The Pensions Ombudsman

Ombudsman's Determination

Applicant	Mr N
Scheme	Civil Service Injury Benefit Scheme (**CSIBS**)
Respondents	MyCSP
	Scottish Prison Service (**SPS**)

Outcome

1. I do not uphold Mr N's complaint and no further action is required by MyCSP or SPS

Complaint summary

2. Mr N's complaint is that his application for a Permanent Injury Benefit (**PIB**) has not been properly considered.

3. Mr N says there are five parts to his complaint. Namely:-

    1. The unacceptable time it has taken for his PIB application to be considered.
    2. The appointment of Dr Groom to decide his application.
    3. The outcome decision on the degree of apportionment.
    4. The outcome decision on the degree of impairment.
    5. Health Management (**HM**), the Scheme's Medical Advisor's (**SMA**), responses to his four Med9 complaints.

4. The fifth part of Mr N's complaint has not been accepted for investigation as HM is not within the jurisdiction of The Pensions Ombudsman's Office (**TPO's Office**) to investigate.

Background information, including submissions from the parties

5. Relevant extracts from the CSIBS Rules (as amended) are provided in Appendix 1. A summary of the relevant medical evidence is provided in Appendix 2.

6. Mr N was a residential prison officer for the SPS.

7. Following an extended period of sickness absence for work related stress, Mr N's employment ended on 16 September 2016. SPS originally advised MyCSP that this was on age grounds. But, in December 2018, SPS notified MyCSP that this should be

changed to resignation[1], in accordance with a COT3 agreement that SPS and Mr N had entered into to resolve Mr N's Employment Tribunal claim.

8. Prior to Mr N leaving SPS, MyCSP determined that Mr N had suffered a qualifying injury.

9. On 19 September 2016, Mr N applied for a PIB. He was then over his pension age, 55.

10. Around the same time, Mr N opted to take additional tax-free cash[2] and a reduced pension from the Principal Civil Service Pension Scheme – Classic section. Mr N's standard pension (that is, before commutation) was a pension of £15,594.14 per annum[3].

11. On 16 December 2016, the then SMA, Health Assured (**HA**), wrote to MyCSP requesting guidance on how the term 'permanent' should be interpreted in Mr N's case.

12. From January 2017, MyCSP informed Mr N that HA's query was with the Cabinet Office (**CO**).

13. On 2 March 2017, Mr N contacted the CO for a timescale on answering the query. The CO referred the matter to MyCSP. MyCSP then realised it had not raised HA's query with the CO. MyCSP did so on 24 March 2017[4].

14. In May 2017, Mr N requested and was provided with a Stage One Internal Dispute Resolution Procedure (**IDRP**) form. In June 2017, Mr N submitted the completed form to MyCSP.

15. The SMA contract transferred from HA to HM on 3 July 2017.

16. On 3 August 2017, MyCSP emailed an incomplete letter to HM relating to the CO's guidance on the interpretation of permanence.

17. An internal MyCSP email, dated 8 August 2017, said Mr N was now happy that the SMA had been advised and he no longer wished to proceed with his subject access request (**SAR**) and IDRP.

18. On 16 August 2017, HM emailed MyCSP that it had yet to receive the response to the query raised by HA in December 2016. HM said Mr N had advised that it should have

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[1] Mr N resigned claiming constructive dismissal - alleging breach of contract and discriminatory conduct by SPS.

[2] In December 2015, at age 55, Mr N took an initial tax-free lump sum and abated his pension.

[3] Information taken from 19 June 2017 pension loss letter from Ms Terras (Carlisle & Collins Actuaries and Pension Consultants) to Mr N's Solicitor in relation to Mr N's Employment Tribunal case.

[4] Query raised with the CO's Pensions Technical and Compliance department.

received correspondence from MyCSP on 3 August 2017, but this had not been received.

19. On 18 August 2017, MyCSP informed HM that confirmation of the CO's guidance had been provided on 3 August 2017, but it noted only the first page of the letter had been sent. MyCSP said the complete letter had been provided on 9 August 2017 and enclosed a further copy. The letter advised that, as Mr N was over pension age, his application should be assessed based on permanency to State Pension Age (**SPA**)[5].

20. HM commenced the review of Mr N's application. It was then discovered that several medical reports[6] were not with the application paperwork. Mr N was updated on 23 August 2017.

21. On 30 August 2017:-

    - HM informed Mr N that it was awaiting medical reports which did not appear to have been included in his medical case file on transfer from HA.

    - Mr N asked HM why his case had been referred to Dr Saravolac (Specialist Occupational Physician) without all the medical information?

    - HM replied that the case data had been successfully transferred, but it was unclear why the mentioned medical reports had not been made available to Dr Saravolac. It said it was doing its utmost to progress matters and obtain the medical evidence before providing advice on his application.

    - Mr N replied that Dr Saravolac had previously informed him that she required five letters from his GP practice. Mr N said this was concerning as the information had been previously submitted to HA. Mr N said he was sceptical whether supporting information, sent to HA over the last 11 months, had also been made available. Mr N said his trust in the process was fragile and this had exacerbated his stress and wellbeing.

22. On 1 September 2017:-

    - HM emailed Mr N that it had been in contact with his GP surgery and a letter would be sent that day to the surgery outlining the change in SMA and that authorisation had been obtained to release the requested information without cost. HM said it would progress his application expediently once the reports had been received.

    - Mr N submitted to HM a letter from Dr McKewan (GP) that had previously been submitted and asked how it and at least four other letters had not been passed to

[5] Mr N's SPA is 66 years and 9 months.

[6] Two letters from Dr McEwan (GP) dated 28 October 2015 and 29 June 2016, a letter from Dr Gourlay (GP) dated 22 July 2015, two letters from Dr Dempster dated 4 February 2015 and 8 September 2015.

Dr Saravolac. Mr N said he was not sure if a psychiatric assessment he had commissioned and submitted, Dr Wylie's report of 16 January 2017, had been passed to Dr Saravolac. Mr N said he intended to raise his concerns with the Information Commissioner's Office (**ICO**).

23. On 4 September 2017:-

- Mr N submitted a Stage One IDRP application to MyCSP. Mr N complained about:-
  - The time it was taking to consider and decide his PIB application.
  - The time the CO had taken to answer the SMA's query.
  - The missing medical information.
  - The submission of his application to Dr Saravolac without all the medical evidence he had provided.
  - Data protection concerns regarding the above.

  Mr N said he wanted his original IDRP submissions to be considered and the matter of HA and HM not being able to locate his medical information to be addressed.

- HM informed Mr N that Dr Wylie's report had been made available to Dr Saravolac and reiterated that it had been in contact with his GP practice who would be providing a further copy of all the relevant medical information.

24. On 12 September 2017, MyCSP informed Mr N that, under the IDRP, it could only consider whether the correct procedure had been followed in assessing his application for a PIB. MyCSP said his concerns regarding the loss of medical evidence by the SMA would be best addressed under the SMA's complaints procedure (**Med9**). MyCSP provided Mr N with a link to the Med9 form.

25. On 13 September 2017:-

- HM issued Dr Saravolac's report. Dr Saravolac assessed the degree of apportionment of Mr N's qualifying injury to his duty to be in the 71% to 90%, medium band, and the degree of earnings impairment caused to be less than 10%, 'not appreciably affected', therefore no award was payable.

- Mr N submitted an email to HM in respect of a Med9 complaint.

- Mr N informed HM that in error he had agreed the content of Dr Saravolac's report. Mr N said he disputed that he had voluntarily resigned from SPS. He said, at the time, he had made all aware not only that he deemed himself constructively dismissed but also that he was not in a state of mental wellbeing or capable of making rational decisions. Mr N said he had made HA aware that he did not want

to leave employment. He was also aware that SPS was processing his capability and looking to dismiss him. This he believed was for whistleblowing.

26. The next day Mr N wrote to HM about perceived inaccuracies in Dr Saravolac's report. HM replied to Mr N on 21 September 2017. HM said:-

- HA had provided Mr N's case file in relation to his PIB application only and not his complete records. As this was out of HM's control, he might want to raise his concerns with MyCSP and/or the CO.

- The Chief Medical Officer (**CMO**) noted that Mr N disagreed with Dr Saravolac's statement that he had resigned from the SPS. But the information provided by the SPS indicated that he had retired at pension age. While the CMO, was willing to review the wording of this, taking into account the information he had subsequently provided about the circumstances at that time, it would unfortunately not alter the outcome of Dr Saravolac's report.

- While Mr N did not understand Dr Saravolac's comment that there was no evidence of ill health consideration, there was no indication in the file received from HA that an application for ill health retirement had been considered. This information was useful in helping to establish permanency of incapacity and the impact on former duties or other work and therefore was relevant in the assessment of earnings impairment. The assessment took account of the likelihood of the scheme member undertaking any form of employment, not merely the role or duties undertaken within the Civil Service.

- If Mr N had previously applied for ill health retirement, the CMO would be grateful if he would submit all the relevant documentation he held. The CMO would be willing to review Mr N's PIB application taking this into account.

27. On 25 September 2017, Mr N requested from HM a copy of his file.

28. On 28 September 2017, MyCSP informed Mr N that his data loss complaint would be referred to the CO and that it was processing his Stage One IDRP appeal.

29. The next day HM sent Mr N a copy of his file.

30. On 3 October 2017 Mr N emailed MyCSP. Mr N said:-

- He wished to formally apply for a further IDRP.

- HA on numerous occasions had confirmed the receipt of medical information. But when he subsequently received his file from HM, via a SAR, he found there were numerous pieces missing.

- His request for an appeal form on 21 September 2017 had not been acted upon and a promised call back from a manager on 29 September 2017, had not occurred. He considered that his request had been refused, which he believed

was maladministration and did not conform with Civil Service policy and procedures and his rights as a member.

31. The same day MyCSP notified Mr N that it had approached HM for further information on his PIB application.

32. On 11 October 2017, Mr N emailed HA for data on his case.

33. On 17 October 2017, a representative for MyCSP's Stage One IDRP team wrote to Mr N. The representative said:-

- HM had now provided a response and it was in receipt of Dr Saravolac's report.
- The five GP letters and Dr Wylie's report were all referenced in Dr Saravolac's report and therefore had been considered.
- HM had responded to Mr N's SAR and Mr N had advised that further documentation, previously supplied by Mr N's GP, was missing. In light of this, HM had agreed to consider Mr N's application afresh.
- Mr N should now submit copies of these documents to HM or to MyCSP for forwarding to HM.
- MyCSP had been instructed to wait for the new medical report from HM before issuing a decision.
- Given that MyCSP and HM had agreed a course of action to resolve Mr N's concerns, a full Stage One IDRP investigation had not been necessary and Mr N's file had now been closed. This did not prevent Mr N from later invoking the IDRP should he exhaust the medical appeal process and remain dissatisfied with the outcome.
- Concerning Mr N's complaint regarding the loss of data in the transfer of information from HA to HM, this had been referred to the CO. As previously advised, the Stage One IDRP team could not investigate the matter as it related to a third party.

34. Dissatisfied, Mr N submitted to MyCSP a SAR and an appeal to the CO. MyCSP replied that it was unable to forward his appeal to the CO as a Stage One IDRP decision had not been issued. MyCSP said his concerns regarding the loss of data and failings in the transfer process were still under consideration by the CO. MyCSP said his SAR request would be responded to.

35. On 18 October 2017, HA replied to Mr N. HA said:-

- When the contract transferred to HM, HA only had consent to release open case data to HM. All historical data was not transferred.
- Access to data could be requested via a SAR until 31 October 2017, thereafter the data would be securely archived.

- HA apologised that the contract transfer had affected the progression of his PIB application.
- HA asked Mr N to confirm the data he required and to verify his identity.

36. On 20 October 2017, HA emailed Mr N. HA said all the data Mr N required was held in closed files. HA said it would provide the data so that his case could be progressed by HM.

37. On 3 November 2017, MyCSP's Scheme Compliance Unit (**SCU**) wrote to Mr N. MyCSP said:-

    - It understood that Mr N remained unhappy, after its letter of 17 October 2017 and subsequent correspondence, with the decision not to complete a full Stage One IDRP investigation.
    - It understood that Mr N wished to submit a Stage One IDRP application for maladministration by MyCSP. As this was not considered in the previous investigation, it would be considered as a new appeal.
    - Mr N should complete and return the enclosed Stage One IDRP form.
    - As previously advised, the handling of Mr N's PIB application was being investigated by the CO, who would contact Mr N in due course.

38. On 8 November 2017, Mr N submitted a completed Stage One IDRP form regarding the administration of his PIB application. Mr N said he had raised an IDRP in May 2017 which had not been concluded. While he had been informed that he had voluntarily cancelled it, he wanted a copy of the letter/email or transcript of the telephone call that confirmed this. Mr N said he had made a SAR to MyCSP in July 2017 for information held on his file. This had not been provided. While he had reported this to the ICO, he wanted an explanation why he had not received the requested information within the timeframe set out in the ICO Guidelines.

39. Mr N was given 60 days to provide what, he felt, was missing from his PIB application paperwork. HM received this on 14 November 2017.

40. On 23 November 2017, the CO wrote to Mr N in respect of his data loss complaint. The CO said:-

    - Mr N's data had not been lost, nor had it been available to access by unauthorised persons.
    - The documents that were transferred from HA to HM were still being held securely by HA.
    - The fact that Mr N's full file was not transferred had caused Mr N distress and had delayed the processing of his application for a PIB.

- It apologised and thanked Mr N for his assistance in providing additional copies of the documents to HM.
- It understood from MyCSP that, as HM had agreed to carry out another assessment, a Stage One IDRP decision had not been issued. This was on the basis that, as Mr N was happy that HM was reconsidering his application, his complaint was resolved. As it appeared Mr N was unhappy with this, it would ask MyCSP to issue a Stage One IDRP decision.
- If Mr N remained unhappy after receiving MyCSP's Stage One IDRP decision he could then submit a Stage Two IDRP application to the CO.
- At this stage it could not complete a Stage Two IDRP investigation, as it had only been passed Mr N's concerns about the loss of medical records and not a full file including a Stage One IDRP decision.

41. The CO forwarded a copy of its letter to MyCSP and asked MyCSP to provide a Stage One IDRP decision on Mr N's concerns regarding the maladministration of his PIB application.
42. On 29 November 2017, HM issued Dr Collins' (Consultant Occupational Physician) report, who advised the same degree of apportionment of Mr N's qualifying injury to duty and the degree of impairment of Mr N's earnings capacity as Dr Saravolac.
43. On 1 December 2017, Mr N emailed MyCSP. Commenting on Dr Collins' report, Mr N said the medical adviser (**MA**) on numerous occasions had referred to decisions made in Dr Saravolac's report, which was concluded without all the medical evidence. The MA also referred to a GP letter which still had not been located, but which the MA erroneously noted from Dr Saravolac's report was made available. Mr N said he believed because he had reported the loss of medical data to the ICO this had influenced the way he had been treated. The CO had his complaint, but it required MyCSP's Stage One IDRP decision.
44. Mr N chased MyCSP on 6 December 2017.
45. On 7 December 2017, MyCSP notified Mr N that its aim was to issue a Stage One IDRP decision by 9 January 2018. In the same email MyCSP confirmed that it had reviewed Dr Collins' report and believed the appropriate course of action was to refer Mr N's concerns to HM so that it could address these directly with him. MyCSP said Mr N could formally do this by completing a Med9 form. MyCSP said if he wished to appeal the injury benefit decision, he would need to follow the medical appeals process.
46. On 14 December 2017, MyCSP asked HM to clarify the level of apportionment.
47. On 19 December 2017:-

- Mr N submitted a Stage Two IDRP application. Mr N said:-

  - There had been maladministration of his PIB application. MyCSP had informed him in December 2016 that HA's technical query had been passed to the CO. But it appeared, based on documentation he had received from MyCSP via a SAR, that MyCSP did not refer the query to the CO until April 2017. When MyCSP received the CO's answer in July 2017, it initially failed to send the complete document to HM which further delayed matters.
  - MyCSP's Stage One IDRP response did not address his complaint.
  - A SAR submitted in July 2017 was not completed by MyCSP until December 2017. The ICO duly upheld his complaint. He could only assume because of the content of the information, MyCSP was reluctant to admit to the lies it had told.
  - MyCSP's record that he left the SPS naturally through age was incorrect. He had provided evidence that he was constructively dismissed. This he perceived led to the adjudicating physician being misled.
  - MyCSP had assured him that his application would be considered afresh. But Dr Collins' subsequent review constantly referred to and was guided by Dr Saravolac's initial review.
  - He perceived that by highlighting his concerns, whistleblowing to the ICO and complaining about HM and MyCSP, he had been labelled a troublemaker, and that every effort was being made to frustrate him and delay his application.

- The same day Dr Collins replied to MyCSP's 14 December 2017 query. She said:-
  - The level of apportionment was based on the medical information provided. In particular, Dr Wylie's 16 January 2017 report. In the report, Dr Wylie had undertaken a detailed consideration of the GP records in formulating his clinical opinion of the diagnosis. In this, Dr Wylie noted:-
    - A series of prior attendances at the GP surgery for symptoms / treatment for impaired mental wellbeing, from February 2002 into early 2003, in July 2003, November 2007, February 2008, January and March 2009 and 13 January 2014.
    - Letters from a Community Psychiatric Nurse dated September and November 1997, regarding treatment for anxiety.
    - A letter from a Specialist in Oral Maxillofacial Surgery, dated 9 February 2009, which gave an opinion that the symptoms under consideration were likely to be due to underlying depression for which GP treatment was recommended.
  - Based on this prior history, Dr Wylie had diagnosed a recurrent depressive disorder. In the context of this diagnosis, Dr Wylie gave his opinion that Mr N

would have been predisposed to the development of further episodes of depression.

- She believed Dr Wylie's opinion was supported by the medical evidence and that consideration of this was required in the degree of apportionment.

- However, the medical evidence indicated that the onset of the symptoms leading to the previously recognised qualifying injury lay principally within Mr N's perception of mistreatment by his employers and it was this which perpetuated the absences previously considered for injury benefit. In recognition of this, she had given an opinion of the apportionment of Mr N's qualifying injury as being 71% to 90% attributable to his duty.

48. On 9 January 2018, MyCSP notified Mr N that it could not approve his PIB application as the degree of impairment of his earning capacity had been assessed as less than 10%.

49. On 6 February 2018, MyCSP issued its Stage One IDRP decision. MyCSP noted under the heading 'The Complaint':-

- Mr N was challenging the PIB decision. Mr N believed, without being examined, unqualified persons had assumed that he would make a full recovery.

- Mr N was dissatisfied with the delay in confirming that permanency meant until his SPA of 67.

- Mr N believed he was being discriminated against because he had chosen to work beyond his pension age.

- Mr N had stated that it had been suggested that if/when he reached SPA, his mental health had improved to a point where he no longer met the conditions of the Equality Act 2010, he would no longer be deemed disabled.

- Since submitting his Stage One IDRP application, Mr N had sent further emails regarding his injury benefit application and a SAR. In an email received on 17 December 2017, Mr N had requested an additional Stage One IDRP investigation into the implications that this experience had had on his health.

50. Under the heading 'Conclusion', MyCSP said:-

- It was not medically qualified and must rely on the SMA's expertise.

- It could only comment on the procedural aspect of Mr N's application for a PIB and any subsequent appeals, while ensuring it acted in accordance with the CSIBS rules.

- While the CSIBS rules did not specifically state that an injury must be permanent; as the purpose of an injury benefit assessment was to determine impairment of a member's earnings capacity, the issue of permanency was a relevant factor for the SMA in considering the level of impairment. So, permanence in this context

related to the individual's earning capacity rather than the permanence of their condition.

- It used the SMA's medical assessment to determine if a member's injury qualified for a temporary or permanent award. A PIB award was granted when the member suffered a qualifying injury and the conditions of impairment of earnings capacity were met.

