PO-16517

Ombudsman's Determination

Applicant	Mr S
Scheme	TfL Pension Fund (**the Fund**)
Respondent	TfL Trustee Company Limited (**the Trustee**)

Outcome

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

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

Complaint summary

3. Mr S is unhappy that his application for ill health early retirement (**IHER**) has been refused.

4. Mr S disagrees with the Trustee's decision that his state of incapacity is unlikely to continue until Normal Pension Age (**NPA**). Mr S says his condition is unlikely to improve sufficiently in order for him to undertake any employment before his NPA.

Background information, including submissions from the parties

5. Mr S was employed by Transport for London (**TfL**) as an Advanced Train Maintainer. As a result of this, Mr S was also a member of the Fund. Relevant extracts of the Fund's Trust Deed and Rules, in relation to IHER, are provided in Appendix 1.

6. On 13 August 2012, Mr S began a leave of absence from work as a result of ill health.

7. On 13 September 2012, Mr S completed TfL's depression and anxiety questionnaires. The results from the questionnaires showed that Mr S suffered from severe depression and anxiety.

8. On 25 September 2012, Mr S met with TfL's Occupational Health doctor, Dr Reetoo. Dr Reetoo assessed Mr S and found he was, "…not fit to return to his normal duties or any other duties at present." Dr Reetoo also said that it was unlikely that Mr S was going to be able to return to work in any capacity for at least the next six weeks and was unable to provide a timeframe for Mr S' return after six weeks.

9. On 17 December 2012, a TfL Depot Manager held a long-term sickness meeting with Mr S. Mr S was asked to provide an update on his condition, and he said his General Practitioner (**GP**) has referred him for Cognitive Behavioural Therapy (**CBT**), but he did not know when treatment would start. Mr S said that he did not want to be hurried or pressured back to work.

10. On 28 January 2013, Mr S met Dr Reetoo, who commented that Mr S' condition was improving. Dr Reetoo said, "I anticipate after the termination of his current medical certificate, [Mr S] could be considered fit for a graduated return to his normal duties from the [sic] 14 February 2013 over a period of 8 weeks."

11. It seems Mr S had a graduated return to work but had to take emergency annual leave, before taking further sick leave on 29 March 2013. On 31 May 2013, Mr S met with Dr Chavda, TfL's Specialist Registrar in Occupational Medicine. Dr Chavda described Mr S' condition:

> "...he is significantly symptomatic and not fit to work in any capacity at this stage. I cannot give you a timeframe for return to work as his symptoms have been ongoing for many months and although he has had a number of sessions of counselling, there is no other treatment at present."

12. Dr Chavda also noted that Mr S was considering applying for IHER.

13. In July 2013, TfL called Mr S to discuss Dr Chavda's report. Mr S was asked what was meant by Dr Chavda's statement, "Mr S also tells me that he is considering retirement." Mr S said that he had suggested he should be retired on medical grounds, but felt that the report was not consistent with this. When asked, Mr S confirmed that he did not know when he would be able to return to work but felt that he was not ready to return in any capacity.

14. On 2 August 2013, Mr S' employment was terminated on medical grounds.

15. In September 2013, Dr Chavda provided a report on Mr S' circumstances, saying he was not fit for work in any capacity at the time of his last assessment. Dr Chapman, a senior doctor, reviewed the report and commented, "most individuals make a good recovery from depression especially if the [sic] fully engage with the treatment. I am not clear from the records if he has done so and you may wish to check this with his GP."

16. On 18 September 2013, Dr Gowans, Mr S' GP, completed a Medical Form for the Fund. Dr Gowans opined that Mr S was permanently incapacitated because he, was too stressed to return to his job at TfL, had not experienced any improvement in his mental health and would not be able to cope with the travel.

17. On 24 September 2013, Christine Houghton, a counsellor for IAPT, updated Dr Gowans regarding Mr S' counselling sessions. She told Dr Gowans that Mr S had completed 18 sessions of counselling where he, "engaged in the process and made

good progress." However, Ms Houghton noted that, "his difficulties around his proposed return to work" meant that they agreed to end his sessions.

