended by the psychiatrist.

The recommended EMDR treatment was tried for only two sessions in about 2018 by a psychologist but she felt that further treatment was not required as his level of

symptoms was not sufficiently high enough to need it. She suggested that he could try phasing back into teaching work again.

[Mr H]'s GP has reported that she feels he is unfit for teaching work again. I agree that this may be the case at the current time (March 2019), now that he has tried reasonable treatments. At the time he applied for ill health retirement in July 2015 however this would not have been my opinion for the reasons mentioned above.

[Mr H] has now had suitable treatment in the form of medication, CBT, recent psychiatric assessment and two sessions of EMDR (a specific treatment for PTSD). His mental health now appears reasonably good when there are no work-related triggers present. With regards to his fitness for other non-teaching work – he has been working as a builder since leaving teaching. Therefore, he is not likely to meet the criteria for Total Incapacity either at the current time or at the time of application in 2015.

Concluding advice:

It is my opinion that this applicant **does not** meet the criteria for being permanently ***incapacitated for teaching*** as defined by the above Teachers' Pensions Regulations when he applied in 2015.

Appendix 2

Teachers' Pensions Regulations 2010

As relevant, paragraph 3, 'Ill-health retirement', of Schedule 7 provides:

"(1)…a person (P) falls within this paragraph if—

(a) P was in pensionable employment at any time after 31st March 1972,
(b) P ceases to be in pensionable employment,..,
(c) P satisfies either Conditions 1, 2 and 3 or Condition 4, and
(d) P makes an application under regulation 107 for retirement benefits…

(2) Condition 1 is that P is incapacitated and is likely to be incapacitated permanently.

(3) Condition 2 is that immediately before satisfying Condition 1—

(a) P was in pensionable employment,
(b) …or
(c) P was, with the consent of P's employer, on non-pensionable sick leave, on non-pensionable family leave or on a career break which, in every case, followed on immediately after a period of pensionable employment.

(4) Condition 3 is that P's application under regulation 107—

(a) is made within 6 months after the end of pensionable employment…, and
(b) is signed by P's employer.

(5) Condition 4 is that P's ability to carry out any work is impaired by more than 90% and is likely to be impaired by more than 90% permanently."

Schedule 2, 'Glossary of Expressions', defines:

'incapacitated' as:

"unfit by reason of illness or injury and despite appropriate medical treatment to serve as a teacher, organiser or supervisor."

Regulation 65, 'Total incapacity benefits' provides:

"(1) This regulation applies where—

(a) an ill-health pension becomes payable to a person (P) because P satisfies Conditions 1, 2 and 3 set out in paragraph 3 of Schedule 7 (Case C: ill-health retirement), and

(b) P satisfies Conditions A and B.

(2) P satisfies Condition A if P's ability to carry out any work is impaired by more than 90% and is likely to be impaired by more than 90% permanently.

(3) P satisfies Condition B if immediately before satisfying Condition A—

(a) P was in pensionable employment,

(b) P was paying contributions under regulation C9 of TPR 1997 or regulation 19 (election to pay contributions by a person serving in a reserve force), or

(c) P was taking a period of non-pensionable sick leave, a period of non-pensionable family leave or a career break which, in every case, followed on immediately after a period of pensionable employment.

(4) A total incapacity pension is payable to P from the entitlement day.

(5) Except as otherwise provided in these Regulations, the total incapacity pension is payable for life.

(6) Where P is a pre-2007 entrant, a total incapacity lump sum is payable to P on the entitlement day.

(7) The annual rate of the pension and the amount of the lump sum are to be calculated in accordance with regulation 66 (annual rate of total incapacity pension and amount of total incapacity lump sum).

(8) The entitlement day is the date on which the ill-health pension mentioned in paragraph (1) becomes payable to P."

As relevant, regulation 107, 'Payment of benefits on application to Secretary of State', provides:

"(1) Benefits under these Regulations are payable by the Secretary of State.

(2) Despite any provision of these Regulations according to which a benefit becomes payable at a certain time, no benefit is to be paid unless paragraphs (3) to (5) have been complied with.

(3) A written application for payment must be made to the Secretary of State.

(4) The applicant must provide the Secretary of State with such relevant information in the applicant's possession or which the applicant can reasonably be expected to obtain as the Secretary of State may specify in writing.

(5) An application for ill-health retirement benefits…must be accompanied by all the medical evidence necessary for the Secretary of State to determine that the applicant is entitled to the benefit or benefits including, where applicable, evidence that the person's ability to carry out work is impaired by more than 90% and is likely permanently to be so.