- As the SMA had assessed Mr N's impairment of earnings capacity as less than 10%, it (MyCSP) had refused his application. The SMA had considered reports from specialists, Mr N's GP and Occupational Health. Based on these reports the SMA had completed the medical assessment without the need for seeing Mr N. It could not uphold this part of Mr N's complaint.

- It accepted that its seeking clarification on what was deemed 'permanent' under CSIBS rules was prolonged and had a detrimental effect on Mr N for which it apologised.

- It did not accept that Mr N was subject to discrimination based on remaining in employment past his pension age. If an injury was not expected to improve in the future, the impairment of earnings should be considered as permanent. Those approaching or over pension age should not be treated differently in this regard, because there was nothing in the rules prohibiting individuals over pension age being eligible for an injury benefit award. In assessing an application, the length of time an individual could continue in a profession in normal circumstances / for most people would be at least until SPA. Mr N's SPA was age 67, so the SMA reviewed the potential for improvement to Mr N's earnings capacity up to this age.

- There was no evidence that Mr N had been advised that he would no longer be deemed disabled if he did not meet the qualifying conditions for a PIB at SPA and subsequently lose his entitlement.

- A member disabled within the meaning of the Disability and Equality Act 2010 did not necessarily meet the requirements under the CSIBS rules as the qualifying conditions were different.

- It was unable to comply with Mr N's request to return documents to him as these had been destroyed. Only original and certified copies of certificates were automatically returned to members. It apologised for inaccurate advice he had previously received.

- Mr N's concerns about its handling of his case were currently under investigation by the CO.

51. Later the same month, Mr N submitted a Stage Two IDRP appeal. Mr N said:-

- He wished the matters raised to be investigated by the CO.

- He wished to be personally assessed by the SMA.

- He wanted an unreserved apology from MyCSP.
- He wished to be assessed medically about the effect this had all had on him.
- He wanted his application for a PIB to be considered afresh.
- He wanted the SMA to acknowledge the loss of his personal data.

52. Commenting on the Stage One IDRP decision Mr N said:-

- The SMA had not processed his application correctly. During the transition from HA to HM, psychiatric reports had been lost. This matter had been referred to the ICO.
- As result of this loss, on 3 November 2017, MyCSP informed him that the review of his application by HM should be carried out afresh. But Dr Collins' subsequent report constantly referred to the initial review by Dr Saravolac and was guided by it. Dr Collins did not consider all the submitted information. GP reports, psychiatric reports and court documentation, the latter evidencing that, before he left SPS, SPS was going to dismiss him or was in the process of completing capability measures due to his absence, were not considered. The SMA had erroneously noted that there was no reference to ill health retirement.
- No reference was made to the fact that MyCSP had lied to him for a period of nine months about the referral of HA's technical query to the CO.
- The decision referred to "most people" and "at least" to pension age. This was subjective. He did not fall within the category of most people. He wanted his case decided as an individual.
- He considered himself disabled. He had been deemed unfit for work since 29 January 2016. He believed he should be given a face to face assessment by the SMA to decide otherwise.
- MyCSP had incorrectly informed him that: (i) the documentation evidencing that it had lied to him had been destroyed; and (ii) it had not retained his assessment notes and who made the decision.

53. In April 2018, Mr N submitted a further Stage Two IDRP application. Mr N said:-

- He had submitted numerous requests and important information to MyCSP, on numerous occasions, without a reply or acknowledgement.
- MyCSP had informed him that his request for an IDRP was refused.
- He had made numerous calls to MyCSP and had been assured a same day call back, which had not occurred.

- On three occasions the ICO had instructed MyCSP to provide him a copy of the technical query that it had submitted to the CO. This information had not been received.

- As a result of this; the altering of his records; purposeful misleading; and the loss of his medical records, his health had considerably deteriorated. He had sought continuous psychiatric help, had his medication increased, and had been certified unfit for work. He now had had to obtain the services of a solicitor to address the situation.

54. On 14 May 2018, the CO issued two Stage Two IDRP decisions. In the first, the CO said:-

    - There was no doubt that this had been a protracted and drawn out process and included unacceptable delays.

    - Some medical reports were not transferred from HA to HM. In its letter of 23 November 2017, it had apologised for this; and it now apologised again.

    - MyCSP's Stage One IDRP decision of 17 October 2017 had failed to respond to Mr N's complaint of maladministration. But, in its Stage One IDRP decision of 6 February 2018, MyCSP had subsequently acknowledged the delays and had apologised for any detrimental effects this had on Mr N. A full response on this would be issued by the CO under separate cover.

    - MyCSP acknowledged receipt of Mr N's PIB application on 7 October 2016. Due to incorrectly believing that the information supplied by SPS was incomplete, MyCSP did not submit the application to HA until 24 October 2016.

    - In December 2016, HA contacted MyCSP for technical guidance regarding the definition of permanence.

    - Having examined a large number of emails between MyCSP, HM and the CO, it could find no evidence of any deliberate attempts to mislead Mr N. On 5 January 2017, MyCSP had contacted the CO for the definition of permanence for a member near pension age and received the CO's reply on 11 January 2017. MyCSP incorrectly believed at this point that further clarification from the CO had been immediately sought regarding what permanent meant for somebody who was over pension age. Unfortunately, this was not the case. MyCSP subsequently submitted the query to the CO in March 2017 and chased the matter on 1 June 2017. MyCSP received the CO's response on 31 July 2017.

    - Following the CO's reply, and a conversation with Mr N on 8 August 2017, MyCSP noted that Mr N no longer wished to proceed with the SAR he had submitted to MyCSP in July 2017. In October 2017, Mr N submitted a SAR which MyCSP replied to in December 2017.

- Mr N believed the manner of his departure from SPS had been incorrectly recorded and that this had detrimentally affected his PIB award. But, in an email dated 21 September 2017, HM had confirmed that, while SPS had indicated that Mr N had retired at his pension age and HM was willing to review the wording of this, taking into account the information Mr N had subsequently provided about the circumstances at that time, it would not alter the outcome of its provided report.

- It had found no evidence that Mr N's case had been treated less favourably due to his complaints and the way he had left SPS.

- For these reasons Mr N's appeal was partly upheld regarding the administration of his case. There were unacceptable delays between MyCSP and the CO in determining how to treat his PIB application.

- For the distress and inconvenience caused, MyCSP and the CO must pay Mr N £250 each.

55. In the second Stage Two IDRP decision, in respect of Mr N's complaint about the assessment of his PIB, in particular the decision around permanency and how it is calculated, the CO said:-

- There was no question that Mr N considered himself disabled under the Equality Act 2010. However, as MyCSP had said in its February 2018 Stage One IDRP decision, Mr N still had to meet the qualifying criteria under the CSIBS rules to be entitled to an award.

- The decision to award a PIB was based on the SMA's assessment of the impairment of earnings capacity. In Mr N's case, and for others over pension age, this was to SPA. Permanency was part of the assessment, as the SMA needed to factor in the prospect of improvement and increased earnings ability over time.

- In the assessment process, the SMA must assess the applicant's physical and mental capabilities using the medical evidence. Also considered was the individual's experience, skills and qualifications, to assess the likelihood of their undertaking any form of employment before SPA. It was also the individual's capacity for work and earnings that was assessed not the availability of any specific roles.

- Based on these criteria, the SMA determined that Mr N's permanent impairment of earnings capacity was under 10%, not entitling him to a PIB.

- For these reasons the CO could not uphold Mr N's complaint.

56. On 10 June 2018, Mr N completed another Stage Two IDRP application. Mr N said:-

(i) He had written to MyCSP on numerous occasions without receiving an acknowledgement.

(ii) He had submitted important information for his PIB appeal and the appeal application without receiving an acknowledgement. He had requested on numerous occasions when his appeal would be heard without receiving a reply.

(iii) MyCSP had refused to issue a Stage One IDRP decision. This had not been addressed.

(iv) He had requested transcripts of calls without success.

(v) He wished MyCSP to admit its maladministration had had a profound effect on his wellbeing.

(vi) As a result of malpractice by SPS and MyCSP he was not fit for work and had not been for 20 months.

(vii) His financial loss was £750 per month.

57. The next day Mr N appealed the PIB decision.

58. Mr N's Stage Two IDRP appeal was considered by MyCSP as an appeal under Stage One IDRP. On 20 June 2018, MyCSP turned down Mr N's appeal. Responding in the same order as Mr N's points (see paragraph 56 above), MyCSP said:-

(i) This had been addressed under the CO's Stage Two IDRP decision.

(ii) This had been addressed in its email to Mr N of 4 April 2018. It had apologised and had confirmed that his appeal was being considered by HM.

(iii) In the same email it had explained that the failure to acknowledge one email did not fall under the remit of the IDRP. Any other failings were addressed under the CO's Stage Two IDRP decision.

(iv) It could only comment on the calls Mr N made following his Stage Two IDRP submission as everything prior to then was addressed under the Stage Two IDRP decision. It had reviewed the calls: 11 and 15 January 2018, 14 and 15 February 2018, 4, 16 and 17 April 2018. Either no call back was requested, a same day call back was made or in the case of Mr N's call on 17 April 2018 he was called back the next day.

(v) This had been addressed under the CO's Stage Two IDRP decision.

(vi) This had been addressed under the CO's Stage Two IDRP decision.

(vii) This aspect of Mr N's complaint was considered under the CO's Stage Two IDRP decision.

59. On 11 July 2018:-

- Mr N notified HM that he would be submitting further medical evidence and asked when his appeal was to be considered.

- HM updated Mr N on the status of his appeal. HM said the medical adviser had requested that Mr N's case be brought to the attention of the CMO (**Dr Birrell**). Dr Birrell was on leave until 16 July 2018. His case would be scheduled for review on Dr Birrell's return.

60. Later the same month, HM informed Mr N that his appeal could not be considered until he provided new medical evidence to be considered.

61. On 30 July 2018, HM (Dr Birrell) wrote a letter to MyCSP asking whether the referral should be treated as a first or second appeal of the PIB decision and clarification as to whether the appeal was considered to have been received within the 12 months allowed, or alternatively whether it required authorisation to proceed. However, as the process for an injury benefit appeal required new medical evidence and Mr N had not submitted any new medical evidence with his appeal, the case would be closed at this point. HM sent the letter to Mr N and said it would be released to MyCSP unless he asked it not to do so.

62. Mr N received the letter on 14 August 2018. The same day, Mr N emailed HM that he did not accept the review. Mr N said he had made several requests to HM not to hear his case until his Solicitor presented his medical records and the review of an independent psychiatrist. Mr N said these requests had been acknowledged and he had been informed that the review would not occur until HM was in receipt of this information. Consequently, it should be dismissed.

63. On 21 August 2018, Mr N completed a Med9 complaint. Mr N said:-

    - His PIB application had taken an unacceptable amount of time to process.
    - He had been assured that his case would be reviewed by the CMO. This had not happened.
    - He had been assured that the review would not occur until HM had all his medical records and a consultant's report he had privately funded. This had not happened.
    - He had repeatedly requested to be seen by an appropriate medical consultant. This had been refused, which contradicted section 8.3.18 of the Injury Benefit Guidelines.
    - He wanted the above matters investigated and responded to. He wished to be seen by a competent appropriate physician and compensation for the effect this maladministration and incompetence had had on his health.

64. On 5 September 2018, HM replied to Mr N's Med9 complaint. HM said:-

    - While his case had taken a long time to complete, it had actioned each stage very promptly, once it had received what it required.
    - HM understood that its previous administrative team leader on the Civil Service pensions contract, who had left HM, had informed Mr N that his case would be

reviewed by the CMO, when in fact it had been passed to a senior medical adviser. HM apologised for the misunderstanding, but the selected medical adviser was a suitable clinician to review his case.

- HM had reviewed Mr N's case on three separate occasions. Each time it had reviewed all the documents that were provided, including the specialist report.
- While Mr N had been advised by the previous team leader that his case would remain open until receipt of Mr N's privately funded report, it was required to provide advice within timescales laid down by the CO. It could not keep files open indefinitely in the expectation of receiving reports that sometimes never arrived. Therefore, the decision was taken to close the case.
- On Mr N's view that he should have been provided with a medical appointment or an independent medical assessment, PIB appeals were normally considered based on the information submitted. However, the CMO was happy to personally carry out an assessment or arrange an assessment by another senior medical adviser. If Mr N wished for this to proceed, he could request this when he submitted the new medical evidence.

65. On 10 September 2018, the CO issued a Stage Two IDRP decision in respect of Mr N's complaint that he was unhappy with the service he had received from MyCSP and his belief that maladministration and malpractice by MyCSP and SPS had left him unfit for work and £750 a month worse off. The CO did not uphold Mr N's complaint. The CO said:-

- Mr N's complaints regarding MyCSP not acknowledging other correspondence, loss of medical records, the delayed response to a technical query raised with the CO, perceived financial loss, and his application 'falling off the radar', were all addressed in the CO's Stage 2 IDRP decisions of 14 May 2018. The decisions provided Mr N with referral rights to TPO's Office and the process involved.
- Regarding MyCSP not acknowledging Mr N's email of 3 June 2018 and failing to issue correspondence via his solicitor, this was an administrative error and MyCSP had apologised for both incidents. There was no evidence to suggest that either error was intentional.
- MyCSP had explained, in its 4 April 2018 email to Mr N, why it did not consider the issue of a failed acknowledgement to an email to be eligible for an IDRP decision. Nevertheless, the issue had now been considered at both stages of the IDRP.

66. On 6 November 2018, MyCSP notified TPO's Office that it had no further comments to make in addition to the decision made at both stages of IDRP.

67. On 21 November 2018, Mr N's Solicitor submitted Mr N's PIB appeal submissions to MyCSP and a letter from Dr Birrell in which she had offered to deal with the appeal.

herself. Mr N's Solicitor asked MyCSP to forward Mr N's appeal submissions and papers to Dr Birrell.

68. The Solicitor's letter advised that Mr N was appealing the assessment of the degree of impairment of his earning capacity.

69. In a statement, Mr N said:-

- His mental health had further deteriorated.
- He had continuously been certified as unfit for work since 29 January 2016.
- He had undergone 12 CBT sessions, which had adversely affected him and therefore were discontinued.
- He was currently prescribed S…
- He remained unemployed and was not fit for gainful employment.

70. On 18 January 2019, HM chased MyCSP for a response to its letter of 30 July 2018 (see paragraph 61). The same day Mr N complained to MyCSP about the delay. MyCSP replied that it was not aware of any questions raised by HM from July 2018. Mr N asked MyCSP who was responsible for the current maladministration so that he could raise a fresh IDRP. Mr N said he had made an appointment with his consultant as he was not handling the situation very well and asked MyCSP to advise on the outcome of this latest issue.

71. HM arranged for Mr N to see another medical adviser on 6 February 2019. Mr N attended the appointment and was told it had been cancelled. A new appointment was arranged. Mr N saw Dr Griffin (Occupational Physician) on 11 February 2019. In his subsequent report, Dr Griffin said Mr N's mental wellbeing would not progress favourably while he harboured anger about SPS and his MyCSP experiences and he would continue to remain unfit for any work for at least the foreseeable future. But should this change, Mr N's health/mood would not itself prevent him from being capable of his previous full duties or comparable roles/responsibilities.

72. Dr Birrell subsequently considered Mr N's appeal.

73. The new medical evidence comprised:-

- A supplementary report from Dr Wylie dated 17 August 2018.
- A letter to the GP surgery from Ms Marr (Trainee Clinical Associate in Applied Psychology) dated 10 September 2018.
- A letter to the GP surgery from Dr Shankar (Locum Consultant Psychiatrist) dated 19 December 2018.
- Updated GP records to 20 December 2018.

- A Statement of Fitness for Work and a consultation note from Mr N's GP both dated 26 February 2019.

74. Additional submissions comprised:-

- A report from Mr Cameron (Vocational Consultant) dated 26 October 2018[7].

- A letter from Ms Terras (Carlisle and Collins Ltd)[8] to Mr N's Solicitors detailing the commissioned valuation of Mr N's pension loss as a result of resigning from SPS in September 2016.

- Papers relating to the Employment Tribunal application.

75. On 4 April 2019, Dr Birrell completed her report. The report was amended on 23 April 2019. Dr Birrell assessed Mr N's degree of apportionment as in the 71% to 90% medium band and the degree of earnings impairment as 10% to 25%, 'slight impairment'.

76. On 28 April 2019, Mr N asked MyCSP if he could submit a second PIB appeal, albeit more than 12 months had passed since the original decision to turn down his PIB had been made[9].

77. On 30 April 2019, the Department for Works and Pensions wrote seven letters to Mr N. Each concerned a claim for Industrial Injuries Disability Benefit (**IIDB**) in respect of a separate accident while Mr N was working for SPS. Each letter informed Mr N that it had been decided that the accident detailed was an industrial injuries accident, it was dealing with his claim for IIDB and he would receive a letter asking him to attend a medical examination.

78. In May 2019:-

- MyCSP informed Mr N that his second PIB appeal request was time-barred.

- Mr N asked MyCSP to review its decision. Mr N said:-

  - Dr Birrell's report was littered with factual and medical inaccuracies.

  - He would be appealing the level of apportionment as he had been to court and gained seven judgements on accidents/incidents while working for SPS that had been upheld in his favour.

[7] A summary of this report is provided in Appendix 3.

[8] Collins and Carlisle Ltd "specialise in actuarial reports and expert witness statements for the legal profession". The letter details the calculation of Mr N's future pension loss and appears to have been commissioned in relation to his Employment Tribunal claim. I have not detailed the calculation as it is not relevant to the calculation of Mr N's PIB award.

[9] The CSIB appeal procedure has only 1 stage, but 2 separate appeals may be made within 12 months of the initial award decision.

    - He was awaiting fresh medical evidence that should be available imminently.
    - He had not been a factor delaying the processing of his application.

- MyCSP turned down Mr N's first PIB appeal.
- Following subsequent email exchanges, MyCSP granted Mr N a second PIB appeal[10].

79. In June 2019, Mr N submitted a Stage 2 IDRP application in respect of the Med9 responses he had received from HM, specifically concerning the loss of personal data, dissatisfaction with HM's responses and the cancellation of a medical assessment and request for reimbursement of costs.

80. MyCSP informed Mr N that the CO could not consider the matter until it had received a Stage One IDRP decision. MyCSP said in limited circumstances the conduct of the SMA could be investigated under the IDRP if it had a direct effect on the benefits payable to a member. For example, if medical evidence was not considered that could alter the outcome of a medical application. However, Mr N's Stage Two IDRP application appeared to be directly related to his dissatisfaction with HM, including its Med9 responses, and not necessarily regarding his benefit entitlement. MyCSP asked Mr N to clarify his application.

81. On 11 July 2019, Mr N replied to MyCSP. In the first of two emails, Mr N said:-

    On the loss of personal data

    - His GP had sent hard copies of his medical records and psychiatric reports to HA. He had been informed that, when the SMA contract transferred from HA to HM, the medical data had not been forwarded on. He was asked to obtain replacements at his own cost. Nobody could inform him where the original hard copies were.
    - HM went ahead and returned a decision on his PIB application without his medical records. An IDRP was raised, and the decision was that his case should be considered afresh by a different clinician, this time with the replicated medical records.
    - The second decision highlighted that there was still medical information missing but it would not affect the outcome.
    - His complaint about a data protection breach was upheld by the ICO.
    - HM's Med9 response to the above fell short of what he expected.

[10] MyCSP granted the second PIB appeal as over the 12 months appeal period Mr N had been waiting for the outcome of several Stage One and Stage Two IDRP applications.

- The CO had assured him that the upload of his medical records had not been lost. But what had happened to the hard copies?

On maladministration

- To refer to the first, second and fourth bullet points above.
- Nearly three years had passed since he had applied for a PIB. He had countless examples of maladministration. Why had his application taken so long?

On the cancellation of the medical assessment and request for reimbursement of costs incurred

- The response from HM was unacceptable. He had incurred expenses travelling to attend the appointment and was only told it had been cancelled 30 minutes after it was meant to begin.