18. On 31 October 2013, Dr Sheard, Consultant Occupational Physician and the Fund's Independent Medical Advisor (**IMA**), submitted his report to TfL. Dr Sheard said: -

> "There is no evidence of treatment with antidepressant medication at therapeutic dose for a reasonable period of time, any specialist opinion or treatment or argument that cognitive behavioural therapy or similar treatments will not have a positive impact upon his well-being. In the circumstances my opinion is that:
>
> - [Mr S] is currently unfit for work
> - This was likely to be the case at the time his employment was terminated
> - There is no reasonable medical evidence that this state of incapacity is likely to be continuing to NPA".

19. The Trustee had to assess whether Mr S was capable of returning to employment prior to his NPA. Dr Sheard went further by stating his expectation that Mr S would be able to return to work within 12 months. Dr Sheard concluded, "I am unable therefore, even on the balance of probabilities, to support the contention that Mr S meets the criteria for ill health retirement under Rule 19(1) in that although his employment has been terminated I would anticipate Mr S' health improving sufficiently to allow a return to work within 12 months."

20. On 4 November 2013, the Trustee wrote to Mr S to confirm that he was, "not entitled to receive enhanced benefits because the medical information supplied does not confirm that you are entitled to an ill health pension under Rule 19(1)." The Trustee explained that there was no evidence to suggest that Mr S' incapacity would continue to prevent him from carrying out remunerative employment up until his NPA.

21. On 12 November 2013, Mr S appealed the decision.

22. On 15 November 2013, the Trustee confirmed that its decision remained unchanged. The Trustee referred to the IMA's opinion that, "…there is no reasonable medical evidence that your state of incapacity is likely to continue to NPA." The Trustee also prompted Mr S to provide any evidence of him receiving any further specialist treatment.

23. On 19 November 2013, Mr S lodged a further appeal. He claimed that he was being discriminated against by the Trustee due to his age and mental health. Mr S also had concerns about Dr Sheard's report because Dr Sheard had not assessed him, but relied on medical records to reach his opinion.

24. Mr S asked for a report from his GP. On 6 December 2013, Dr Gowans provided a report and confirmed that she did not believe Mr S would be fit to work within the next year. Dr Gowans stopped short of providing a long-term prognosis.

25. On 23 December 2013, the Trustee wrote to Mr S to ask him to attend another medical examination with the Fund's IMA. Mrs S replied, on behalf of her husband, and said that Mr S was unable to travel to London due to ill health, but agreed to attend a local clinic.

26. The Trustee requested for Mr S to be examined by a medical advisor who was local to him. Dr Hunt, a regional Consultant Occupation Physician, assessed Mr S and shared his opinion with Dr Sheard. On 14 February 2014, Dr Sheard produced another report, saying:

> "…neither of us are persuaded, even on the balance of probabilities, that specialist treatment, including the use of antidepressant medications, perhaps in combination and at therapeutic dose for extended periods with cognitive behavioural talking therapy type treatments will not have a positive impact upon his wellbeing sufficient in time to allow him to return to even safety critical work such as Advanced Train Maintainer activities."

27. Dr Sheard also reiterated that he, "…remains of the opinion that the criteria of the Finance Act 2004 are unlikely to be met as there is no evidence to suggest any impairment would continue until Scheme pension age."

28. Following Dr Sheard's report, the Trustee wrote to Mr S to advise him that he was not entitled to receive IHER.

29. On 10 June 2014, Mr S was assessed by Dr Perumal, a Senior House Officer to Dr Onyon. The report provided commentary on Mr S' medical history, but did not comment on Mr S' ability to work.

30. In November 2014, Dr Gowans assessed Mr S' condition again. When writing this report, she considered Fran Newton, Christine Houghton and Dr Perumal's views. She changed her opinion to say that it was impossible to say whether Mr S would remain permanently incapacitated.