82. In the second email, Mr N said, that within Dr Birrell's two April 2019 reports there were several factual inaccuracies, omissions and contradictions. He believed these were the result of his whistleblowing, and comparing and highlighting HM's maladministration. Mr N asked MyCSP whether this fell under IDRP or should be included in his second PIB appeal submission.

83. On 25 July 2019, MyCSP replied to Mr N. MyCSP said the content of his latest Stage Two IDRP application related to similar concerns that had already been addressed under both stages of the IDRP and it did not believe the points he had raised in his 11 July 2019 emails were appropriate for the IDRP for the following reasons:-

    - The loss of personal data related to incidents previously addressed under the IDRP.
    - A factor that delayed the initial medical assessment was the time taken to clarify the definition of permanency for members over SPA. This had previously been addressed under the IDRP.
    - The IDRP team was not able to comment on the length of time taken by the SMA to evaluate medical evidence or to source any medical evidence.
    - The cancellation of the medical assessment/appointment did not appear to fall under the IDRP, unless it could be proven that it had affected the outcome of Mr N's PIB application.
    - The claimed factual inaccuracies in Dr Birrell's report should be included as part of his second PIB appeal. It was HM's responsibility to rectify any factual inaccuracies and assess if any correction affected the outcome of the medical assessment.

84. On 7 August 2019, Mr N submitted his second PIB appeal and a Stage One IDRP application.

85. In respect of his second PIB appeal Mr N said:-

- He wished to appeal the degree of apportionment of 71% to 90%. He had not previously appealed this because he had outstanding court appearances that were important to any further appeal. These had been heard and decided on by the Courts and Tribunal Services:-

  - The content of Dr Collins' letter of 19 December 2017 was factually incorrect and misleading. His attendances at the GP surgery in 2002, 2003, 2007 and 2008 were for immediate family bereavements. The letters to the Community Psychiatric Nurse were in relation to his failing to revive a prisoner who had committed suicide. The maxi-facial surgery was the result of a workplace assault, and therefore an accepted qualifying injury. Each occasion did not affect his productivity at work nor was he signed off work by his GP.

  - He had seven accepted instances of Industrial Injuries at work. These incidents and the subsequent bullying, victimisation and harassment were wholly responsible for the decline in his mental health.

  - His annual appraisals highlighted that he consistently performed to an exceptional standard or exceeded expectations over a constant and sustained period. This evidenced that his work was not affected by any suggestion of being predisposed to depression, or when Dr Collins had suggested that he had an impaired mental wellbeing.

  - He refuted that the decline in his mental health began prior to 2014.

  - Dr Cherukuri's (Psychiatrist) report stated that he did not have a history of mental health issues prior to the accepted Industrial Injuries and qualifying injury.

  - He had been signed off work since 29 January 2016.

  - He believed apportionment was 100% the responsibility of the actions of SPS.

- Ill health retirement was not considered.

- There were "17 points of factual inaccuracies, omissions and contradictions in Dr Birrell's report". Namely:-

  1. In her 4 April 2019 report, Dr Birrell stated that she had considered the available medical evidence. An accompanying note advised that "We will not change any professional opinions in the report but are content to review any factual inaccuracies…". If that had been followed, why did Dr Birrell then issue an amended report on 23 April 2019?

  2. Dr Birrell incorrectly said he failed to attend his most recent appointment for CBT. After 12 sessions it was agreed that he was not benefitting from CBT. He

had submitted a letter from the NHS psychological department stating this was the case, but it had not been considered. He had to provide a further copy.

3. Dr Birrell highlighted MyCSP's letter of 24 June 2015 advising that it accepted that he had a qualifying injury. But there was no mention of the letters he received in November 2015, January, May, and July 2016 of further qualifying injuries. He perceived that these omissions did not give Dr Birrell the whole picture and the effects on his mental health.

4. Dr Birrell stated there was no evidence that HM had been asked to consider him for ill health retirement. While that might be correct, he was informed by SPS on several occasions that he was being referred for capability and/or ill health retirement. His perception was that he was being dismissed. It was stated and precedent set that an individual may qualify for an injury benefit based purely on their perceptions since their symptoms were just as genuine. He had submitted court documents that stated SPS was planning to dismiss him on capability or ill health grounds. This was not considered by Dr Birrell.

5. Dr Birrell stated that Dr Wylie felt unable to provide a definitive prognosis of how long his impairment would last. But in his report, dated 31 July 2018, Dr Wylie said, "He remains signed off sick from work and remains such, given his continuing mental health difficulties, … in my opinion he is experiencing a degree of impairment of greater than 75% equating to total impairment" Given the question is degree of impairment, he perceived this to be an important omission in Dr Birrell's report.

6. Dr Birrell had referred to prescribed medication[11] in August 2018 as reasonable but not maximal. He believed the statement was outdated and therefore factually incorrect.

7. Dr Birrell stated, "that there is clearly no medical solution here", but in the next paragraph referred to a statement that alternative anti-depressant pharmacotherapy and adjunctive pharmacotherapy had not been tried. He believed this was a contradiction.

8. Dr Birrell stated it was not his medical condition that prevented him from returning to work. But his GP, several psychiatrists, an independent psychiatrist, occupational health and a vocational consultant, and Dr Griffin had all stated he was not fit and had not been fit for work since January 2016.

9. Dr Birrell previously stated that there was no medical solution, but suggested, if the primary stressor could be removed, he could return to work and attain the highest median earnings referred to in Mr Cameron's report. If there was no medical solution, how could he avail a number of treatment options? How could he remove the primary stressor?

[11] Sertraline.

10. He was on a maximum daily amount of antidepressant. He had lost his mental faculties. He did not sleep. Yet Dr Birrell suggested he could work, despite not having a solution for his accepted disability and the breakdown in his mental health.

11. Dr Birrell stated there was insufficient medical evidence to conclude, on the balance of probabilities, that he was permanently incapable of alternative gainful employment. But Dr Griffin had reported that, if he could not, or did not, progress beyond/through his held/fixated mood aggravators, he would continue to remain unfit for any work for at least the foreseeable future and Dr Birrell had stated there was clearly no medical solution here. This was an important omission and another example of selective referencing.

    Dr Birrell referred to the median average earnings. This was submitted by Mr Cameron. 19 occupations and median salaries were listed in Mr Cameron's report, the average being £18,636. Dr Birrell's calculation highlighted the top salary of the 19 and not the average. This minimised any monetary award Dr Birrell might reluctantly have to suggest to the pension provider.

12. Dr Birrell recommended impairment of between 10% to 25% but did not reference Mr Cameron's recommendation of over 75% impairment. This was an important omission.

13. The impairment suggested by Dr Wylie was also greater than 75%. Dr Birrell made no reference to that either. Again, he perceived this was because of the monetary implications to the pension provider.

14. There was no reference to the 12 counselling sessions he undertook through SPS. This was an important omission.

15. The actuary's report highlighted and projected his loss of earnings. It was compiled by an accredited firm. But the report was dismissed by Dr Birrell as not relevant. This was an important omission.

16. Dr Birrell stated that it was not his medical condition that would prevent him from working, yet his doctors all suggested that he was unfit for work as a result of his severe depression and anxiety. "Is severe depression and anxiety not a medical condition? I believe this is a contradiction to the assessments of professional people who have examined me personally on many occasions, but not that of someone who has never assessed me at all."

17. He had an accepted severe depressive and anxiety disorder. He had commissioned reports from Dr Wylie, a vocational consultant and an accredited actuary, who each personally assessed him. He also saw Dr Griffin. He was not seen or assessed by either Dr Birrell or Dr Collins. He believed any assessment if not carried out by a psychiatrist should at least refer to their notes in full. Was severe depression and anxiety not a medical condition? He

believed this was a contradiction to the assessments of professional people who had examined him on many occasions.

86. Mr N said he wanted the 17 points to be considered concurrently under both Stage One of the IDRP and second stage of the PIB appeal process.

87. In late September 2019, HM informed Mr N that presently it did not have a senior medical advisor with no previous involvement with his case to review his second PIB appeal. But it had identified an experienced physician and had the agreement of the CO to proceed on that basis.

88. The next month Mr N submitted further medical evidence that he wished to be considered in the medical assessment. MyCSP forwarded this to HM and HM confirmed to MyCSP that it had been saved to the case.

89. In late November 2019, Mr N submitted further medical evidence. HM notified Mr N, and subsequently MyCSP, that this would not be considered as the medical file had been passed to the external clinician (Dr Groom, Consultant Occupational Physician)[12] on 7 November 2019.

90. The following month MyCSP asked HM for a progress update. HM replied that, due to its complexity, the external clinician was still reviewing the case.

91. In January 2020, Mr N asked MyCSP for an update. MyCSP informed Mr N that HM had advised that the medical assessment was still under review by the external clinician. Mr N's request for the external clinician's details was refused. Mr N was informed that HM had confirmed it could not advise which medical professional was assessing his case.

92. On 10 February 2020, Dr Birrell sent an internal email to HM's Customer Service Administration Team. Dr Birrell said that Dr Groom did not have access to:

> "HMLO to check and sign the report – it has been on the case since 30/1/20. Unfortunately it has been typed as a Dr to Dr report, but in the circumstances please would you send this to him by email to check and sign.
>
> Once the final version is available it will need to be transferred the text [*sic*] into section 5 of the attached NATAPCS010 [the **Form**] and section 1 completed. I will complete the remaining sections as necessary"

93. On 19 February 2020, Mr N received the completed Form[13] in advance from HM. In section five, Dr Groom assessed Mr N's degree of apportionment as in the 71% to

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[12] HM's current CMO has informed Mr N that Dr Groom was employed by HM as a Medical Director until July 2016. Subsequently he undertook some consultancy work for HM as a contractor. This ceased in September 2019. Dr Groom was asked to consider Mr N's second PIB appeal based on his experience, as all of HM's senior physicians at the time had had previous involvement in Mr N's case.

[13] Dated 12 February 2020.

90% medium band and the degree of his earning impairment as in the band 25% to 50%, 'Impairment'. The same day Mr N sanctioned the report's release to MyCSP.

94. The next day Mr N complained to MyCSP that the CO had approved an external independent clinician suggested by HM, but Dr Groom was HM's Medical Director.

95. On 27 February 2020, an officer for the CO replied to Mr N:-

- The CO was aware that HM used independent medical advisers (**IMA**).
- The CO was not required to approve the IMA used. This responsibility rested with HM.
- The CO had no problem with HM engaging an IMA to progress a case.
- While not stated in the medical review and appeal guidelines, it was deemed standard practice.
- HM had a dedicated team that provided medical advice to the Scheme.
- If, for whatever reason, HM required the opinion of an IMA, this could include another physician within HM who was not part of the team to the CSIBS.
- Any outstanding Med9 complaints he should escalate with MyCSP to be investigated by the appropriate authority within MyCSP.

96. In March 2020:-

- MyCSP wrote[14] to Mr N that it agreed he was eligible for a PIB award.
- Mr N disagreed with the CO officer's response and asked that his complaint be considered by a CO Casework Manager. The CO Casework Manager replied:-
    - The CO's involvement was to agree the process of HM appointing an IMA, not the individual.
    - Dr Groom sat above the day-to-day management and decision-making in cases handled by HM.
    - The CO as the contract and pension Scheme Manager was asked verbally and in general terms by HM if using their Medical Director to review Mr N's second PIB appeal was acceptable. The CO agreed that it was, being a sensible and practical approach in all the circumstances.
    - The CO was content that the Manging Director was both external and independent. The previous physicians who had looked at his case had been in the same position.
    - There had been no collusion between the CO and HM in his case.

[14] On 4 March 2020.

- The CO appointed the SMA after a thorough open tender process. The qualifications of the physicians, their experience in advising pension schemes, and their reputation for integrity and the application of the CSIBS rules was paramount.

- MyCSP issued its Stage One IDRP decision on Mr N's 7 August 2019 application. The Adjudicator said:-
  - Given the nature of the 17 points raised, only the SMA was able to provide a definitive answer on the questions Mr N had raised. It was therefore necessary to await the outcome of the SMA's assessment.
  - As advised in previous correspondence, the IDRP team was not medically trained and must rely on the expertise of the appointed SMA, so the determination focused on the procedural aspects of the points raised in Mr N's Stage One IDRP rather than matters of medical opinion.
  - The crux of Mr N's application related to the content of Dr Birrell's 4 April 2019 report, which Dr Birrell amended on 23 April 2019. But Mr N had also raised concerns relating to Dr Groom's impartiality.
  - Considering the latter first, he noted that Mr N had raised his concerns directly with the CO and the CO had responded on 27 February 2020.
  - It was understandable that the SMA's use of the word 'independent' had added to Mr N's concerns in regard to HM's impartiality and his belief of collusion with the CO. However, Dr Groom's employment status would only be a concern if there was evidence his assessment and report had been completed in a biased or unfair manner. As he (the Adjudicator) was not medically trained, he was not able to comment on Dr Groom's opinion or how he had reached it.
  - It should also be noted that at no point was HM required or directed to refer Mr N's second PIB appeal to an independent party. Under the Scheme rules the SMA provided medical advice to the Scheme, there was no discretion for an independent medical body to be automatically appointed to assess an injury benefit appeal. Instead, HM chose to refer Mr N's appeal to Dr Groom for the reasons stated in its email of 27 September 2019[15].
  - On Mr N's 17 points, Dr Groom stated in his report that Dr Birrell had previously considered the errors and issued an amended report, and any further disagreements Mr N may have were in relation to Dr Birrell's opinion and interpretation of the medical evidence.
  - In light of this, he had referred to Dr Birrell's amended report when addressing Mr N's concerns.

[15] See paragraph 87.

MyCSP commented on Mr N’s 17 points in the same order:-

1. When the SMA produced a report, it allowed the applicant to review the content and highlight any factual inaccuracies. Generally, inaccuracies did not alter the outcome of an application/appeal or the SMA’s opinion. As stated by Dr Groom, Dr Birrell issued an amended report after Mr N highlighted inaccuracies in the original report to the SMA. There was no reason to question the reasoning for issuing an amended report, as it was clearly in line with the guidance provided. Therefore, this aspect of Mr N’s complaint was not upheld.

2. Dr Birrell noted that Mr N failed to attend CBT, which Mr N cited as a factual inaccuracy. But the letter from NHS West Lothian was dated after Dr Birrell’s amended report. In the letter NHS West Lothian apologised for recording that Mr N had failed to attend his final session and said its record had been corrected to ‘cancelled appointment’. This suggested that the information available to Dr Birrell was that Mr N had failed to attend CBT. While this was incorrect, the maladministration rested with NHS West Lothian and not Dr Birrell. Nonetheless, Dr Groom’s February 2020 assessment accurately reflected Mr N’s CBT, so any impact the inaccuracy may have had on Mr N’s stage one PIB appeal was rectified at stage two. Therefore, this aspect of Mr N’s complaint was not upheld.

3. Mr N had not provided specific dates for the correspondence he believed Dr Birrell had not considered. On Mr N’s member file, there were letters dated 24 November 2015 and 6 January 2016 - the former from MyCSP to the SMA regarding an application for a temporary injury benefit award or extension to paid sick leave, the latter from MyCSP confirming an extension of paid sickness absence. The letters referred to previous applications to which Mr N received outcome reports produced by the SMA. While Dr Birrell did not make direct reference to either letter, she did list the outcome reports as part of her assessments.

   The purpose of the SMA’s latest report was to assess Mr N’s conditions for a PIB award. As such it was understandable why the SMA had not referenced the letters issued by MyCSP.

   He was unable to locate the correspondence Mr N said was issued by MyCSP in May and July 2016.

   Therefore, this aspect of Mr N’s complaint was not upheld.

4. Despite stating that SPS had advised that it would refer him for an ill health retirement assessment; Mr N had admitted that an application was not submitted to the SMA. Consequently, regardless of the reasons for this, it was factually accurate for the SMA to say that it had not received an ill health application for Mr N. Additionally, the SMA was not required to now complete such an assessment in light of Mr N’s perceptions based on documents provided by SPS. Therefore, this aspect of Mr N’s complaint was not upheld.

5. While Dr Birrell did not specifically reference Dr Wylie's evaluation of over 75% impairment, Dr Birrell did note Dr Wylie's opinion that Mr N was not fit for any employment. Given that 75% impairment or over equated to total impairment, he was content that Dr Birrell had suitably considered Dr Wylie's report when coming to her opinion. Whether or not Mr N agreed with Dr Birrell's interpretation of Dr Wylie's report was a matter of medical opinion. Therefore, this aspect of Mr N's complaint was not upheld.

6. It was apparent from NHS published guidance available in December 2018 that Dr Birrell's comment that prescribed medication of S… was reasonable but not maximal was factually incorrect. Therefore, this aspect of Mr N's complaint was upheld.

   However, this did not necessarily affect the outcome of Mr N's first PIB appeal, as Dr Birrell said she did not anticipate any increase in medication would necessarily improve Mr N's condition.

7 to10.

The general theme of these points was Mr N's belief that Dr Birrell had provided conflicting information regarding how his condition affected his ability to obtain employment and any remedies which might improve this.

In her report, Dr Birrell clarified her statement regarding Mr N's employment capability by stating, as long as his primary stressor remained, there was little medication that would improve his condition. Should Mr N's primary stressor be removed, it was possible that his conditions might improve and in turn his employment capability. This was a sentiment echoed in Dr Saravolac's September 2017 report and Dr Groom's February 2020 report.

Dr Birrell's statement regarding the removal of Mr N's primary stressor and his disagreement with this related solely to medical opinion and not factual error. Therefore, this aspect of Mr N's complaint was not upheld.

11. Mr N's two concerns were Dr Birrell's belief that there was insufficient evidence to demonstrate that he was unable to obtain gainful employment and Mr N's perceived omission of information provided by Mr Cameron.

Again, Mr N's concerns regarding Dr Birrell's opinion was a medical matter. In her amended report, Dr Birrell listed the evidence she had considered when forming her opinion. This included Dr Griffin's report. He (the Adjudicator) was unable to comment on how Dr Birrell had evaluated this evidence, only that she had considered it.

When assessing Mr N's application, the SMA was required to consider how his medical conditions impacted on his chance of obtaining

employment. This required the SMA to consider roles Mr N could have reasonably obtained based on his skill set and/or education were it not for his medical condition.

As part of his report, Mr Cameron provided a number of median annual gross pay figures for varying types of full-time employment in the UK. Dr Birrell used the median salary of a male employed as a security guard or similar role as supplied by Mr Cameron. Additionally, in an email dated 28 August 2019, Dr Birrell clarified that she found the figures provided by Mr Cameron were consistent with those published by the National Careers Service.

Therefore, this aspect of Mr N's complaint was not upheld.

12. Dr Birrell confirmed she did consider Mr Cameron's report. Mr Cameron was not a certified medical practitioner. This was not to disparage Mr Cameron's opinion but rather to illustrate how the SMA considered the information he provided.

    The purpose of Mr Cameron's report was to provide an outlook on the types of employment that might be available to Mr N based on his skill set, qualifications and education. While Mr Cameron was also invited to give his opinion on Nr N's level of impairment, this was not provided with a certified medical knowledge regarding Mr N's condition and chances of recovery or improvement.

13. This aspect of Mr N's complaint was addressed under point 5 above.

14. Due to the amount of evidence submitted it was reasonable that the content of Dr Birrell's report focused on evidence she deemed relevant to her decision. Dr Birrell had confirmed she considered notes from consultations with Mr N's Occupational Health provider as part of her assessment; this aspect of Mr N's complaint was not upheld.

15. To reiterate, the extent of his role was to comment on whether the medical evidence was considered and not how the SMA interpreted it. Dr Birrell had confirmed that she did consider the Actuary's report. Whether Dr Birrell deemed it relevant or not was a matter of medical opinion which he could not comment on.

16. Similarly to his response to points 7 to 10 above, the SMA did not dispute that Mr N suffered from depression and anxiety but believed both conditions would improve to the extent that Mr N could obtain employment again should he remove his primary stressor.

17. In Dr Birrell's amended report, the list of medical evidence considered

included both of Dr Wylie's reports, notes on Dr Griffin's assessment, the Actuary's report and Mr Cameron's report. While Mr N disagreed with the extent that Dr Birrell referenced this evidence in her report, this again was a medical opinion which he (the Adjudicator) could not comment on. Nor could he add comment as to why Dr Birrell, or Dr Collins previously, decided not assess Mr N in person.

Therefore, this aspect of Mr N's complain was not upheld.

- The Adjudicator continued:-
  - It was difficult to ascertain the outcome that Mr N wished to achieve by pursuing the IDRP.
  - Mr N was aware from previous correspondence and IDRP determinations that the IDRP could not overturn the opinion of the SMA and it would not result in a change to the outcome of his PIB applications and appeals.
  - The CSIBS rules clearly stated only the SMA could decide regarding a PIB assessment or appeal. The highest level of remedial action that might be considered was for the SMA to complete a further review. But in this instance, Mr N had raised his Stage One IDRP application in conjunction with his second PIB appeal. As such any remedial action in the form of a further review was already in progress.
  - Given that Mr N had raised the same points in his Stage One IDRP application and second PIB appeal, the SMA now had the chance to reconsider Mr N's application knowing the perceived inaccuracies he had highlighted.

97. On 27 July 2020, the CO issued its Stage Two IDRP decision on HM's use of Dr Groom:

"I have reviewed the correspondence that has been issued to you from the Casework team, including your Subject Access Requests (SAR's), our initial reply of 27 February 2020 in which an explanation is given to why the Doctor in question is considered both external and independent, and all the subsequent correspondence between you and the Casework team.

I am sorry that you feel that your previous complaints to the Cabinet Office were not investigated correctly but having reviewed the correspondence I am satisfied that on each occasion the complaints procedure was followed as required."

Mr N's position

On the unacceptable time the application process has taken.

98. Mr N says:-

- Three and a half years to complete his PIB application is not within the agreed process.
- Senior Managers at MyCSP lied to him for six months, from December 2016 to July 2017, that a technical query raised by the SMA had been referred to the CO. The CO failed to act at that time.
- HA/HM lost his medical records, including GP and psychiatric reports.
- HM proceeded to make a judgement knowing that medical records were missing.
- HM and MyCSP failed to follow the correct process.

On the appointment of Dr Groom to decide his application and the content of Dr Groom's report.

99. Mr N says:-

- Dr Groom is the Medical Director of HM. HM had assured him that a report in relation to his second PIB appeal would be compiled by an independent external clinician. Clearly this was a premeditated action to mislead him.
- Dr Groom did not apply the median figure detailed in Mr Cameron's report. He applied a greater amount that negated the difference in salary to his detriment.
- Dr Groom states, "it is not clear…" and then goes on to make a wrong assumption that his GP had re-referred him for further psychiatric sessions. Dr Groom wrongly states that the psychiatrists did not have access to his full records. The psychiatric department had full access to his full medical history. The psychiatric reports were submitted to the SMA but the SMA lost them. Dr Groom refers to entries in his GP records. The entries that refer to apportionment are noted in Dr Wylie's reports as illegible.
- Dr Groom refers to a comment by Dr Wylie as to why he (Mr N) could not recollect or comment on a discrepancy[16]. The entries are marked illegible[17]. The two appointments were the result of a close family bereavement.
- Dr Groom states that "Dr Wylie's report should be given most weight". Dr Wylie states that his impairment to future earnings would be over 75%. But Dr Groom

[16] This refers to Dr Wylie's comment that the GP records noted that Mr N had suffered depressive episodes prior to 2014, but Mr N had stated that he had had none. Dr Wylie attributed this to an error of memory on Mr N's part.

[17] This refers to a handwritten entry on the GP notes dated 28 October 1991.

states this to be 25% to 50%. He sees Dr Groom's comments as a complete contradiction.

- Dr Groom states that ill health retirement was not considered. But SPS' HR department informed him in April 2016 that he was being referred for ill health retirement. This was an untruth, but one example of many acts of bullying and victimisation. He has the court documents and responses from SPS which clearly state he was being referred for ill health retirement.
- Dr Groom states that Dr Birrell corrected her factual errors, despite stating in her original report that she had read all the available evidence.
- Dr Groom correctly states that he applied for two jobs. But during the recruitment process he had to tell the companies that he was unfit for work. No interview took place and each company informed him that he was not suitable for the position.
- Despite not speaking with or seeing him, Dr Groom decided that he has the capacity for work. His GP practice and seven psychiatrists, who he has been under for five years, dictate that he is not fit for work. He is currently signed off work until November 2020 and continually has been since 29 January 2016. Dr Griffin, the independent medical assessor for HM, declared that he would not be fit for work for the considerable future[18].

The outcome decision on the degree of apportionment.

100. Mr N says:-

- It is important to note the weight HM put on Dr Wylie's reports.
- The referral to decide on the degree of apportionment is based on GP notes. The decision to deduct 10% from apportionment is based on two illegible entries.
- He worked for SPS for 31 years and six months. His GP did not sign him off work for depression and anxiety and he was not off work for either condition prior to the index injury. SPS consistently recorded his attendance as exemplary and his productivity at work as exceptional prior to the index qualifying injury. He does not believe that would have been the case if he had then been suffering from acute depression and anxiety.

The outcome decision on the degree of impairment.

101. Mr N says:-

- Dr Groom compiled an in-depth report.

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[18] Dr Griffin said: "If [Mr N] cannot, or does not progress beyond/through his currently held/fixated mood aggravators I anticipate he would continue to remain, esp on a balance of probabilities, unfit for any work **for at least the foreseeable future** [my emphasis]."

- He had three previous reports from HM clinicians: Drs Saravolac, Collins and Birrell.
- Dr Saravolac's report was compiled without access to his medical records, which the SMA had lost. After an IDRP that took several weeks, the report was dismissed, and a new report was to be done "afresh".
- The new report by Dr Collins constantly referred to Dr Saravolac's dismissed report. On appeal it was decided that Dr Birrell would do the next report.
- Dr Birrell's 4 April 2019 report omitted several facts and was amended on 23 April 2019. The amended report contained numerous factual inaccuracies, omissions, and contradictions.
- It was then decided by HM, on approval from the CO, that an independent external clinician would be identified to complete a final report.
- After receiving Dr Groom's report, he asked the CO, HM and MyCSP which company his medical records had been sent to. He was informed that the information would not be disclosed. He has duly raised a complaint with the ICO.
- Dr Groom is the Medical Director of HM and has a working relationship with Drs Birrell, Collins and Saravolac. So, Dr Groom is not external or independent and has a bias towards his colleagues.

102. Additionally, Mr N points out that he was not seen by HM. Mr N says he continually requested to HM that he be examined by a qualified psychiatrist and not by a general clinician.

Adjudicator's Opinion

103. Mr N's complaint was considered by one of our Adjudicators who concluded that no further action was required by MyCSP or SPS. The Adjudicator's findings are as follows:-

Ill health retirement

- The Adjudicator put to one side Mr N's view that he should have been referred for ill health retirement while employed by SPS, as the complaint that TPO's Office had agreed to investigate concerned Mr N's application for a PIB and the process that was followed. If Mr N wanted to apply for retrospective ill health retirement it would be necessary for him to contact his former employer.

Oral hearing

- The Adjudicator said the Ombudsman tended not to exercise his discretion to hold an oral hearing unless he was of the view that a complaint could not be adequately and appropriately determined without him hearing directly from the parties. Section 146(2) of the 1993 Act required complaints to be made in writing.

It was the Adjudicator's view that the written submissions and evidence provided were adequate to determine Mr N's complaint.

PIB

- PIB is a discretionary benefit. A person is eligible for a PIB when they suffer a qualifying injury that impairs their earning capacity by more than 10%. Impairment of earning capacity is assessed by the SMA and is the extent to which the member's earning capacity for the remainder of their expected working life has been impaired by the qualifying injury. The assessment relates only to the effects of the injury sustained through the causal incident(s). Additionally, for qualifying injuries sustained on or after 1 April 2003, the SMA assesses whether the illness is "wholly" or "mainly" attributable to the nature of the duty. Where a person met the mainly attributable test then the SMA will proceed to apportion the extent to which their duties caused their injury.

- When reviewing the SMA's advice, MyCSP would not be expected to challenge matters of medical opinion. While it could be expected to review all the available medical evidence, it could only be expected to do so from a lay perspective.

- So far as their medical opinions are concerned, HM's clinicians are not within TPO Office's jurisdiction. They are answerable to their own professional bodies and the General Medical Council (**GMC**).

- The decision to pay the benefit is for MyCSP (on behalf of the Minister) to make. But the assessment of impairment of earning capacity is for the SMA to make. MyCSP is not able to come to its own decision as to impairment but could/should ask for a review if it considers the SMA's decision to be flawed. For example, because of an error or omission of fact.

- Mr N pointed out that he was not seen by HM's clinicians. But it was for each doctor to decide if a face-to-face consultation with Mr N was necessary. Clearly each medical adviser considered that they had sufficient information/evidence to give their advice without personally examining Mr N.

- Nevertheless, prior to Dr Birrell's assessment, HM did refer Mr N to Dr Griffin. Dr Griffin said he anticipated Mr N's mental wellbeing not progressing favourably while he harboured anger about SPS and his MyCSP experiences. Should this change, presently Mr N's health/mood would not itself prevent him from being capable of his previous full duties or from undertaking/performing comparable roles/responsibilities to his previous job.

- Mr N said he had continually requested to be examined by a qualified psychiatrist and not by a general clinician. But there was no requirement under the CSIBS Rules for HM to comply with Mr N's request. The requirement was for HM, as the appointed SMA, to assess the degree of Mr N's impairment of earning capacity and to apportion the extent to which his duties caused his injury.

- Mr N's application was first considered by Dr Saravolac. Mr N said Dr Saravolac considered his case when HA/HM knew it had lost GP and psychiatric reports. But in her report Dr Saravolac noted the medical evidence she had considered, which included the five GP reports and Dr Wylie's January 2017 assessment[19], a report from Dr Haselgrove (Consultant Psychiatrist) and notes from consultations with the OH provider.

- Dr Saravolac said the medical evidence available confirmed that Mr N had a history of impaired mental health wellbeing. The GP, in his report of 4 February 2015, commented that in 2002 Mr N had some anxiety for which he was prescribed medication, while in 2006 he had some emotional response on the coming anniversary of his father-in-law's death and also some complaints of work stress. It was also noted that in 2011 Mr N attended the GP following the death of his mother. Dr Wylie had commented that in the GP record he had reviewed it was suggestive of a previous episode of depression since Mr N had been prescribed medication. In the circumstances the estimate of the degree to which Mr N's illness had been caused by the effect of the injury sustained through the causal incident was likely to be between 71% to 90% attributable.

- Dr Saravolac noted that Mr N continued to experience symptoms and remained under the review of the psychiatric services. She also noted Dr Wylie's comments that it would be reasonable to consider CBT and of particular importance in progressing Mr N's recovery would be closure on the current litigation to Mr N's satisfaction.

- Dr Saravolac gave her opinion that, with a resolution of the litigation process and continuation of treatment under the specialist services, Mr N was likely to regain functional improvement and an ability to resume work of a similar nature and pay to his former employment. For that reason, Dr Saravolac concluded that it was likely that Mr N's earning capacity had been impaired by the effect of the injury by less than 10%.

- Mr N's application was next assessed by Dr Collins. In her report, Dr Collins noted Dr Saravolac's opinion and appeared to have considered all the medical evidence. Noting Dr Wylie's report, Dr Collins gave her opinion that Mr N's history of depressive episodes was relevant to the development of further symptoms. However, the main factor underpinning Mr N's condition related to his perception of events at work. Dr Collins duly assessed Mr N's injury as being 71% to 90% attributable to duty.

- Dr Collins said the medical evidence indicated that Mr N had developed significant symptoms of mixed anxiety/depression, he had been exposed to appropriate treatment, his prognosis depended significantly on the resolution of the litigation with his employer and that Mr N remained unfit for work. Dr Collins said she

[19] In her report Dr Saravolac incorrectly dated Dr Wylie's report 27 October 2016, which was the date Dr Wylie saw Mr N.

understood that the court case had now been concluded and while this had not been to Mr N's complete satisfaction, and Mr N continued to have difficulty with the consequences of this, it was likely that this would be addressed by a pending course of CBT. Dr Collins said it was not unreasonable to expect improvement in Mr N's condition sufficient for him to be able carry out work at his previous grade and similar remuneration. Consequently, while Mr N was currently unable to work, with the benefit of future treatment, the degree to which Mr N's earning capacity had been permanently impaired by the effect of his injuries was likely to be less than 10%.

- Mr N's first PIB appeal was considered by Dr Birrell after Mr N had seen Dr Griffin. Mr N said Dr Birrell's original report was littered with factual and medical inaccuracies. But Dr Birrell appeared to have either corrected these in her amended report or merely noted the medical evidence then available and what others had said. For example, Dr Wylie's comments in his supplementary report.

- A difference of medical opinion, say between the SMA and Mr N's treating doctors, was not sufficient for the Ombudsman to find that MyCSP's acceptance of Dr Birrell's opinion meant that its decision was not properly made.

- Dr Birrell noted that Mr N was appealing the assessed degree of impairment of his earning capacity. Dr Birrell gave her opinion that it was not Mr N's medical condition per se that was preventing Mr N from returning to work in the near future, but rather his ongoing perception of injustice from his former employer which was perpetuating his psychological ill health and blocking his recovery. However, Dr Birrell recognised that it was possible for individuals to qualify for an injury benefit award purely based on perceptions since their symptoms are just as genuine.

- Dr Birrell said:-

  - Mr N was unable to detail what outcome he would consider satisfactory, but it was not unreasonable to assume that resolution and conclusion of the ongoing problems in respect of his PIB award should be beneficial in this respect.

  - If Mr N's primary stressor could be removed, it was anticipated that Mr N would then be able to avail himself of a number of treatment options, that would reasonably be expected to result in improvement in his condition, sufficient to enable him to return to some form of work.

  - Mr N's case was very finely balanced, and she did not disagree with the previous assessments of her colleagues. But, given Mr N's ongoing perceptions and incapacity with no foreseeable end date in sight, it was unlikely that he would make sufficient recovery in his condition to be able to carry out work at his previous grade with similar remuneration. Nevertheless, there was no medical reason to accept that he would not be able to undertake alternative work in due course.

- Dr Birrell correctly said she was required to assess Mr N's capability for work, not whether he was employable in the labour market as Mr Cameron had done. Using the information in Mr Cameron's report, Dr Birrell said it appeared that security guards and related occupations would be a reasonable use of Mr N's transferrable skills with gross median earnings of £23,009 per annum. Therefore, if Mr N was currently fit for alternative work his net annual earnings potential would be in the order of £6,000 less than his current salary if he had remained in his job at SPS. Dr Birrell therefore estimated the degree to which Mr N's earnings capacity had been impaired only by the effects of the injuries sustained through the causal incident was in the band 10% to 25%.

- While Mr N commented that Dr Birrell had not discussed the respective views of Dr Wylie and Mr Cameron that his impairment was over 75%, it was evident that Dr Birrell had considered both reports.

- Dr Wylie's view, expressed in his 31 July 2018 report, in answer to the question "…to what degree do you estimate [Mr N's] general earnings capacity has been impaired only by the effects of the qualifying injury (which has been accepted)?" was clearly limited to the fact that Mr N was presently unable to undertake employment. That is, Dr Wylie was giving his opinion on the current impairment of Mr N's earning capacity. In answer to an earlier question, noted in the same report, "Will [Mr N] be capable before the state pension age, of carrying out work at his previous grade with similar remuneration? If not why?", Dr Wylie said it was not an issue within his area of expertise to comment on as he was not familiar with the detailed requirements of Mr N's previous occupation or what occupations might offer Mr N a similar remuneration.

- Mr Cameron, in his report, provided a detailed breakdown of the range of earnings[20] for 19 occupations which he considered were likely to be open to Mr N if he was fit for work. Mr Cameron said since Mr N had no previous experience of such work and since it was also the case that average earnings in Scotland were lower than in the UK as a whole, it was probable that Mr N's income would be around the average lower quartile rate for the 19 occupations listed. That was £15,691 gross per annum, £14,073 net of tax and national insurance deductions.

- It was relevant to consider the effect of a person having to start a new profession with no previous experience, as but for the incapacity the person would not have had to do so. However, the person's location was not a relevant factor in the calculation of a PIB award, as this would be compensating a person for where they live rather than their incapacity.

- Mr N noted, out of the 19 occupations Mr Cameron listed, Dr Collins had chosen the top median salary, rather than average median salary for the 19 occupations. But that was not unreasonable, as Dr Collins considered that Mr

[20] Annual gross full-time pay: median, lowest decile, lower quartile, upper quartile, highest decile.

N's skills/experience were best transferrable to that of a security guard and related occupations. This happened to have the highest median salary.

- Mr Cameron said Mr N had advised that it had always been his intention to work full-time to November 2017; and then continue part-time with SPS and obtain a second part-time job. Putting to one side Mr N's pension, Mr Cameron calculated that this would leave Mr N with a net annual income of just under £6,000 more than his residual earning capacity was likely to be if he ever managed to get back to the labour market. Coincidentally, Dr Collins' approach matched this sum.

- Mr Cameron then considered Mr N's age as a factor in his earnings capacity. But age was not a factor when making a PIB award, as this would be compensating for an employer's prejudice rather than the person's incapacity.

- Finally, under the heading 'Any other information considered relevant', Mr Cameron noted Dr Wylie's view that Mr N remained unfit for any form of work and referred to the findings of a Briefing Paper presented to the House of Commons in June 2018 entitled 'People with Disabilities in Employment' and a report entitled 'Mental Health and Work' published by the Royal College of Psychiatrists in July 2013. Mr Cameron gave his opinion, based on Dr Wylie's evidence and the research findings, that Mr N's degree of impairment was over 75%. However, his own calculations showed that, if Mr N was fit for alternative employment, he could expect to earn in the region of 60% of the full-time salary of a Band D prison officer at the top of the pay scale.

- There was no reason why MyCSP should not have accepted Dr Birrell's analysis.

On Dr Groom's independence

- Mr N did not dispute Dr Groom's clinical knowledge or fitness to practise. But said he was assured that his second PIB appeal would be considered by an independent external clinician.

- There appeared to be some confusion as to Dr Groom's position at the time he gave his opinion on Mr N's second PIB appeal. The CO informed Mr N that HM's Medical Director, sat above the day-to-day management and decision-making in CSIBS cases. The CO said, in general terms, HM had asked if using its Medical Director to review Mr N's second PIB appeal was acceptable. It had agreed that it was a sensible and practical approach in all the circumstances and was content that the Medical Director was both external and independent. HM later informed Mr N that Dr Groom was its Medical Director until July 2016 and subsequently he had undertaken some consultancy work for HM as a contractor. This had ceased in September 2019. HM asked Dr Groom to consider Mr N's second PIB appeal based on his experience, as all its senior physicians at the time had had previous involvement in Mr N's case. In his report Dr Groom stated

he had had no previous involvement in the case and that he was an independent specialist occupational physician.

- Nevertheless, it was reasonable for Dr Groom to provide his medical opinion on Mr N's second PIB appeal. Procedurally there was no requirement for Mr N's appeal to be considered by an external clinician independent of HM.

- Mr N said Dr Groom's opinion was biased towards his former colleagues. But Dr Groom had considered the available medical, and other, evidence and had reached his own opinion. As a medical professional, Dr Groom could be expected to offer an unbiased opinion based on the facts of the case. Mr N had offered no evidence of bias on Dr Groom's part.