31. On 27 November 2014, Dr Sheard produced a further report. Dr Sheard noted that: -

> "…it is now possible that [Mr S] meets the criteria for ill-health retirement under Rule 19(1) in that his employment has now been terminated on health grounds, and he has been unable to return to work within 12 months… there is no evidence to show that any impairment will continue until scheme pension age."

32. On 5 December 2014, the Trustee convened a committee (**the Committee**), to discuss Mr S' appeal. The Committee was joined by Dr Sheard and Mr Norris, Mr S' representative from The National Union of Rail, Maritime and Transport Workers (**RMT**). Mr Norris was given the opportunity to present Mr S' case. Mr Norris raised concerns regarding Dr Sheard's opinion that Mr S would be able to return to work within 12 months. Mr Norris felt that this was overly optimistic, he explained that Mr S

had been suffering from a long-term illness since 2006 and had not been able to return to work in the previous 12 month period.

33. Mr Norris also expressed concerns about a statement made by Dr Sheard saying that, "Mr S is noted to be considering retirement and this is identified as a significant barrier to any return to work." Mr Norris explained that Mr S was not considering retirement, and highlighted *Mrs Robinson v The City of London Corporation*, in which the independent medical advisor had made similar comments which the Pensions Ombudsman deemed irrelevant.

34. Mr Norris returned to the subject of whether Mr S' health could improve. He noted that Mr S had tried four different types of antidepressants, without success. Mr Norris also sought to make it clear that Mr S had undergone 18 counselling sessions, which showed that he was making positive steps to engage with appropriate treatment. Mr Norris said this highlighted that Mr S was not getting any better despite undergoing significant treatment. Mr Norris concluded that he felt it was clear that Mr S would not get better in a short period of time, if ever.

35. Mr Norris left the meeting and Dr Sheard responded to some of his concerns. Dr Sheard informed the Committee that there was no evidence that Mr S had, "…taken a reasonable dose of antidepressants for a reasonable period of time, he had not been assessed by a consultant psychiatrist, had counselling, or treatment for post traumatic stress or had a reasonable course of Cognitive Behavioural Therapy (**CBT**)."

36. Dr Sheard went on to inform the Committee that, "…it was an increasingly common problem that where significant input was needed the NHS did not provide it, and so the patient did not receive the treatment needed." The Chairman commented that, "…it was a problem for the Committee that if the member was unable to engage in treatment, they may be able to qualify for ill-health pension through the passage of time since they left the service."

37. The Committee went on to discuss whether Mr S fulfilled the criteria of Rule 19(1) and the relevant provisions of Finance Act 2004. The Committee said:

> "The Committee agreed that at the date [Mr S] left service he did not meet the criteria as they were of the opinion that if he was under specialist care, and on a reasonable dose of antidepressants for a reasonable period of time, Mr S should be able to return to work in the period before his scheme pension age."

38. The Committee went on to consider granting Mr S IHER from deferred status. The Committee decided that they needed more information before they could make a decision. The Committee agreed that it would take, what it called, an 'unusual' step of requesting a report from a psychiatrist, before coming to a decision.

39. On 13 March 2015 Dr Briscoe, a Consultant Psychiatrist, assessed Mr S before sharing his opinion with Dr Sheard. Dr Briscoe did not conclude that Mr S was incapable of remunerative employment in the long term. Dr Briscoe said that on the

balance of probabilities, if Mr S attended a further 15 sessions of CBT with an appropriately qualified clinical psychologist over a period of six to nine months, he would likely recover from his illness sufficiently to enable a return to work. Dr Briscoe seconded Dr Sheard's opinion that Mr S was unfit for work when his employment was terminated but there was no medical evidence that his incapacity would continue until NPA.