On apportionment

- It was for Dr Groom to weigh all the evidence and reach a conclusion. Dr Groom attached most weight to Dr Wylie's 2017 report on the grounds that Dr Wylie had spent considerable time with Mr N and had access to all the GP records, the occupational health notes, and hospital records.

- Dr Wylie gave his opinion that Mr N had a recurrent depressive disorder. Dr Wylie said this was based on the medical records indicating that Mr N had previously suffered from depressive episodes sufficiently severe for the GP to treat him with antidepressant medications. Dr Wyle maintained his position in his 2018 supplementary report.

- Mr N said prior to the index injury at work his GP had never signed him off work for depression or anxiety and that his employer consistently recorded his attendance as exemplary and productivity as exceptional. Nevertheless, in his 2017 report, Dr Wylie detailed the GP handwritten notes for 2002 and 2003. These included: the prescription of antidepressant A…in February 2002; its increased dosage the same month; maintenance in June and July 2002; reduction in December 2002; "off all treatment" in March 2003; and the prescription of antidepressant T…in July 2003. Dr Wylie then detailed entries in the GP computerised records, including reference in November 2007 to the antidepressant SSRI and in February 2008 to the antidepressant F…

- Based on the medical evidence, Dr Groom gave his opinion that it was not unreasonable to attribute up to 90% of Mr N's illness to the agreed qualifying injury.

- There was no reason why MyCSP should not have accepted Dr Groom's opinion on apportionment.

On Mr N's earning capacity

- In assessing a person's earnings capacity, the SMA was required to consider the person's capability for work. There was no requirement to consider the

person's age or their location. Additionally, the availability of work or the likelihood of the person being offered work was not relevant.

- In his report, Dr Groom correctly stated that the consideration he was being asked to make was not whether Mr N would ever be able to secure a job, but rather what influence the qualifying injury had had on his earning capacity.

- Dr Groom noted that while Mr Cameron had considered Mr N's employability on account of his age this was not a matter that he should consider.

- Dr Groom disagreed with Mr Cameron's view that Mr N had "few if any transferable skills". Dr Groom considered that Mr N continued to retain capacity for work and that it was not unreasonable to conclude that if Mr N focussed on recovery rather than his sense of injustice, then a capacity for work would very much be in his best interests.

- Dr Groom considered Mr Cameron's identification of appropriate salaries to Mr N's skill set in 2017 to be relevant, as the figures were drawn up at the time when the assessment of Mr N's earnings impairment was first being made. Dr Groom noted that the median gross annual pay by age range of £18,355 was almost exactly the same as the gross annual average median of £18,636 for full-time males in the UK for a variety of jobs that Mr Cameron assessed as potentially suitable for Mr N. Dr Groom considered that a combination of these two figures was not unreasonable as a reflection of Mr N's earning capacity, and taking into account Mr N's skills and experience compared to his final salary at SPS, Dr Groom gave his opinion that Mr N's earning loss was in the 25% to 50% band of impairment.

- Mr N said Dr Groom's view contradicted his comment that Dr Wylie's report should be given most weight as Dr Wylie's opinion was that his impairment of future earnings was over 75%. But, Dr Wylie's view, expressed in his 31 July 2018 report was clearly limited to the fact that Mr N was presently unable to undertake employment. That is, Dr Wylie was giving his opinion on the current impairment of Mr N's earning capacity.

- There was no reason why MyCSP should not have accepted Dr Groom's approach.

On the unacceptable time the application process has taken.

- Mr N applied for a PIB in September 2016. MyCSP acknowledged Mr N's application in early October 2016, but belatedly did not submit it to HA until 24 October 2016.

- On 16 December 2016, HA contacted MyCSP for technical guidance regarding the definition of permanence as Mr N was past pension age. MyCSP failed to properly refer the query to the CO until 24 March 2017, a delay of three months. The CO answered MyCSP's query on 31 July 2017, a delay of over four months.

- In August 2017, MyCSP updated HM and HM commenced its review of the medical evidence. HM then discovered five GP reports had not been transferred to it by HA.
- In September 2017, the reports were obtained from Mr N's GP and HM issued Dr Saravolac's report.
- In October 2017, after obtaining a copy of his file from HM via a SAR, Mr N notified MyCSP that HM's file was missing further evidence. After the submission of this evidence, HM issued Dr Collins' report at the end of November 2017.
- In December 2017, Mr N contested Dr Collins' report and MyCSP sought and obtained clarification from Dr Collins. In January 2018, MyCSP notified Mr N that, as his impairment of earnings was less than 10%, its decision was that he was not entitled to a PIB.
- In May 2018, in its Stage Two IDRP decision, the CO said there was no doubt that Mr N's application had been a protracted and drawn-out process and included unacceptable delays. The CO and MyCSP each paid Mr N £250 for this. The total sum was not unreasonable and in keeping with the recommended sum for significant non-financial injustice set out in the TPO Office's current guidance.
- On 21 November 2018, Mr N's Solicitor submitted Mr N's PIB appeal of MyCSP's decision.
- On 11 February 2019, Mr N saw Dr Griffin. On 4 April 2019, HM issued Dr Birrell's report and, following comments on it by Mr N, issued Dr Birrell's amended report on 23 April 2019.
- In May 2019, MyCSP accepted Dr Birrell's opinion and allowed Mr N a second PIB appeal. In August 2019, Mr N submitted his appeal. HM issued Dr Groom's report in February 2020 and the following month MyCSP issued its PIB decision accepting Dr Groom's opinion.
- Based on the above sequence of events, it was the Adjudicators view that from May 2018 MyCSP did not delay Mr N's PIB application.

104. Mr N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. I have noted Mr N's further comments but they do not change the outcome, I agree with the Adjudicator's Opinion.

Ombudsman’s decision

Oral hearing

105. I will begin with Mr N’s request for an oral hearing. I acknowledge receipt of Mr N’s emails of 17, 18 and 19 December 2020

106. I have the power to hold an oral hearing under the procedural discretion contained in Section 149(4) of the Pension Schemes Act 1993. However, I tend not to exercise my discretion unless I am of the view that a complaint cannot adequately and appropriately be determined without me hearing directly from the parties. For example, I might require clarification of the parties’ statements or there is some ambiguity in the evidence presented to me.

107. I have decided that an oral hearing is unnecessary as the evidence, including Mr N’s written submissions, is sufficient to determine Mr N’s complaint.

The time the PIB application has taken

108. Mr N says he cannot see that the Adjudicator considered the timescales under the CSIBS rules or guidelines for the processing of PIB applications. He says it is agreed that MyCSP and the Cabinet Office failed to process his application correctly and that this matter was addressed on 21 May 2018. But it then took MYCSP, the SMA and the CO until February 2020 to complete his application. He considers this to be unacceptable.

109. Mr N has submitted a recent email exchange he has had with MyCSP. Mr N asked MyCSP how long it expected to complete a normal PIB application. MyCSP replied:-

    - On receipt of a completed application, it had 10 working days under the contractual arrangement with the CO to either make a decision or arrange for information to be referred to the SMA for a medical assessment.

    - While the case was with the SMA for medical assessment, the timeframe was determined by the SMA’s own contractual agreements with the CO.

    - On receipt of the SMA’s medical report it had a further 10 working days to reach a decision.

110. MyCSP’s reply to Mr N was not in respect of an appeal of a PIB decision, but a PIB application. Nevertheless, my assessment of whether MyCSP took reasonable time is not fettered by a service level agreement between MyCSP and the CO; and I take into account the specific circumstances of Mr N’s case.

111. Mr N’s first PIB appeal was submitted on 21 November 2018. MyCSP referred the appeal to HM in December 2018. The matter remained with HM until late April 2019. MyCSP issued its decision in mid-May 2019.

112. Mr N submitted his second PIB appeal on 14 August 2019. MyCSP referred the appeal to HM. In late September 2019, HM notified Mr N that it had identified an experienced physician who could consider his case and had the agreement of the CO to proceed on that basis. Subsequently, HM informed Mr N that it had referred his medical file to the clinician on 7 November 2019. Dr Groom completed his report on 12 February 2020, which Mr N received in advance on 19 February. The same day Mr N authorised HM to release the report to MyCSP. MyCSP issued its decision on 4 March 2020.

113. Based on these events, I do not find that MyCSP unreasonably delayed the PIB appeal process from May 2018. I also consider that the pre-May 2018 delay to have been adequately redressed by the payment of £250 each by MyCSP and the CO.

Dr Saravolac's report

114. Mr N says Dr Saravolac's report should have been dismissed by the Adjudicator. He says that this was determined under the IDRP and HM were to produce a report "afresh". Instead, Dr Saravolac's report appears to have been an influencing factor on the Adjudicator's Opinion.

115. I disagree. The IDRP decision, dated 17 October 2017, did not determine that Dr Saravolac's report should be dismissed. It recorded that Mr N had advised HM that further documentation was missing, and it had agreed to consider his case afresh. Dr Saravolac's report remained part of Mr N's medical history and, as such, is relevant to the material facts of the case. It was appropriate for the Adjudicator to consider this report, along with the others relating to Mr N's case, and I do not consider that any undue weight was given to it.

The appointment of Dr Groom

116. Mr N says he cannot see any evidence that the Adjudicator referred to the appropriate guidelines concerning the independence of the appointed clinician.

117. Mr N refers to sections 3.2.10 (specifically an information note) and 12.1.7 of the 'Medical reviews and appeals guide' for the Civil Service Pension Scheme and the CSIBS (the **Guide**).

118. Section 3.2.10 refers to ill health retirement appeals, while 12.1.7 refers to PIB review requests (an informal appeal) following an initial award decision.

119. Dr Groom considered Mr N's second PIB appeal. Section 9.3.1 of the Guide says:

> "Any second appeal is considered by a SMA physician different from either the one who gave the original advice and/or who considered the first appeal. In most cases, the physician considering the second appeal will be a senior physician."

120. As HM did not have a senior clinician who had not been involved, after consulting with the CO, it referred Mr N to Dr Groom. I agree with the Adjudicator that

procedurally there was no requirement for Mr N's appeal to be considered by an external clinician independent of HM. Nevertheless, Dr Groom had left HM and confirmed that he was an independent specialist. I do not consider that Dr Groom's opinion has been shown to have been biased by his past association with HM. As the Adjudicator said, as a medical professional, Dr Groom can be expected to give a medical opinion based on the facts of a case. The onus is on Mr N to show any bias and he has failed to do so. Unsubstantiated allegations of bias should not and do not form a basis for finding that MyCSP should not have relied on Dr Groom's advice.

Dr Groom's report

121. Mr N says Dr Groom signed for work he did not complete and refers to section 71 of the General Medical Council's 'Good Medical Practice'. This says:

> "You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading. a You must take reasonable steps to check the information is correct. b You must not deliberately leave out relevant information."

122. Firstly, doctors are not within my jurisdiction, so I cannot consider whether there has been any breach of the GMC's 'Good Medical Practice' guidelines.

123. From Dr Birrell's 10 February 2020 internal email[21] it is evident that HM was in receipt of Dr Groom's opinion. Dr Birrell refers to Dr Groom having submitted a "Dr to Dr report".

124. The Form subsequently signed by Dr Groom has five sections. The first section, 'Details of application' comprises: 'Full Name', 'Date of Birth', 'Grade', Staff Number', 'Department', 'Episode Number', 'Date of Injury', 'Nature of Injury' and 'Last day of Service'. The second section is for listing the medical evidence considered. This is not completed, but the medical evidence is detailed in section five. Section three is a tick box for the degree of impairment and section four is a tick box for the degree of apportionment. Section five is Dr Groom's detailed medical assessment. The information in sections one, three and four is contained in section five.

125. There is no suggestion that Dr Groom colluded with Dr Birrell in the completion of section five of the Form, or that the text from Dr Groom's "Dr to Dr report" was not correctly transferred to section 5 of the Form.

126. I do not find that the sections of the Form completed by HM changed the outcome of Dr Groom's opinion causing Mr N injustice.

The decision on the degree of apportionment and impairment

127. Mr N says the GP notes Dr Wylie referred to were illegible. In fact, in his January 2017 report, Dr Wylie noted one illegible word and one poorly legible entry in the GP

[21] See paragraph 92.

handwritten notes from January 1987 to January 2005. This did not impinge on Dr Wylie's understanding of the GP notes and his noting of the prescription of anti-depressant medication.

128. Mr N says it is unfair to deem a series of close family bereavements the catalyst for him being predisposed to an accepted injury at work. Mr N comments that his "production, performance, time keeping and attendance" at SPS was consistently recorded as "exceptional" and did not reflect an employee who was suffering from depression and anxiety.

129. It is not for me to comment on the medical opinion of a doctor. I am only concerned with the decision-making process.

130. Mr N says the Guide was not adhered to as submitted medical evidence was not considered by Dr Groom. Mr N says HM refused to pass to Dr Groom medical evidence that he had submitted three months prior to the issuance of Dr Groom's report.

131. HM appears to have referred the medical evidence file to Dr Groom on 7 November 2019. Mr N made a further submission after this date to MyCSP, which MyCSP forwarded to HM. HM informed both MyCSP and Mr N that as the medical file was already with Dr Groom the new documents would not be considered as part of the medical assessment.

132. While, with the benefit of hindsight, HM could have referred the further medical evidence to Dr Groom, as his report was not completed until February 2020, its decision not to do so, as the medical file was already with the clinician, was not unreasonable. A line must be drawn at some point; as is the case with applications to me. Nonetheless, this matter does not amount to maladministration by MyCSP since it had been willing to forward on the late submission.

133. Mr N comments that the Adjudicator suggested that Mr Cameron's report was solely relating to age. He says this was a small part of an in-depth report.

134. I disagree, the Adjudicator considered the content of Mr Cameron's report in some detail. He correctly commented that, while Mr Cameron had considered Mr N's age as a factor in his earnings capacity, age is not a factor when making a PIB award, as this would be compensating for an employer's prejudice rather than the person's incapacity.

135. Mr N says:

> "The adjudicator notes that Dr Groom disagrees with an expert vocational consultant [by] whom I was assessed and interviewed at great length and considerable cost for court purposes. In addition it is actually correct that I have never spoken to, met, engaged in any form of communication [with Dr Groom]."

136. But Dr Groom is an occupational health expert, and it was for Dr Groom to decide whether he required a consultation with Mr N. Clearly, Dr Groom considered that he had sufficient evidence to give his recommendation without seeing Mr N.

137. Mr N says Dr Groom failed to evidence base that he has transferable skills and that he is "healthy enough (mentally) to carry out those duties".

138. I disagree. In his report Dr Groom said it was clear from the many documents and items of correspondence received from Mr N that he did have work capacity at least equivalent to his endeavours in composing letters and submissions arguing his case. Dr Groom said Mr N's efforts required "intellect, concentration, application and resilience", all of which Mr N clearly retained. Dr Groom noted Dr Griffin's opinion that, if Mr N was able to progress beyond his mood aggravators, he believed it would not prevent him from undertaking or performing comparable roles and responsibilities to his previous job with SPS. Dr Groom gave his opinion that with further treatment, as identified by Dr Wylie in late 2018, and Mr N's commitment to move on and recover, he could undertake work well before age 65.

139. Mr N says the Adjudicator incorrectly said that he (Mr N) had declared that Dr Wylie's report should be given the most weight. But Mr N has misread the Adjudicator's comment. The Adjudicator was referring to Dr Groom's view that most weight should be given to Dr Wylie's report.

140. Mr N says, if the medical evidence he submitted in November 2019 had been considered by Dr Groom, it would have been obvious at the time of his report, and is the case now, that his impairment of earnings remained over 75%.

141. But the fact that Mr N takes a different view to Dr Groom is not sufficient for me to find that MyCSP's acceptance of Dr Groom's opinion means that its decision was not properly made.

142. Mr N says there is a level of convenience when deciding on the degree of impairment and apportionment and far too many contradictions. Mr N says HM's clinicians and the Adjudicator accepted Dr Wylie's comment that there was a predisposed element to his injury, but discarded Dr Wylie's view on impairment. Similarly, the HM clinicians and the Adjudicator accepted Mr Cameron's analysis of the median average pay for males in the UK but discarded Mr Cameron's view that he has no transferrable skills.

143. I disagree. Neither Dr Wylie nor Mr Cameron are occupational health experts. Dr Wylie's view on Mr N's impairment was clearly a current view on Mr N's capacity for work, rather than to age 65 as required for his PIB award. But, as with a difference of medical opinion, a difference of opinion on Mr N's transferrable skills is not sufficient for me to find that MyCSP's acceptance of Dr Groom's opinion means that its decision on Mr N's second PIB appeal was not properly made. Nonetheless, Dr Groom used the median average salary for the roles Mr Cameron had identified that someone with Mr N's skills and experience could do.

144. Mr N has submitted a recent email exchange he has had with the personal assistant to the general manager of the mental health team (**MHT**) who have treated him. Mr N asked if the clinicians (Drs Haselgrove, Ononye and Cherukuri) had access to his complete medical records. He was informed that any clinician would be able to access both his electronic patient record and his paper case notes. Mr N has asked that this be considered in light of Dr Groom's comment that the reports from the hospital doctors indicate that they did not have sight of his complete primary care records, while Dr Wylie did and noted relevant entries carefully in his first report.

145. Again, this is not sufficient for me to be able to say that MyCSP's acceptance of Dr Groom's opinion means that its PIB decision was not properly made. It was for Dr Groom to attach weight to the medical evidence. Dr Groom preferred Dr Wylie's Report, which included extracts from the GP medical records.

146. Mr N has been at pains to highlight points at which the processing of his PIB application may have been less than ideal. However, for me to uphold a complaint, it is not simply the case that I must identify maladministration; I must also be satisfied that the individual has, as a result, sustained injustice. Mr N appears to have lost sight of this fact. The outcome of his case has not been adversely affected by the sometimes less than perfect approach taken by MyCSP (or HM) and consequently he has not sustained injustice.

147. I do not uphold Mr N's complaint.

Anthony Arter

Pensions Ombudsman
21 December 2020

Appendix 1

148. The relevant rules are the CSIBS Rules (as amended). These were made, on 22 July 2002, under section 1 of the Superannuation Act 1972, and came into force on 1 October 2002. Rule 1(ii) provides that benefits are paid at the discretion of the Minister.

149. Part 1 of the Scheme Rules contains the provisions for 'Persons employed in the Civil Service'. Rule 1.1 states that "This part of the scheme applies to persons serving in … the Civil Service … who: are injured … in any of the circumstances set out in Rule 1.3 …". Rule 1.3 then sets out the "Qualifying conditions" for a PIB. It states:

   "… benefits in accordance with the provisions of this part may be paid to any person to whom the part applies and

   (i) who suffers an injury in the course of official duty, provided that such injury is wholly or mainly attributable to the nature of the duty; or

   (ii) … or

   (iii) who contracts a disease to which he is exposed wholly or mainly by the nature of his duty …"

150. Rule 1.5 provides that reference to "injury" in the following provisions of the scheme should be taken to include a reference to "disease".

151. Rule 1.6 provides:

   "Subject to the provisions of this part, any person to whom this part of this scheme applies whose earning capacity is impaired because of injury and:

   (i) whose service ends before the pension age … may be paid an annual allowance and lump sum according to the Scheme Medical Adviser's medical assessment of the impairment of his earning capacity, the length of his service, and his pensionable earnings when his service ends; …"

152. Rule 1.7 provides that the annual allowance referred to in Rule 1.6 will, when added to certain other benefits, provide an income of not less than a guaranteed minimum. The guaranteed minimum incomes are set out in a table and vary according to length of service and level of impairment to earning capacity. There are four levels of impairment: slight (10% but not >25%); impairment (>25% but not >50%); material (>50% but not >75%); and total (>75%).

153. Rule 1.9a provides that, where rule 1.3(i) applies and the injury is mainly but not wholly attributable to the nature of the duty, the amount of benefits payable shall be reduced to take account of the extent to which the injury is not wholly attributable to the nature of the duty. There are three levels of apportionment for a qualifying injury: low band (50% to 70%), medium band (71% to 90%) and high band (>90%).

Appendix 2

Medical Reports

Dr Dempster (GP), 8 September 2014

154. In answer to questions raised by OH[22], Dr Dempster said:-

- Initially Mr N had a dental injury at work which caused him to take time off. Concurrently there were work stressors, which predated the dental injury. These had a growing effect on his wellbeing while he was off work and became the main reason for continued absence.

- Mr N had fully recovered from his dental injury. Mr N was agitated about historical work stressors, but there had been a general improvement in his mental health owing to progress in resolving the issues.

- Mr N perceived there had been a breach of confidentiality involving correspondence between himself and the HR department of his employer. This seemed to have added considerably to his stress related illness.

- Mr N had a dental injury in 1990 which was like his most recent one. There was no previous stress related illness.

Dr Dempster (GP), 4 February 2015

155. In a letter to OH, Dr Dempster said:-

- Mr N was seen by a colleague on 17 June 2014. Clinical entry: “ongoing problems at work”. Completed HAD’s mood evaluation, scored 6 for anxiety and 4 for depression. Provided with a sick leave certificate.

- Seen again on 30 June 2014. Appeared to have symptoms of stress related illness. Provided with another certificate.

- Last seen on 18 November 2014. Noted that Mr N still dissatisfied with his work situation and that this might be impacting on his self-confidence.

- Mr N consistently complained of work situation as the trigger for his stress related illness. No recent mention of any other contributing factors.

- Notes in April and May 2014 indicate Mr N was upset and frustrated about his work situation. No other entry around this time was suggestive of a mental illness.

- In February 2002, Mr N attended his previous GP practice complaining of fatigue and poor sleep. Prescribed A… Reviewed again in March 2002 and A…increased.

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[22] The questions asked by OH are not known.

- In January 2006, Mr N attended the practice. Upset at the coming anniversary of his father-in-law's death and complained of work stress. A review later in the month demonstrated an improvement.

- In July 2011, Mr N attended the practice following the death of his mother and a medical certificate was provided.

- There was no recent information regarding Mr N's family or social circumstances.

Dr Gourlay (GP), 22 July 2015

156. In a letter to OH, Dr Gourlay said:-

- Mr N was absent from work from 12 June to 15 July 2014. He was seen on 17 June 2014 describing problems at work, feeling stressed, no thoughts of self-harm.

- Mr N was last seen on 30 June 2015. He continued to suffer stress related to ongoing work problems.

- There was no record in the notes of any other factors that had contributed to his stress.

- There was no record of any mental health conditions.

- He had checked Mr N's medical records for any domestic relationship problems. 4 July 2011 – "Mother died very angry at the world and wonders if more medically could have been done", 5 September 2012 – "family relationships causing problem" and 30 June 2013 – "very volatile, tearful, lost sister in law on Christmas Eve, was very close".

- Mr N was referred to the mental health services for counselling regarding his frustration and anger about work-related activities. He was not seen.

- On 30 June 2015 prescribed M…but did not take. Still distressed by work situation, has poor sleep and ruminates on the problem.

Dr Dempster, 7 September 2015

157. In a letter of referral to Adult Psychiatry, Dr Dempster said:-

- Mr N had several longstanding grievances at work which he had a very fixed ideation about. He had seen a counsellor, but nothing had changed.

- He thought Mr N would benefit from seeing a psychiatrist or CPN.

- When he last saw Mr N he was beginning to realise that he was developing a paranoia and perhaps needed to address it.

Dr Haselgrove (Consultant Psychiatrist), 12 February 2016

158. The report recorded a diagnosis of "Severe depressive episode secondary to chronic work stress", "no previous psychiatric history" and "no past medical history".

159. Dr Haselgrove said:

"My impression of [Mr N] is that he is experiencing a severe depressive episode without psychotic features. His depression appears secondary to chronic work stress. I note that this man has insight into his difficulties and today was accepting of help. I have advised him that I do think it necessary for him to commence antidepressant medication which he agreed to do. I have also suggested that he take a short course of Z…and D…as required in order to help with his anxiety and insomnia. I have also suggested that he take a period of one-two weeks sick leave from work but he was resistant to this. I have asked for him to be reviewed at your surgery over the next couple of weeks and he will be seen again in clinic in approximately one month's time."

Dr Ononye (Locum Consultant Psychiatrist), 25 February 2016

160. Dr Ononye noted that Mr N had been signed off work for three months and he was expected to resume in May 2016. Mr N said he liked his job but for the grievances at work which had been ongoing for the past 26 months.

161. Dr Ononye said:-

- There was evidence of anger, misery and anxiety and Mr N appeared to believe that there was a strong possibility that he would be laid off "(paranoid ideation)". Other aspects of his mental state were within normal limits.
- Mr N appeared to be suffering from agitated depression and his underlying paranoia made him feel a scapegoat.

162. The 'Management Plan' noted:-

- It had been suggested that Mr N get in touch with his Solicitor.
- Meanwhile, Mr N should continue with C…and Z, but if his symptoms became progressive the dosage of C should be doubled.
- There could be a need for an antipsychotic if Mr N's paranoid ideation became disturbing.
- Mr N's next appointment was scheduled for six months' time.

Ms Aitken (Wellbeing Practitioner for OH Assist), 1 April 2016

163. Ms Aitken said:-

- It was important to take forward the work-related matters Mr N described, as this would be instrumental in facilitating improvement in his health.

- Mr N was undergoing counselling.
- There had been a diagnosis of work-related stress leading to severe depressive illness.
- Mr N remained unfit for work and it was unlikely that he would be able to return to work for the foreseeable future.

Dr Simpson (Occupational Physician for OH Assist), 22 April 2016.

164. In a report to the Prison's HR Manager, Dr Simpson said:

> "[Mr N] presented with symptoms of anxiety and anxious thinking styles. He has experienced some challenging situations in his workplace, including a breach of confidentiality. There have been other management issues which in turn have affected his wellbeing. Throughout the sessions[23] further issues were presented at work due to which [Mr N] experienced further distress.
>
> The outlook is that to enable [Mr N] to improve in health some degree of resolution to his work related concerns will be essential. Treatment can only achieve so much without such resolution. However, further specialist input will enable him to cope better with the work matters and progress towards fitness. Progress is likely to be slow and I would therefore advise you give consideration to re referral to Occupational Health in around 2 months."

Dr Ononye, 13 June 2016

165. In a letter to Mr N's GP, Dr Ononye said:-

- Mr N had attended a follow-up review on 26 May 2016.
- Mr N said Prison Officials had told him his complaints would not be looked into but would be handled by an independent body.
- Mr N maintained that Prison Officials were lying to him and the decisions were affecting his mood and self-esteem.
- Mr N's dosage of C… had been doubled. This had calmed down Mr N considerably.
- Mr N still experienced intermittent insomnia and a lack of libido.
- Mr N believed some members of staff had ganged up against him and that all his problems were work-related. Mr N said there had been data protection breaches. This had continued to impact on his mental health, and he believed his integrity had been hurt.

[23] The report followed a final CBT session.

- The impression gathered was that this was an adjustment disorder presenting as a mixed anxiety and depressive disorder. There were no risks presently.
- Mr N would continue on C… and Z…and R…could be introduced at night if his suspicion and paranoia caused concern.
- He had suggested the need for Mr N to work closely with his Solicitors.
- The next appointment had been scheduled for three months’ time.

Dr McEwan (GP), 29 June 2016

166. In a letter to OH, Dr McEwan said:-

- Mr N had a diagnosis of work-related stress causing severe depression.
- Mr N was currently signed off work to 23 August 2016. He did not think Mr N would be able to return to work by then.
- There were no other occupational factors contributing to Mr N’s ongoing sickness absence.
- Mr N felt work was not addressing his issues in a useful way and this had held him back from returning to work.

Dr Cherukuri (Locum Consultant Psychiatrist), 10 August 2016

167. In a letter to Mr N’s GP, Dr Cherukuri said:-

- Mr N reported ongoing issues with work-related problems.
- Since his last review he had been through an investigation with an independent body and was awaiting its report.
- Mr N reported his Solicitor had been quite helpful and had written to the necessary officials to see his case through to its end.
- On examination, Mr N was slightly anxious and spoke relevantly and coherently. It was quite apparent that he was very frustrated. Other aspects of his mental state seemed to be within normal limits. No risks were highlighted.
- He had advised Mr N to continue the medication to help with his anxiety symptoms, work closely with his Solicitor and Union and follow-up also with Occupational Health.

Dr Cherukuri, 28 November 2016

168. In a letter to Mr N’s GP, Dr Cherukuri said:-

- Mr N reported that he continued to feel victimised, had been “shut down” at work and was not referred on to any occupational health assessment. After consulting

his Solicitor, he had resigned in September 2016. But he found it difficult to move on as he felt there was no closure. He wanted an employment tribunal to issue its verdict.

- Mr N had negative ruminations about work and how he felt let down after 32 years' service. This left him quite anxious and frustrated.
- He had advised Mr N to cut down on his alcohol intake and had discussed other measures, including finding support with friends and improving his social network as a pathway towards him moving on.
- He believed most of Mr N's difficulties stemmed from difficulty in moving on.
- Mr N did not believe counselling would help but they could look at this at a later date.

Dr Wylie (Consultant Psychiatrist), 16 January 2017

169. Dr Wylie noted:-

- The report had been commissioned by Mr N's Solicitors in relation to issues pertaining to Mr N's claim against SPS for mishandling his personal data.
- Mr N stated prior to the index events at work he had never suffered any significant emotional difficulties, attended his GP with such nor undergone any formal psychiatric assessment or treatment.
- GP handwritten notes: the prescription of antidepressant A…in February 2002, dosage increased the same month and maintained in June and July 2002, dosage reduced in December 2002, off all treatment in March 2003 and the prescription of antidepressant T…in July 2003.
- GP computerised records: November 2007 - "Impression depression discussed SSRI[24]", February 2008 – "requested f[25]…", January 2009 – "noting low mood" and March 2009 - "low mood for a long time".

170. Under 'Opinion', Dr Wylie said:-

- Mr N recounted enjoying his career as a prison officer and holding himself in high esteem.
- Mr N recounted from around 2014 that he had been subject to various stressors at work, ultimately relating to data protection issues and his perception of how he was being treated by management.
- Mr N was suffering from a Depressive Disorder. It was of a "recurrent" nature, based on the medical records indicating that Mr N had previously suffered from

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[24] An antidepressant.
[25] An antidepressant.

depressive episodes sufficiently severe for the GP to treat him with antidepressant medication.

- He was unable to definitively comment on why Mr N had indicated that he had never previously suffered from any emotional difficulties nor attended his GP with such, which might simply reflect an error of memory on the part of Mr N.
- Having previously suffered from a Depressive Disorder, Mr N would have been predisposed to the development of further episodes.
- Based on the available information, however, the onset of Mr N's Depressive Disorder ultimately lay within the stressors of his perception of mistreatment by his employers, the data breaches and his grievances not being appropriately addressed.
- Mr N's GP had treated Mr N with antidepressant medication, he was signed off sick and in January 2016 referred to local psychiatric services where the diagnosis (as above) was made by the assessing consultant psychiatrist.
- Alternative antidepressant medication was commenced from which some benefit was experienced, albeit the symptomology remained in the same spectrum.
- Mr N remained under the review of the psychiatric service.
- He recommended that Mr N's antidepressant pharmacotherapy remain under its guidance. He further recommended that CBT be considered.
- Of particular importance in progressing Mr N's recovery would be a resolution to the current litigation to Mr N's satisfaction.

GP record, 23 August 2017

171. "adjustment disorders. Had recent very large payout, but still rather aggrieved and working through things. Await psychology assessment…"

GP record, 4 September 2017

172. "has had recent issues with previous agency who have lost previous medical documents, has consented for release of medical records. In the interim feels that mood has dipped and sleep affected. Also recommence C…"

Dr Saravolac (HM – Specialist Occupational Physician), 12 September 2017

173. In her report, Dr Saravolac acknowledged receipt of the requested GP reports. Dr Saravolac said she had reviewed the information and had sufficient documents to proceed with providing her advice on Mr N's PIB award and associated degree of apportionment and impairment.

174. Dr Saravolac noted:-

- The medical evidence considered: Dr Wylie's report of 16 January 2017[26], Dr Haselgrove's report of 28 January 2016, five GP reports respectively dated 8 September 2014, 4 February 2015, 22 July 2015, 28 October 2015 and 29 June 2016, previous reports from scheme advisors and notes from consultations with the OH provider.

- The nature of Mr N's condition was stated as being due to depression.

- MyCSP was satisfied that Mr N had sustained a qualifying condition and that the CO had clarified that permanency was to Mr N's state pension age.

- The criteria for a PIB.

175. Dr Saravolac said:-

- She could find no evidence that HM had been asked to consider an application for ill health retirement in respect of Mr N.

- The medical evidence available confirmed that Mr N had a history of impaired mental health wellbeing. The GP, in his report of 4 February 2015, commented that in 2002 Mr N had some anxiety for which he was prescribed medication, while in 2006 he had some emotional response on the coming anniversary of his father-in-law's death and also some complaints of work stress. It was also noted that in 2011 Mr N attended the GP following the death of his mother. Dr Wylie had commented that in the GP record he had reviewed it was suggestive of a previous episode of depression since Mr N had been prescribed medication. In the circumstances the estimate of the degree to which Mr N's illness had been caused by the effect of the injury sustained through the causal incident was likely to be between 71% to 90% attributable.

- The starting point for assessing earning capacity was how it had been affected. There was a need to assess the applicant's capability, not whether he was or was not employable. To assess the degree of disablement the applicant's background skills, qualifications, and kind of employment that could be undertaken allowing for the effects of the qualifying injury were relevant. It was also relevant whether the person could manage the job full-time or would have to work part-time. It was not necessary for the person to have found work for an assessment to be made of earning capacity. It was also important to remember that earnings in any current job did not necessarily accurately reflect potential earnings, particularly if the present job was not commensurate with the person's experience, skills and educational qualifications.

- The medical evidence confirmed that Mr N had been experiencing symptoms consistent with a depressive disorder on the background of perceived stressors within the working environment and perception of mistreatment by his employer.

[26] The date of the report was incorrectly noted as 27 October 2016 – the date Dr Wylie saw Mr N.

- She understood that initially Mr N had been treated by his GP, however, he had been seeing a psychiatrist from January 2016 who introduced alternative antidepressant medication from which he had derived a degree of benefit with some amelioration in the severity of his symptoms. She understood Mr N continued to experience the symptoms and remained under the review of the psychiatric services. Dr Wylie commented that it would be reasonable to consider CBT and of particular importance in progressing Mr N's recovery would be closure on the current litigation to Mr N's satisfaction.

- It was often difficult to conclude that an illness would not resolve or improve until all evidence-based treatment currently widely available for the illness had been completed. The reason for the difficulty was the realistic expectation in most circumstances that remaining treatment options would improve symptoms and functional capability and ability to return to work.

- On the balance of probability, it was not unreasonable that, with a resolution of the litigation process and continuation of treatment under the specialist services, Mr N was likely to regain functional improvement and ability to resume work of a similar nature and pay to his former employment. For that reason, the estimate of the degree to which Mr N's earning capacity had been impaired only by the effect of the injuries sustained by the cause of the incident was likely to be less than 10%.

Dr Van Der Speck (Locum Consultant Psychiatrist), 14 September 2017

176. In a letter to Mr N's GP, Dr Van Der Speck said:-

- Mr N had reported several issues in relation to his case against his former employer had been resolved. But he did not feel that he had had a complete resolution as the people who caused the issues for him remained in their respective roles at work. He was also upset that the situation had led to a change in his circumstances and mental health problems.

- Mr N described that there was a "huge vacuum" in his life. He felt low at most times and described his sleep as "rubbish" and his appetite as variable. He said he was not able to enjoy things as much as he had in the past and had fleeting suicidal thoughts but no plan or intent. He felt guilty about what he had put his family through due to his preoccupation with the case. He continued to have anxiety symptoms with no clear precipitant.

- On examination, Mr N was well kempt and made good eye contact. There was no psychomotor retardation or agitation. His speech was normal. His mood was subjectively low and objectively he appeared depressed.

- He had made no changes to Mr N's medication and he would be referring him to Psychology.

- He had discussed with Mr N referral to the CPN service, but Mr N was not currently ready. Mr N would discuss the matter with his GP in the future.

- Mr N was to be reviewed in six months.

GP record, 23 October 2017

177. “adjustment disorders. Is awaiting CBT despite financial recompense, still feels naturally aggrieved and angry re nature and treatment. Not fit present[ly] to undertake other work.”

Dr Wilson (Chartered Clinical Psychologist), 2 November 2017

178. Dr Wilson said:-

- On the CORE-10 Mr N scored in the “moderate” range.
- She had discussed with Mr N his grief and loss reaction regarding his previous job. She explained to Mr N that a natural healing needed to take place over the next 12 months when he is distanced from what has happened. However, there was a caveat in that Mr N had said that he still had two parts of dispute related issues that he was still dealing with.
- Mr N had agreed to do c-CBT[27] in the meantime to help him to relax and step back, with assertiveness and decision-making and tackle low mood and anxiety.
- While she felt c-CBT was probably enough she had agreed to put Mr N on the waiting list for CBT should he require it.
- Mr N was not keen on taking medication for stress and anxiety, but she had recommended to Mr N that he see his GP regularly.

Dr Collins (HM – Consultant Occupational Physician), 29 November 2017

179. Dr Collins noted:-

- The medical evidence considered. In addition to that listed in Dr Saravolac’s report this comprised reports from: Dr Van der Spec dated 21 June 2017, Dr Cherukuri dated 10 August 2016 and 16 November 2016, Dr Ononye dated 25 February 2016 and 13 June 2016, the GP dated 7 September 2015, 10 March 2016, 23 August 2017, 4 September 2017 and 23 October 2017 and the OH provider dated 15 December 2015 and 1 April 2016.
- MyCSP had accepted Mr N’s condition as a qualifying injury.
- The criteria for a PIB.
- Mr N’s state pension age.
- The GP surgery had provided copies of previous reports. While she was unable to identify one of the GP reports listed in Dr Saravolac’s September 2014 opinion, this had been superseded by subsequent more recent GP reports and

[27] Computerised Cognitive Behavioural Therapy.

contemporaneous notes from the GP surgery in August/September/October 2017 and notes transcribed from that missing report were within HM's file documentation.

- From the information provided by Mr N's GP, and confirmed by Mr N, Mr N was now reducing his prescribed medication with a view to discontinuance in time. Psychological therapy had been recommended by the mental health team and a referral for this had been made. Mr N had confirmed that he had been advised the waiting time for such treatment was 10 to 12 months.

180. Dr Collins said:-

- She had assessed Mr N's injury as being 71% to 90% attributable to duty.
- The starting point for assessing earning capacity was how it had been affected. There was a need to assess the applicant's capability, nor whether he was or was not employable. To assess the degree of disablement the applicant's background skills, qualifications, and kind of employment that could be undertaken allowing for the effects of the qualifying injury were relevant. It was also relevant whether the person could manage the job full-time or would have to work part-time. It was not necessary for the person to have found work for an assessment to be made of earning capacity. It was also important to remember that earnings in any current job did not necessarily accurately reflect potential earnings, particularly if the present job was not commensurate with the person's experience, skills and educational qualifications.
- The medical evidence indicated:-
    - Mr N had developed significant symptoms of mixed anxiety/depression.
    - Mr N had been exposed to appropriate treatment.
    - The prognosis depended significantly on the resolution of litigation with his employer relating to these issues.
    - Mr N remained unfit for work.
- The key issue in relation to Mr N's future earning capacity related, therefore, to the likely benefit of future treatment, together with the potential for any spontaneous improvement in his condition in relation to life events, particularly a conclusion to the litigation process.
- She understood from Dr Van der Spec's report of 21 August 2017 that the court case had now been concluded. While this had not been to Mr N's complete satisfaction, and he continued to have difficulty with the consequences of this, it was likely that this would be addressed by a pending course of CBT.
- It was her opinion, with the benefit of CBT and further treatment options if required, together with a continuation of existing medication if necessary, now that

the underpinning factor of litigation had been concluded to foresee Mr N’s condition further improving.