40. On 24 April 2015, following Dr Briscoe's psychiatric report, the Committee met to decide whether Mr S met the criteria for IHER from deferred status. The Committee was concerned that the report suggested Mr S was likely to remain unfit for work unless treatment commenced. The Committee sought clarification on treatment options by asking, "if Mr S took Dr Briscoe's report to his GP and said this was the treatment he needed, would he be likely to be able to obtain the treatment[?]". In addition, the Committee contemplated the, "…probability that the treatment would have a positive impact if it were taken now, given the duration of time that had passed." Dr Sheard responded and opined, "necessary treatment would be available to Mr S, but it could take nine months to one year to get it." Dr Sheard went on to say that it would now take longer for Mr S to get better, but that he had not got to a stage where recovery, prior to retirement age, was not possible.

41. The Committee unanimously agreed that if Mr S received and engaged in reasonable treatment options he would most likely be able to undertake remunerative employment before his NPA.

42. On 11 May 2015, the Trustee wrote to Mr S to decline his claim for an IHER.

43. Mr S remained unhappy so he contacted The Pensions Advisory Service (**TPAS**) for assistance.

44. On 19 October 2015, TPAS wrote to the Trustee to ask it for some more information about the Fund rules and the valuation of Mr S' pension. The Trustee responded the following month, explaining that Mr S had exhausted the Fund's Internal Disputes Resolution with respect to an IHER claim under Rule 19(1). However, the Trustee made it clear that Mr S still has the option to appeal the decision to decline his application from deferred status. TPAS replied in April 2016 to say that Mr S would like the Trustee to reconsider its decision in refusing IHER on the grounds that his health has deteriorated. TPAS felt the best way forward was for the Trustee to contact Mr S directly.

45. On 18 April 2016, the Trustee wrote to Mr S with the details of how to appeal the decision about his IHER from deferred status.

46. On 4 August 2016, Dr Hadert, clinical psychologist, wrote to discharge Mr S from the Arden Memory Service. Dr Hadert confirmed that Mr S had cancelled two appointments, saying he did not want to pursue any support for his emotional health or assessment of memory.

47. On 13 September 2016, Dr Sandoo, a GP, wrote to say that Mr S had recently joined the surgery and had started on a course of medication in the last week.

48. On 3 November 2016, the Trustee wrote to Mr S to decline his claim for IHER.

49. On 24 February 2017, the Committee met again to discuss Mr S' Stage Two appeal. The Committee was joined by Dr Sheard, the IMA and Mr Norris, Mr S' representative from RMT. The Committee discussed whether Mr S met the criteria for IHER from deferred status. Although there was some recent medical testimony, the Committee wanted to make it clear that Mr S was being assessed in accordance with his condition in December 2014, the date when Mr S made a claim. The Committee decided:

> "…that the substantive evidence gathered between Dr Briscoe's report and the current date did not provide significant new evidence to support a conclusion that Mr S had undertaken and engaged in all reasonable treatment options available and that these had either been unsuccessful or would be unlikely to be successful."

50. The Committee also commented that there had been evidence of sporadic engagement by Mr S during treatment.

51. On 10 March 2017, the Trustee wrote to Mr S to decline his request for payment of his deferred pension on health grounds.

52. On 14 March 2017, Mr S brought the complaint to this Office.

Adjudicator's Opinion

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

- It was not the role of the Ombudsman to review the medical evidence and come to a decision as to Mr S' eligibility for IHER. The Ombudsman's role in this matter was to look at the decision-making process. It is for the Trustee to decide the weight it attaches to any of the medical evidence and it is open to the Trustee to accept the opinion of its own medical advisors, unless there is a cogent reason why it should not. The Trustee considered Mr S' application for IHER from active and deferred status, the Adjudicator made findings on both applications and considered them separately.

IHER from active status

- On 2 August 2013, Mr S' employment was terminated on the grounds of ill health. Both parties accept that, at the time of termination, Mr S was unable to undertake his duties for the foreseeable future. It is from this date that the Trustee had to

consider whether Mr S would have been able to return to remunerative employment before his NPA.

- The Trustee considered that Mr S' condition had the potential to improve sufficiently to allow a return to employment before his NPA. However, Mr S contends that he knew he would not be able to return to work.

- The Committee engaged with medical opinion and probed Mr S' prognosis, asking why Mr S' condition had not improved and why Dr Sheard expected recovery in the next 12 months. The Adjudicator found that the level of scrutiny applied to medical evidence demonstrated that the Trustee's gave adequate consideration to Mr S' IHER application.

IHER from deferred status

- Recognising Mr S had not been able to return to employment since leaving active service, the Committee considered granting Mr S IHER from deferred status. The date it used to assess the application was 5 December 2014.

- The Trustee acted with diligence by paying for a consultant specialist opinion to assess Mr S.

- The Committee asked the right questions about the side effects caused by antidepressants and the difficulty in obtaining CBT. The Committee explored treatment options by asking, "if Mr S took Dr Briscoe's report to his GP and said this was the treatment he needed, would he be likely to obtain the treatment[?]". The Committee also contemplated the probability that the treatment would have had a positive impact on Mr S. The Adjudicator found that the Committee ensured that all barriers to recovery were considered before deciding it was likely that Mr S would recover sufficiently to undertake some form of remunerative employment.

54. Mr S did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr S provided his further comments which do not change the outcome.

55. Mr S has told me that, despite attending 18 counselling sessions, he has not been able to return to work. He also highlighted that he has been unable to work for almost five years. In addition, Mr S contests that the side effects caused by some medications mean he is unable to complete certain treatments and he should be assessed in light of this.

56. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Mr S for completeness.

Ombudsman's decision

57. My role in this matter is not to decide whether Mr S is entitled to IHER – that is for the Trustee to decide in consultation with its IMA. Also, it is not for me to agree or disagree with any medical opinion.

58. My role is to consider whether the decision was reached in a proper manner. There are some well-established principles which a decision maker is expected to follow in exercising its discretion. Briefly, the decision maker must consider and weigh all the relevant factors and no irrelevant ones. But the weight to attach to any piece of evidence is for the decision maker to decide. A decision maker could, if it wished, attach no weight at all to a piece of evidence. The only requirement is that the evidence is considered. Further, the decision maker must not reach a decision which no reasonable decision maker, properly directing itself, could arrive at in the circumstances.

59. If I am not satisfied that the decision has been taken properly I can ask the decision maker to look at the matter again. However, I will not usually replace the decision maker's decision with a decision of my own, nor can I tell them what their subsequent decision should be.

60. The Trustee based its decision not to pay Mr S' benefits, under Rules 19(1) and 19(4), on the advice it received from its own medical advisers and specialist opinion. I do not find that it was maladministration for it to do so.

61. As mentioned previously, it is for the Trustee to decide whether Mr S is entitled to IHER. To qualify for IHER, whether from active or deferred status, Mr S would have to show the Trustee that it was unlikely for his health to recover sufficiently to allow him to return to any sort of employment.

62. When Mr S applied for IHER from active service, on 2 August 2013, the Committee expected Mr S to recover sufficiently to undertake employment. I acknowledge that Mr S has not worked since his employment was terminated. However, the fact that expectation of recovery is not realised is not evidence that the decision is incorrect. I must assess whether the Trustee's assessment could be considered perverse. Given the exploration of Mr S' prognosis and the scrutiny placed on the reasons why Mr S had not seen a recovery in the preceding 12 months, I cannot say that the decision was perverse.

63. I find the same to be true for the application for IHER from deferred status. Whilst I can see that, at this point, Mr S had spent another year unable to work, there is evidence on file to show that his prognosis was carefully examined. The Committee asked for further, specialist, medical opinion and this also gave rise to an expectation of recovery. With this in mind, I find the Trustee followed a correct process in ensuring that all relevant evidence was considered.

64. I note Mr S' reference to the 18 counselling sessions he had attended, which did not enable sufficient recovery for him to return to work. The Minutes from the Committee meeting show that both the Committee and the medical professionals were aware of this, but Dr Briscoe, "did not believe that Mr S had undergone reasonable treatment to make him better." The Committee engaged with the medical opinion that, "if Mr S was provided with 15-20 sessions of CBT, provided by an appropriately qualified clinical psychologist over a period of nine months, he would recover from his illness."