- She had no reason, on the basis of the medical evidence, to foresee that Mr N would remain incapacitated from work up to his state pension age, and it was not unreasonable to foresee an improvement in his condition sufficient for him to be able carry out work at his previous grade and similar remuneration. This being the case, while Mr N was currently unable to work, with the benefit of future treatment the degree to which Mr N’s earning capacity had been permanently impaired by the effect of his injuries was likely to be less than 10%.

Ms Marr (Trainee Clinical Associate in Applied Psychology) under the supervision of Ms Murray (Clinical Associate in Applied Psychology), 19 February 2018

181. Ms Marr said:-

- Mr N continued to report difficulty coping following the prolonged workplace dispute.
- Mr N felt while a financial settlement had been offered no one had been held accountable. He considered this was unjust and left him feeling angry and unable to trust others. Mr N reported spending most of his time ruminating about the dispute and working on another complaint he had raised in relation to his pension. He was aware this was having a detrimental impact on his mental wellbeing and had had a damaging impact on his relationship with his wife.
- Mr N reported experiencing suicidal ideation. He denied any intent to act.
- Mr N had not managed to make use of the computerised CBT intervention. He advised that he had attempted to use it a few times but found the process frustrating.
- Mr N reported some uncertainty about how their work together might help him as his main focus continued to be pursuing his complaints related to his workplace dispute.
- Despite this, Mr N reported he would like to improve his mental wellbeing. They had agreed to meet for a further session to formulate his difficulties with the view to then commencing CBT.
- She planned to meet with Mr N for a further four sessions to consider his ability to engage with psychological therapy at this time.

Dr Murphy (Locum Consultant Psychiatrist), 29 March 2018

182. In a letter to Mr N’s GP, Mr Murphy said:-

- Mr N continued to feel angry and distressed about the circumstances of his finishing work with SPS. Mr N described the financial settlement has “hush

money". It meant nothing to him as he had lost his career, integrity, marriage and mental health.

- It was far from a therapeutic interview. Mr N was defensive throughout and particularly annoyed about the suggestion that a financial settlement with the prison authority would terminate his psychological problems.
- Mr N had agreed to increase his dosage of S…and he would attend therapy.

Dr Wylie, 31 July 2018

183. In a supplementary report commissioned by Mr N's Solicitors in relation to Mr N's first PIB appeal, Dr Wylie said:-

- The report should be read in conjunction with his report of 16 January 2017.
- Mr N continued to suffer from a Depressive Disorder of a "recurrent" nature.
- On the balance of probabilities, Mr N's impairment was severe.
- The impairment had persisted to date since around the Spring of 2014.
- It was very difficult to comment on how long Mr N's condition was likely to last or Mr N's prognosis for recovery. While there had been waxing and waning in the severity of the symptomatology, Mr N appeared to have found it very difficult to move on. He appeared to derive no benefit from CBT and had been treated with antidepressant medication. The dosages were reasonable but not maximal and as yet alternative antidepressant pharmacotherapy and adjunctive pharmacotherapy had not been tried.
- The current treatment plan appeared to be solely pharmacological.
- It was difficult to see that without a change in Mr N's perspective how he would move on as he was presently unable to state what he would consider to be a satisfactory resolution of his current affairs.
- An alternative treatment plan would be a more intensive psychological therapy and review of Mr N's pharmacotherapy, which probably would need to be accessed privately.
- There appeared to have been little improvement in Mr N's psychiatric condition, nor with receiving a financial settlement from SPS.
- Mr N appeared to be considerably entrenched in his position. He appeared to wish for a degree of retribution against the people he perceived to have wronged him, in so much as they should go through the "due process" which was denied him.

- Mr N was not currently fit for work.

184. In answer to the question would [Mr N] be capable before SPA of carrying out work at his previous grade with similar remuneration, Dr Wylie said it was not within his area of expertise to comment on. However, he was not fit from a psychiatric perspective to be in gainful employment.

185. In answer to the question to what degree he estimated Mr N's general earnings capacity had been impaired[28] only by the effects of the accepted qualifying injury, Dr Wylie said, as Mr N was presently unable to work, his general earning capacity had been significantly impaired. In his opinion, Mr N was experiencing a degree of impairment of greater than 75% equating to total impairment.

Ms Marr, 10 September 2018

186. In a letter to Mr N's GP medical practice, Ms Marr said:-

- Mr N had been discharged from the Psychology Department.

- Prior to his non-attendance, Mr N had expressed some ambivalence about engaging in any further therapy.

- As documented in detail by colleagues in both psychiatry and psychology, at assessment Mr N was finding it difficult to adjust following a prolonged dispute with his workplace, which was finalised with a financial settlement. Mr N felt angry about the resolution, as he felt the employer had not been held accountable. As a result of these experiences, Mr N was consumed by rumination, which was having a detrimental impact on his mood and relationships. Mr N reported disturbed sleep, periods of frustration, tension and low mood.

- She had met Mr N for 11 sessions focusing predominantly on behavioural strategies to help Mr N cope with his current situation. Mr N engaged well, setting limits on rumination time.

- Towards the end, Mr N expressed his ambivalence about engaging in any further therapy.

- Considering the ongoing nature of Mr N's complaint against the prison service's department, she agreed with Mr N that it would be difficult for him to make any further gains in therapy at this time.

- At the final session in May 2018, Mr N scored 19 on the CORE-10, however he had just experienced a family bereavement. His CORE-10 score the week before was 11. Indicating mild severity.

[28] Dr N was provided with the Scheme's impairment table.

Dr Shankar (Locum Consultant Psychiatrist), 19 December 2018

187. In a letter to Mr N's GP, Dr Shankar said:-

- Mr N continued to ruminate about the dispute at work settled by financial compensation, which he referred to as "hush money". Mr N believed that "all CBT did was for me to accept that I'm not willing to" and he acknowledged that he was not willing to accept the "gross injustice" of what had happened to him.
- He had suggested optimising S…with the explicit purpose of allowing Mr N to reflect on the choices he made and the consequences that entailed. This might not change Mr N's well entrenched core beliefs but might allow Mr N some respite to the relationship he had with his environment.
- He understood that Mr N had approached a private psychiatrist (Dr Wylie) to obtain an opinion on his unfitness for work. Mr N reiterated that he was unfit for work.
- He had not arranged further General Adult Psychiatry follow up but if the clinical situation changed significantly he would happily review Mr N again.

Dr Griffin (Occupational Physician), 11 February 2019

188. Dr Griffin noted:-

- Mr N's primary cause of incapacity as recurrent depression and other relevant medical condition as workplace stress.
- Current prolonged mood issues since incident at work in mid-late 2015. Maintained/exacerbated by actions/interactions with his employer and his perceived experiences with PCSPS/MyCSP applications.
- Treatment options tried and planned: NHS GP and Community Mental Health Services. The latter seemingly discharged Mr N in December 2018 back to his GP with continuing S…Repeated, but infrequent, psychiatric assessments/overview, rather than continuous healthcare, via medico-legal activities by Dr Wylie.

189. Dr Griffin said:-

- The overriding aggravator to Mr N's mood experiences was his perceptions of victimisation and of substantial anger.
- Under 'Functional capabilities and restrictions': a daily living questionnaire mainly explored physical capabilities and were mostly favourable. Mr N noted his mood had a substantial adverse impact on his daily activities. Substantial impairment of self-motivation and reduced self-esteem plus extensive rumination on workplace/MyCSP experiences over the last few years.

190. Commenting on Mr N's ability to undertake his normal/former job, Dr Griffin said he anticipated Mr N's mental wellbeing not progressing favourably while he harboured

anger about his work/MyCSP experiences. Should this change, presently Mr N's health/mood would not itself prevent him from medical fitness capable of his previous full duties. Nevertheless, a likely permanent barrier to Mr N returning to work in any capacity with his previous employer was his perceived treatment by it since his whistleblowing.

191. Commenting on Mr N's ability to undertake all work, Dr Griffin said, should Mr N be able to progress beyond his mood aggravators, his mental wellbeing would not prevent him from undertaking/performing comparable roles/responsibilities to his previous job, let alone all/any work. If Mr N could not, or did not, progress beyond/through his currently held/fixated mood aggravators, he anticipated that Mr N would continue to remain unfit for any work for at least the foreseeable future.

Dr Birrell (Consultant Occupational Physician), 23 April 2019

192. Dr Birrell noted:-

- The new submitted evidence comprised:-
    - Medical reports from: Dr Wylie dated 17 August 2018, Ms Marr dated 10 September 2018, Dr Shankar dated 19 December 2018, updated GP records to 20 December 2018.
    - Other reports from: Mr Cameron (Vocational Consultant) dated 26 October 2018, Ms Terras (Associate of the Faculty of Actuaries and Director of Collins and Carlisle Ltd) dated 19 June 2017 and papers relating to the Employment Tribunal claim.
- Mr N had indicated that he no longer wished to appeal against the level of apportionment, 71% to 90% attributable.
- Mr N was appealing against the level of impairment of earnings, as advised by Dr Collins.
- Arrangements had been made for Mr N to attend an independent medical assessment, and he saw Dr Griffin for this purpose on 11 February 2019.
- In June 2015, MyCSP confirmed that Mr N's condition, depression, had been accepted as a qualifying injury for the purposes of the Scheme.
- Mr N's last day of service was on 16 September 2016 and his final annual salary was £28,891.
- The relevant criteria for a PIB award.
- As Mr N was past pension age, the potential for improvement in earning capacity was up to Mr N's SPA, in September 2026.

- There was a considerable amount of medical evidence, including from various specialists, indicating that Mr N had developed significant symptoms of anxiety and depression.
- The previous medical evidence from the occupational physicians and from the psychiatrist suggested that the prognosis of Mr N's condition depended significantly on the resolution of litigation with SPS relating to these issues.
- The medical evidence from Mr N's GP indicated that he remained unfit for work.

193. Dr Birrell said:-

- The key issues in relation to Mr N's future earnings capacity related to the likely benefit of further treatment, together with the potential for spontaneous improvement in his condition in relation to life events, particularly a conclusion to the litigation process.
- It appeared the underpinning factor of litigation had been concluded, but Mr N continued to perceive that he had been mistreated by SPS.
- Dr Wylie's report indicated that Mr N's ongoing perception of injustice was the primary stressor maintaining his mental health difficulties. Mr N had previously suffered depressive episodes sufficiently severe for his GP to prescribe antidepressants. The diagnosis was therefore considered to be recurrent depressive disorder. Dr Wylie felt unable to provide a definitive prognosis on how long Mr N's impairment was likely to last or for the potential improvement in his condition sufficient to enable him to work in the future. But he clearly stated that Mr N was currently not fit for any employment. Dr Wylie had referred to the possibilities of alternate or adjunctive pharmacotherapy. But as Mr N was presently entrenched in his position such treatment may not be successful.
- Mr N was unable to specifically detail what outcome he would consider satisfactory.
- A more intensive psychotherapeutic approach would be appropriate but would require Mr N putting his desire for recovery and motivation above his desire to see those he perceived had wronged him brought to order. It was difficult to see how this could be achieved. Plainly there was not a medical solution.
- Mr N had been treated with antidepressant medication. Initially, C…and subsequently S…Dr Wylie noted in his supplementary August 2018 report that the dosages had been reasonable but not maximal and alternate antidepressant pharmacotherapy and adjunctive pharmacotherapy had not yet been tried.

- Mr N had indicated that he had derived no benefit from CBT, although the new medical evidence from his psychologist stated that Mr N was discharged after failing to attend his last appointment.[29]
- Mr N had seen several NHS psychiatrists. The latest, Dr Shankar, recorded Mr N's condition as an adjustment disorder in the context of possible paranoid or anankastic[30] personality traits.
- She was not aware that possible personality traits had been mentioned by other specialists. Her understanding, as a non-specialist in psychiatry, was that such personality traits might make Mr N more vulnerable to depressive episodes and more resistant to treatment.
- It was clear that Mr N was currently unfit for work.
- The clinicians involved seemed to agree that there were a number of remaining treatment options, both pharmacological and psychological therapies, that would generally be of benefit in treating a depressive and/or adjustment disorder, whether in the context of possible personality traits or not. But a key issue was whether Mr N would be able to engage with and respond to treatment while entrenched in his position.
- It seemed unlikely that Mr N would make any significant recovery while he continued to perceive that he has been unjustly treated by his former employer.

194. Dr Birrell went on to say:

> "As I understand it, it is not his medical condition per se that would prevent him returning to work in the near future and therefore potentially impair his earnings capacity, but rather his ongoing perception of injustice from his former employer which is perpetuating his psychological ill health and blocking his recovery. However, I am mindful that the Pensions Ombudsman has determined that individuals may possibly qualify for injury benefit award purely on the basis of their perceptions, since their symptoms are just as genuine, even if they have had a disproportionate response to what has taken place. [Mr N] is unable detail what outcome he would consider satisfactory, but it is not unreasonable to assume that resolution and conclusion of the ongoing problems in respect of his injury benefit award should be beneficial in this respect. If the primary stressor for his ongoing condition could be removed, it is anticipated that [Mr N] would then be able to avail of a number of treatment options, that would reasonably be expected to result in improvement in his condition, sufficient to enable him to return to some form of work should he wish to do so.

[29] The Hospital subsequently apologised to Mr N, confirming he had cancelled the appointment.

[30] An obsessive-compulsive personality.

I am also aware that the assessment of earnings impairment relates only to the effects of the injuries sustained through the causal incident. I must consider whether his earnings have been permanently impaired as a result of his qualifying injury only. This case is very finely balanced and I do not disagree with the previous assessments by my colleagues. However, given [Mr N's] ongoing perceptions and incapacity with no foreseeable end date in sight, it seems unlikely that he will make sufficient recovery in his condition to be able to carry out work at his previous grade with similar remuneration, even with another employer. Nevertheless, there is no medical reason to accept that he would not be able to undertake alternative work in due course. In other words, in my opinion, there is insufficient medical evidence presented to conclude, on the balance of probabilities, that he is permanently incapable of alternative gainful employment.

[Mr N] has kindly provided an employment report written by a vocational consultant. I note the report was instructed to consider his qualifications and skill set; what roles exist in the marketplace for someone with his skills and experience; whether his earning capacity has been impaired by the qualifying injury; an opinion regarding his employability; whether his age is a factor in his earnings capacity; and any other information considered relevant. *However, in respect of a permanent injury benefit award I am only required to assess the applicant's capability, not whether or not he is employable in the labour market.*

I note that [Mr N] has no formal academic or vocational qualifications and never qualified in a skilled trade, apart from a few years in the early part of his career when he worked as a labourer and a soldier. It is stated that if he was fit for work, the kinds of jobs likely to be open to him would be more of a routine, unskilled, elementary nature, where re-training would not be required other than that provided on the job. Using the information given by the vocational consultant, it would appear that security guards and related occupations would be reasonable use of transferrable skills with median earnings of £23,009 per annum. Therefore, if [Mr N] was currently deemed fit for alternative work his net annual earnings potential would be of the order £6,000 less than his current salary.

It is consistently agreed that [Mr N] remains unfit for any form of work at the present time due to his ongoing psychological difficulties. Whether or not he is able to compete for jobs in the open market if he reaches a point whereby he is able to give consideration to getting back to the workplace is not something that is taken into account in the assessment. Therefore, in my opinion, the estimate of the degree to which the general earnings capacity has been impaired only by the effects of the injuries sustained through the causal incident is 10-25% i.e. slight impairment. However, I appreciate that the decision to award or deny any injury benefit lies with the delegated authority."

Ms Edwards (Mental Health Nurse), 25 July 2019

195. In a letter to Mr N's GP, Ms Edwards said:-

- She had discussed Mr N’s case with Dr Amin-Selin, Locum Consultant Psychiatrist, who felt Dr Shankar’s opinion of paranoid/anankastic personality traits was accurate. Dr Amin-Selim had recommended the continued prescription of S….and to consider adding R…at night. They were both of the opinion that Mr N had had input from several different agencies including Psychology and Psychiatry and had attended counselling. Mr N stated none had helped him.

- She had encouraged Mr N to increase his social interactions and perhaps attend the gym which he used to enjoy and found a distraction from his anxious and paranoid thoughts.

- No further arrangement had been made to see Mr N.

- “[Mr N] admitted that he has become totally preoccupied with the injustice for [sic] his previous treatment with the Prison Service despite the fact that he has an out of court settlement for this. He tells me that he has an ongoing case with his pensions agency at present and continually challenges people by email and has also been in contact with the Cabinet Office. It was very difficult to get him to acknowledge that this is overtaking his life to the detriment of his mental health.

  [Mr N] does not appear to have made much more progress with regards to the paranoid ideation and fixation on getting justice regarding his previous employers. He was keen to get me to include in my report that as a result of his perceived treatment and justice that he has lost all his mental faculties. I have reiterated to him that this would not be possible as I do not believe that he has lost all his mental faculties although it has had a significant impact on his mental wellbeing and that this can be attributed to his situation with his past employers.

  As mentioned I have discussed his case with Dr Amin-Selim…She is in agreement that it would not be helpful to offer [Mr N] any further appointments at this time and has made adjustments to his medication as recommended in the treatment plan. He has engaged in several other forms of therapy including CBT, counselling and further sessions with a psychological therapist and has found none of these to have been any benefit.”

Dr Groom (Consultant Occupational Physician), 12 February 2020

196. In his report Dr Groom confirmed he had had no previous involvement in the case and that he was an independent specialist occupational physician and a Fellow of the Faculty of Occupational Medicine.

197. Dr Groom said he had considered all the medical evidence in a considerable bundle of documents and had noted the outcome of Mr N’s first PIB appeal, Mr N’s written submission of 7 August 2019 and the new medical evidence Mr N had submitted, namely: a referral letter from Dr Strachan (GP) to West Lothian Adult Psychiatry dated 16 May 2015, a counselling report completed by Ms Aitken (a wellbeing practitioner) dated 25 April 2016, GP records from 1 May 2019 to 30 July 2019, an email from Ms Edwards (Mental Health Nurse) dated 15 July 2019 and a letter dated

24 July 2019, a statement of fitness for work completed by the GP dated 2 July 2019 and a second dated 2 October 2019 and prescriptions dated 2 October 2019.

198. Dr Groom noted that Mr N's submission also referred to a dental report, Dr Wylie's reports of 16 January 2017 and 17 August 2018, Mr Cameron's report of 26 October 2018 and Dr Cherukuri's 2016 report. Dr Groom said he had reviewed all of these documents.

199. Under 'Basis of consideration', Dr Groom noted:-

- MyCSP had accepted that Mr N was eligible for consideration of a PIB on account of a qualifying injury.
- The injury was in respect of a depressive illness.
- For qualifying injuries on or after 1 April 2003, attribution of the injury and earnings impairment to the nature of the duty must be considered. This principle of apportionment was assessed in three bands.
- Until his second PIB appeal Mr N had not appealed the determination regarding apportionment.
- The CO had clarified with HM that the term 'permanent' should be interpreted as being until SPA, which for Mr N was 66 years and 9 months.

200. Under 'Background', Dr Groom noted:-

- Dr Saravolac's initial advice had been reviewed as she was unable to take account of medical evidence that was not available to HM at the time.
- Dr Collins advice that Mr N's injury was 71% to 90% attributable to duty and his earnings impairment was less than 10%.
- MyCSP's subsequent decision that no benefit was payable.
- Mr N's appeal of his earnings impairment.
- Dr Birrell's view that Mr N's earnings impairment was 10% to 25% based on the difference between Mr N's final salary and the full-time median earnings of a security guard.
- Mr N's disagreement with Dr Birrell's amended report.