Whilst I can see that Mr S made steps to improve upon his situation, the medical experts suggested that more needed to be done. The Committee asked the right questions, ensuring the treatment required would have been available to Mr S. This examination shows that the correct process was being followed.

65. Mr S expressed concerns about his suitability to antidepressants and how this would affect his prognosis. Whilst I agree with Mr S' position that he should not be forced into a treatment that he does not want, Mr S cannot say that he has exhausted all treatment options without completing a reasonable course of treatment. I am satisfied that the Committee considered Mr S' position on antidepressants. During a Committee meeting, Dr Sheard stated, "he always ruled out experimental treatment, but did not consider that this was the same as not taking antidepressants due to side-effects." I find that the Committee ensured that all barriers to recovery were considered before it came to its decision.

66. I find that the Trustee considered all relevant medical evidence and abided by the Scheme Rules. I do not find that its decision was perverse, so I have no reason to remit Mr S' case back to the Trustee for re-consideration.

67. Therefore, I do not uphold Mr S' complaint.

Anthony Arter

Pensions Ombudsman
29 June 2018

Appendix 1

Relevant Fund Rules

19. Ill-Health Retirement

(1) Subject to Rule 19(5), a Member who leaves Service before Scheme Pension Age and, in the opinion of the Trustees and on production of such evidence as they require, is prevented by mental or physical incapacity from the performance of his duties shall be entitled to benefits under Rule 20 or alternatively under this Rule. If such incapacity is, in the opinion of the Trustees, the result of his own misconduct or neglect, the Trustees may at their discretion disqualify him from taking benefits under this Rule.

(2) The benefit under this Rule shall be:

(a) if Total Membership is less than two years, a lump sum of one quarter of Pensionable Salary, PLUS:

If he has completed at least two years' Linked Qualifying Membership, a pension payable from State Pension Age during his lifetime equal to his Guaranteed Minimum Pension. Rules 24, 25 and 26 shall not apply; or

(b) if Total Membership is more than two years but less than five years, a pension calculated in accordance with Rule 17; or

(c) if Total Membership is at least five years, a pension calculated in accordance with Rule 17 as if Total Membership included an extra period of the shorter of 10 years and the period between the date of leaving Service and the date the Member will attain Scheme Pension Age. The pension so payable in respect of such extra period shall not be exchangeable for a lump sum under Rule 22 except in the circumstances described in Rule 22(5).

If at the date of leaving Service the Member was in Part-Time Service, the extra period shall be multiplied by the fraction C/D; where C is the number of his weekly contractual hours of work at the date of leaving Service, and D is the number of standard weekly contractual hours of work of a full-time employee in the same or equivalent position (which in case of doubt shall be determined by the Participating Employer.)

(3) Subject to Rule 19(5), the pension payable under Rule 19(2) (b) or (c) shall be payable from the date of his leaving Service for the lifetime of the Member.

(4) Subject to Rule 19(5), if a Member who has elected to receive a deferred pension in accordance with Rule 20 becomes, before that pension commences, incapacitated from undertaking remunerative employment by bodily or mental infirmity he shall, on the production of such evidence as the Trustees may require, be entitled to receive immediately the benefits which would have been payable at or from Scheme Pension Age including any increase in the deferred pension accrued to date under Rule 28.

(5) The Trustees may in their absolute discretion vary or suspend the pension payable under Rule 19(2)(b) or (c) or 19(4) as the deem the circumstances justify if the Member:

(a) is, in the opinion of the Trustees, at any time (in the case of a Member leaving Service, whether before or after he leave Service) capable of earning an income, or

(b) does not when so requested supply evidence of continued ill-health satisfactory to the Trustees.

(6) A decision made by the Trustees under paragraph (1) of this Rule to disqualify a Member from taking benefits under this Rule may be reviewed at any time by the Trustees and if, after review, such decision to disqualify is reversed, the Member shall be entitled to take benefits under this Rule as if the decision to disqualify had never been made.