201. Under, 'Medical Evidence', Dr Groom said:

> "The new medical [evidence] provided by [Mr N] for his second appeal confirms that he continues to suffer with a recurrent depressive illness for which he is receiving treatment from his GP. He has been referred for psychological assessment since the first appeal and the latest information available to me regarding his mental health is contained in a report dated 15

July 2019, following his attendance at nurse-led clinic on 11 July 2019. The most recent specialist psychiatric review is that of Dr Shankar, whose report of 8 December 2018 has already been considered by Dr Birrell.

It is clear from the July 2019 assessment that [Mr N] continues to be troubled with what he considers are unresolved feelings about the way he has been treated by his former employer. Notwithstanding an out-of-court settlement, reached in August 2017, the whole situation has adversely affected his mental health and he finds it difficult to identify what would satisfy him in terms of a remedy to the situation. It is apparent that financial resolution is not sufficient. However, the available medical reports indicate that when he is asked what would help he is unable to identify anything.

[Mr N] has engaged in psychological support and has received 11 sessions of cognitive behaviour type therapy but has not found that to have been of any benefit. It has been suggested in the past that once any litigation processes have been exhausted [Mr N] should be able to move on. However I note the July 2019 report from Lesley Edwards, which includes,

"[Mr N] admitted that he has become totally preoccupied with the injustice [sic] his previous treatment with the Prison Service despite the fact that he has out of court settlement for this. He tells me that he has an ongoing case with his pensions agency at present and continually challenges people by email and has also been in contact with the Cabinet Office. It was very difficult to get him to acknowledge that this is overtaking his life to the detriment of his mental health."

Accordingly, the locum consultant psychiatrist covering [Mr N's] geographical area has decided that it would not be helpful to offer [Mr N] any further appointments in the psychiatric outpatient department, but did make some recommendations about [Mr N's] medication.

I understand from the GP notes that augmentation of the first-line antidepressant medication has been attempted but it is not clear whether the addition of r… has been effective. I note that more recently, on 13 November 2019, [Mr N] had an appointment at the Department of General Psychiatry at St John's Hospital, Livingston with Dr Amin-Selim, the locum psychiatric consultant covering the East Calder area. It is not known what the outcome of this assessment was, if it went ahead, but I can only assume that following the July assessment by the mental health nurse in the department, [Mr N] has been re-referred by his GP for further assessment.

All of this suggests, somewhat as expected by those psychiatrists who have seen [Mr N], that he continues to be fixated by a sense of injustice at the way he perceives he has been treated by his former employer. This is likely to be in part as a result of his personality traits, as identified by Dr Shankar in December 2018.

[Mr N] has raised the issue of whether he suffered mental health problems prior to his difficulties at work. He does this specifically in relation to this current appeal, appealing for the first time against the degree of apportionment of his award. Previously he was content with the level of apportionment at 70 to 90%. In support of his position that he never had mental health problems prior to 2015, [Mr N] states that attendances at his GP surgery prior to 2015 were on account of family bereavements. He states that he had no time off work on account of those matters. He also relies on various reports by psychiatrists who saw him during 2016 which state that [Mr N] had no previous psychiatric history. These reports (from Dr Haselgrove, Dr Ononye and Dr Cherukuri) indicate that the hospital doctors did not have the benefit of sight of [Mr N's] complete primary care records. Dr Wylie, the psychiatrist from whom [Mr N] sought a report in 2016 to support his case did have access to [Mr N's] complete primary care records and noted the relevant entries carefully in his report.

Dr Wylie saw [Mr N] on 27 October 2016 and he notes at paragraph 16 of his report, "Relevant information from additional sources", a number of entries in the GP records that identify periods when [Mr N] consulted his GP on account of anxiety and low mood and the GP having prescribed antidepressant medication. These entries in the GP record were made in 1991, 2002, 2003 and 2007. In 2008 [Mr N] requested that his GP prescribed an antidepressant and it was noted in March 2009 that he had suffered "low mood for a long time. Complex issues underlying, loss and illness of family and friends."

In his personal account to Dr Wylie, recorded in his report, [Mr N] insisted that he had suffered no mental health issues prior to 2014, when he reported that following a grievance against management he started suffering with work-related stress. Dr Wylie records, "I note that [Mr N] indicated during the course of assessment for the purpose of this report that he had never previously suffered from any emotional difficulties nor attended his general practitioner with such."

Dr Wylie's opinion is that on account of the mental health problems [Mr N] suffered prior to 2014 the correct diagnosis is one of recurrent depressive disorder. Dr Wylie noted that the depressive episodes suffered by [Mr N] prior to 2014 and noted by the GP had been "sufficiently severe for his general practitioner to treat him with antidepressant medication."

Dr Wylie concluded, "I am unable to definitively comment upon the reason for this apparent discrepancy which may simply reflect an error of memory on the part of [Mr N]."

202. On [Mr N's] 17 points "of factual inaccuracies, omissions and contradictions by the first appeal clinician Dr Birrell", Dr Groom said he considered that Dr Birrell had corrected the factual errors highlighted by [Mr N] in her amended report and that the issues that [Mr N] continued to argue were to do with Dr Birrell's professional opinion

and her interpretation of the evidence she considered. While [Mr N] might disagree with Dr Birrell's interpretation of the evidence and her opinions and challenge them, as he had done with every clinician who had considered his PIB application, that did not mean Dr Birrell's opinions and interpretation of the available evidence were wrong. He could find no evidence that Dr Birrell had drawn unreasonable, bizarre or patently wrong conclusions from the evidence she considered.

203. On apportionment Dr Groom said:

> "Given the foregoing consideration of the available medical evidence I consider that it is not unreasonable to attribute up to 90% of the illness [Mr N] suffers to the agreed qualifying injury. Whatever [Mr N] has told various psychiatrists who have seen him over the years, I consider that Dr Wylie's report should be given the most weight. Dr Wylie spent considerable time with [Mr N] and had access to all the GP records, the occupational health notes and hospital records. It is clear from Dr Wylie's evidence and the primary care records that [Mr N] did have mood difficulties for which he consulted his GP and for which his GP felt it necessary to prescribe antidepressants, on a number of occasions and all well before 2014.
>
> Therefore, [Mr N] having an established diagnosis of a recurrent depressive illness prior to 2014 and considering his enduring personality traits, as identified by Dr Shankar, this made [Mr N] far more susceptible to the difficulties that were to arise following his perceived treatment at work from 2014 onwards. Whilst it is clear that the majority of the attribution of his current mental health problems lies with the agreed qualifying injury sustained at work, I consider that it is reasonable to apportion up to 10% as being the result of pre-existing mental health problems and personality traits. I therefore agree with the previous decisions that 71-90% of the illness should be considered attributable to the qualifying injury, which were accepted by [Mr N] until this appeal."

204. On earnings impairment Dr Groom said:

> "[Mr N] contends that he has no earnings capacity and will never be able to return to the workplace before his state pension age. He believes that he should therefore receive benefits commensurate with total impairment, which means a greater than 75% loss of earnings. As noted earlier, [Mr N] relies specifically on the reports from Dr Wylie, Mr Cameron's assessment of his future earnings and Dr Griffin's report from February 2019.
>
> Dr Wylie's response to the question posed by [Mr N's] solicitor in the letter of instruction, "Please indicate in the table below to what degree you estimate [Mr N's] general earnings capacity has been impaired only by the effects of the qualifying injury", is:
>
> "As stated, I would not consider that at the present time [Mr N] is able, on account of his mental health difficulties, from undertaking employment and

thus his general earning capacity has been significantly impaired. He remains signed off sick from work and as such, given his continuing mental health difficulties, would be in my opinion he is [sic] experiencing a degree of impairment of greater than 75% equating to total impairment."

My interpretation of Dr Wylie's statement is that at the time of his report, 17 August 2018, [Mr N's] degree of earnings impairment was assessed as being greater than 75%. Nevertheless, within the same report, written following a consultation on 31 July 2018, it is noted that [Mr N] told Dr Wylie that he had applied for two jobs and was looking for jobs with the minimum wage. That suggests that [Mr N] considered himself to have some earnings capacity; whether he actually secured the job is immaterial to the consideration of his earnings capacity.

I do agree with Dr Wylie that given the intrusiveness of [Mr N's] enduring rumination on the various matters that he feels he has been dealt an injustice about, that his earnings capacity is likely to be significantly reduced. However, the psychiatric evidence available is that his dealings with Civil Service Pensions have become all consuming. Indeed [Mr N] told Dr Wylie in July 2018, as recorded in his report, that he "thinks about nothing else every day", and "I want the people who did what they did to me to go through the due process" and "I cannot let this go."

[Mr N] has indicated to various clinicians who have assessed him, including to Dr Wylie at the psychiatric assessment in July 2018, that he does not know what would be sufficient resolution to allow him to move on. Dr Wylie records, "[Mr N] himself is unable to specifically detail what outcome he would consider satisfactory." Dr Wylie suggests, and I agree, that with regards to [Mr N's] mental health a more intensive psychotherapy approach would be appropriate and might be more successful, but that such an approach would probably need to be accessed privately. Dr Wylie adds a caveat to his recommendation, "This would, however, require that [Mr N] was motivated to recover from a psychiatric perspective and put his desire for recovery and motivation therefore above that of his desire to see those he perceived as wronged against him brought to order for the perceived behaviour." This is the essence of [Mr N's] current situation, as I see it from the evidence provided.

I consider that it is clear from the many documents and items of correspondence received from [Mr N] that he does have work capacity, at least equivalent to his endeavours in composing letters and submissions arguing his case for the past three years. His efforts manifestly require not only intellect but concentration, application and resilience, all of which he clearly retains. Dr Griffin indicates in his report from 2019 that if [Mr N] were able to progress beyond his mood aggravators then he believed that [Mr N's] mental wellbeing would not prevent him from undertaking or performing comparable roles and responsibilities to his previous contracted job. The issue is whether [Mr N] either wants to or can move on with this matter. The

evidence is such that he may not be able to, but without an attempt at more intensive psychotherapy along the lines suggested by Dr Wylie it is not known whether [Mr N] can progress.

Mr Cameron's assessment of [Mr N's] earning capacity considers a variety of information sources, including Dr Wylie's conclusions, [Mr N's] age, likely roles for a person with [Mr N's] skills and experience and analysis of the employment of those with mental health problems, published by the Royal College of Psychiatrists. Mr Cameron calculates that [Mr N] has sustained an earnings loss of, for the sake of argument, around £10,000 per year as he is no longer employed as a Residential Officer for the Scottish Prison Service. Mr Cameron cites the Annual Survey of Hours and Earnings (ASHE) published by the Office of National Statistics in November 2017, which at the time of the first consideration of [Mr N's] injury benefit was the latest available confirmed earnings data.

An assessment of earnings impairment should be completed on leaving employment, which [Mr N] did in September 2016. Prior to his absence from work on account of work-related stress [Mr N] was working a full week. Mr Cameron uses a standard 37.5 hour week when considering [Mr N's] earning potential. The consideration I am asked to make is not whether [Mr N] would ever be able to secure a job, but rather what influence the qualifying injury has had on his earnings capacity. Mr Cameron considers [Mr N's] employability on account of his age but that is not a matter that I should consider. Mr Cameron concludes that [Mr N] has "few if any transferable skills", a conclusion that I do not agree with and struggle to find evidence for.

I consider that [Mr N] continues to retain capacity for work. I believe that it is not unreasonable to conclude that if [Mr N] focussed on recovery rather than his sense of injustice, then a capacity for work would very much be in his best interests. Worklessness, for whatever reason, is not in [Mr N's] best interests and is associated with poor health, particularly mental health difficulties. There is much medical literature providing evidence to support the contention that work is in most cases good for individuals, not just for the financial benefit it provides but for the other non-financial benefits that working affords. I therefore consider that with further treatment, as identified by Dr Wylie in late 2018, and commitment from [Mr N] to move on and recover, that he could undertake useful and beneficial work well before his state retirement age.

I consider that Mr Cameron's identification of appropriate salaries to [Mr N's] skill set in 2017 is still relevant now, as those figures were drawn up at the time when the assessment of [Mr N's] earnings impairment was first being made. The median pay by age range of £18,355 is almost exactly the same as the average median of £18,656 for full time males in the UK for a variety of jobs that Mr Cameron assessed as potentially suitable for [Mr N]. I consider that a combination of these two figures is not unreasonable as a reflection of [Mr N's] earning capacity, taking into account his skills and experience. Using

[Mr N's] final salary, as given in the bundle, of £28,891, these two figures give an earnings loss of 35 or 36%, either of which is in the 25 to 50% band of impairment. I do not believe that the evidence available to me supports the contention that [Mr N's] earnings capacity equates to more than 75% earnings impairment.

Dr Wylie suggests within the second of his reports that the remedy to the ongoing issues for [Mr N] appears not to be financial. It may be that the exact quantum of his injury benefit is not important to him. If not, then it is difficult to understand why he has appealed the injury benefit decision again. If what [Mr N] said to Dr Wylie reflects his true target in this matter, in that he wishes those whom he considers were responsible for his agreed injury to undergo "due process", then he is misguided if he thinks that challenging decisions made about the permanent injury benefit award is an appropriate way to achieve that aim."

Appendix 3

Mr Cameron's (Vocational Consultant) Employment Report, 26 October 2018.

205. In his report Mr Cameron said he had been instructed to consider:-

- Mr N's qualifications and skills set.
- What roles existed in the marketplace for someone with Mr N's skills and experience.
- Whether Mr N's earning capacity had been impaired by his recurrent depressive disorder.
- Mr N's employability.
- Whether Mr N's age was a factor in his earning capacity.
- Any other information considered relevant.

On Mr N's qualifications and skill set

206. Mr Cameron said Mr N had no formal academic or vocational qualifications. Apart from a few years early in his career, when he worked as a labourer and as a soldier, he had not qualified in a skilled trade. The vast bulk of his career had been spent as a prison officer. Consequently, as he was unable to work in that capacity, he had few transferrable skills.

On the job roles in the marketplace for someone with Mr N's skills and experience

207. Mr Cameron said If Mr N was fit for work the jobs likely to be open to him would be routine, unskilled and elementary in nature. Examples of such jobs included: care worker and home carer, undertaker, mortuary or crematorium assistant, sports and leisure assistant, caretaker, sales and retail assistant, debt, rent and other cash collector work, call and contact centre work, elementary process work, cleaner, security guard, warehouse operative, kitchen porter, hospital porter, bar staff and other elementary occupations.

On whether Mr N's earning capacity had been impaired by the qualifying injury

208. Mr Cameron said elementary vacancies on the UK government's Universal Job Match website showed in most cases remuneration offered at minimum wage rates. Since April 2018, the National Living Wage had been £7.83 per hour. Based on a standard 37.5 hours working week this equated to a gross annual income of £15,260, £13,664 net.

209. Mr Cameron's report included a table of the range of earnings associated with 19 jobs likely to be within Mr N's skill set and experience. The earnings data was taken from the 'Annual Survey of Hours & Earnings' (**ASHE**) published by the Office for National

Statistics in November 2017. For 'Security guards and related occupations' the table showed:

Annual gross pay full-time males UK 2017	Median	Lowest decile	Lower quartile	Upper quartile	Highest decile
Security guards and related occupations	23,009	15,614	18,366	28,343	x
Average for the 19 jobs	18,636	13,610	15,691	22,449	31,318

210. Mr Cameron said, in respect of the jobs listed, as Mr N had no experience of the work; and since ASHE showed average earnings in Scotland were lower than in the UK as a whole, which the figures in the table were based on, it was improbable that Mr N could expect to enjoy an income at or above average (median) rates. Rather his residual earnings for such occupations would probably be lying around the average lower quartile and rate of £15,691 gross per annum, £14,073 net of tax and national insurance.

211. Mr Cameron said Mr N had advised that his gross annual earnings when he left SPS was approximately £29,000. This was consistent with the level of income of someone at the top of Band D.

212. Mr Cameron's report included a table of the SPS main staff group pay rates: 1 April 2018 to 31 March 2019. The prevailing rates of pay for Band D showed as:

Pay Band	Pay Point			
	1	2	3	4
D	£23,564	£25,768	£28,060	£30,356

213. Mr Cameron said, from the above, if Mr N had still been working at SPS it was likely that his level of income would be £30,356 gross per annum, £23,981 net of tax and national insurance. So, if Mr N was deemed fit for alternative employment his net earnings potential would be around £9,908 less than if he was still working as a full-time prison officer.

On Mr N's employability, comparing his previous intended career path within the SPS too his residual earning capacity

214. Mr Cameron said, Mr N had advised that it had always been his intention to remain in full-time employment with SPS until November 2017, by when he would have secured his full pension, and then remain in employment as a prison officer on a part-time basis working half his previous hours. Mr N said he might have been attracted to taking-up a second part-time job.

215. Mr Cameron said the current average gross annual salary in Scotland for van drivers was £18,579. If Mr N was to have undertaken such work on a part-time basis it was probable, he could have been capable of earning in the region of £9,290 gross per annum. That would take his current annual income up to around £24,468 gross, £20,036 net, plus the continued benefit from his full pension.

216. On that basis, even if his pension payments were put to one side, Mr N's net annual income would have been some £5,963 (that is £20,036 - £14,073) more than his residual earnings were likely to be if he ever managed to get back to the labour market.

On whether Mr N's age was a factor in his earnings capacity

217. Mr Cameron said based on the most recent Annual Survey of Hours and Earnings across all occupations within the economy published by the ONS[31] there was a pattern of regular earnings growth up to age 49, after which median pay started to drop slightly until age 60+ when it diminished more significantly.

Median pay by age range 2017

Description	Median
All employees	23,474
16-17	x
18-21	9,912
22-29	20,593
30-39	25,902
40-49	26,626
50-59	25,092
60+	18,355

[31] Office for National Statistics

218. Mr Cameron said the issue of what Mr N's residual earnings capacity might be had been addressed above. However, the issue was not so much whether age was likely to be a factor in Mr N's residual earnings capacity, but whether Mr N's age was likely to act as a barrier to him getting back to work even if his psychological health recovered. Scottish government research showed clearly that age was a factor in employment and that employment dropped more significantly for males aged 50 to 64.

On any other information considered relevant

219. Mr Cameron noted that Dr Wylie had confirmed that currently Mr N remained unfit for any work.

220. Mr Cameron referred to:-

- A Briefing Paper presented to the House of Commons in June 2018, entitled 'People with Disabilities in Employment', that found less than a quarter of people with mental health conditions were in employment.
- A July 2013 report by the Royal College of Psychiatrist's entitled 'Mental Health at Work' that found:-
  - People with mental health problems find it more difficult to obtain work.
  - About half of employers would not wish to employ a person with a psychiatric illness, albeit companies that had done so did not generally regret their decision.
  - Stigma and discrimination can cause a person to doubt their ability to work.
  - People with mental health problems frequently report being denied opportunities for training, promotion or transfer.
  - One-third of employers would not believe the information on a sicknote from an employee with a mental health problem.
  - Mental health problems often caused fatigue and impaired attention, concentration and poor memory, which could be compounded by the effects of medication.
  - The longer a person was off sick, the more difficult it became for them to return to work and the less likely that they would return to work at all.
  - Disabled people with mental health problems of all types were much less likely to be economically active.

221. Mr Cameron said in the context of such findings it was probable that for as long as Mr N's psychological difficulties persisted, he would remain detached from the labour market and from gainful employment. It was unrealistic to expect Mr N to simply start competing for jobs if he reached the point when he was able to consider getting back

to work. Rather he was likely to require considerable vocational rehabilitation. In his experience between 12 to 18 months. By then Mr N may well be in his 60s and the likelihood of Mr N returning to gainful employment would be remote.

222. Referring to the CSIBS impairment bands, Mr Cameron said, on the basis of Dr Wylie’s evidence and the research findings and conclusions noted above, it was his opinion that Mr N’s degree of impairment as it related to the labour market was over 75%.