PENSION SCHEMES ACT 1993, PART X

DETERMINATION BY THE DEPUTY PENSIONS OMBUDSMAN

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| **Applicant** | Dr N |
| **Scheme** | Teachers' Pension Scheme |
| **Respondents** | Department for Education |

Subject

Dr N complains that DfE (as manager of the Scheme) has wrongly declined her application for ill-health early retirement benefits from the Scheme.

The Deputy **Pensions Ombudsman**’s determination and short reasons

The complaint should be upheld against DfE because whilst untried treatment options were identified they failed to properly consider whether Dr N’s ill-health was likely to be permanent if those options were undertaken.

Furthermore, they did not properly consider Dr N’s appeal against the decision not to award her ill-health early retirement.

DETAILED DETERMINATION

**Background**

1. At the time of Dr N’s application for ill-health retirement the Scheme was governed by the Teachers' Pensions Regulations 1997 (as amended) (the **Scheme Regulations**).
2. The definition of incapacity for a teacher in the Scheme Regulations is a person who "is unfit by reason of illness or injury and despite appropriate medical treatment to serve as such and is likely permanently to be so."
3. The Teachers' Pensions etc (Reform Amendments) Regulations 2006 which came into force on 1 January 2007 amended the provisions in regulation E4(4) of the Scheme Regulations relating to the payment of ill-health retirement benefits.
4. In very simple terms an application made by a teacher in service for an early retirement pension on health grounds received by the Secretary of State after 6 January 2007 was subject to a two tier test, i.e.

- The applicant should no longer be capable of serving as a teacher; and

- The applicant's ability to carry out any work should be impaired permanently by more than 90%

1. According to the Scheme Regulations, if a teacher was in pensionable employment immediately before he became incapacitated, his/her application should be made within six months after the end of the pensionable employment in order to be treated as an "in-service" application. For such applications, early access to Scheme benefits is awarded if the applicant is determined to be incapacitated for teaching whilst enhanced benefits are granted if he/she is deemed to be incapacitated for all work. Those that are "out of service" at the time of application are required to demonstrate total incapacity in order to qualify for early retirement Scheme benefits without enhancement.

Material Facts

1. Dr N’s date of birth is 19 March 1954.
2. She became a teacher at Allerton Grange School on 1 September 2004 where she taught Science to pupils aged 11 to 18.
3. She is a member of the Scheme which has a Normal Pension Age (**NPA**) of 60.
4. She was dismissed from her post on 22 April 2010 on the grounds of ill-health capability having been absent from work through ill-health since 3 April 2009.
5. In June 2009 she had undergone a hysterectomy which had left her with abdominal tenderness around the scar.
6. At the same time she was diagnosed with stress following the death of her father followed by the ill-health and death of her mother in April 2010.
7. Dr N applied for ill-health retirement on 15 May 2010.
8. In answer to Part B Question 7 of her application for ill health retirement “What is the impact of the illness on the physical and mental capability of the applicant to fulfil the duties of a teacher?” Dr N’s GP wrote

“Would be unable to cope with pressure of teaching. Also experiencing pain. Tiredness would impact on work as well as emotional instability. Inability to make decisions – inappropriate when in a teaching environment. Inability to cope in crowded places would make her unable to cope in a classroom. Impaired judgement due to lack of sleep and anxiety. All of these symptoms would make it impossible to cope with teaching in terms of lesson planning, performance management, coping with pupil behaviour, general workload of preparation and marking and practical classroom settings, etc”.

1. In answer to Question 8 “Treatment (with dates) given for present condition…” the GP wrote

“No current medication. Referral to Primary Care mental health team for counselling in progress. Counselling – initially advised by Occupational Health but employers refused to pay and suggested GP referral. Contacted Cruse [bereavement care] but due to snow and family events was unable to attend any sessions”.

1. In answer to Question 9 “Are you satisfied that all reasonable treatment options have been exhausted? If not is any further treatment envisaged or possible?” the GP wrote

“Has been referred back to Mr Lane in gynaecology. Further counselling expected”.

1. TP referred Dr N’s application to Atos Origin Medical Advisers for an independent assessment. The assessment was provided by Dr F who completed his report on 26 July 2010. He summarised Dr N’s two current medical problems and said

“At this stage, both conditions await further treatment. On this basis, neither can be said to cause permanent symptoms, such that incapacity to teach is likely until normal retirement age, some 3 years and 8 months hence”.

1. Dr F concluded by saying “The application for ill health retirement is therefore refused”.
2. TP wrote to Dr N on 27 July 2010. In that letter they said

“In order for you to be granted ill-health retirement the Department for Education (DfE) Medical Adviser has to be satisfied that your illness is of sufficient severity which, even with appropriate treatment, is likely to prevent you from continuing in the profession until your normal pension age.

The Medical Adviser has advised that your health is such that it should not prevent you from continuing in the profession until your normal pension age. In the circumstances Teachers’ Pensions on behalf of the DfE is unable to accept your application for ill health retirement benefits”.

1. The letter enclosed a copy of Dr F’s report and explained to Dr N how she could appeal against the decision.
2. The National Union of Teachers (**NUT**) wrote to TP on Dr N’s behalf to appeal against the decision. With their letter dated 14 December 2011 they enclosed further medical information in support of the appeal as follows:
   1. A letter from Mr B, Consultant Gynaecologist dated 20 September 2011 said

“Various treatments have been tried including different analgesics which have either been ineffective or not tolerated. More recently, she has been referred through to the Pain Team for specialist management who are going to try different strategies. Whilst these may help management of her symptoms, it is extremely likely that they will not be of sufficient benefit to enable a return to teaching in any capacity whether part-time or full-time and at any other establishment until retirement age of 60”.

* 1. A letter from Leeds Primary Care Mental Health Service dated 28 January 2011 confirmed that she had attended short term CBT sessions to manage her anxiety levels and low mood and was to be referred to the stress class run to manage increased levels of stress.
  2. A report from Leeds Primary Care Mental Health Service dated 22 February 2011 said

“Barbara has made good progress in therapy and has demonstrated high motivation to engage in the therapeutic process and has completed her homework which has resulted in gaining benefit from using the CBT treatment techniques we have covered in therapy”

* 1. A letter from Leeds Primary Care Mental Health Service dated 23 May 2011 indicated that Dr N felt that having attended the stress class she had suffered a setback in her recovery. She had also said that she was in a significant amount of pain having sat on a hard chair for a significant length of time.

1. Dr N’s appeal was referred again to Atos Origin Medical Advisers for an independent assessment. The assessment was provided by Dr W who completed her report on 20 December 2011. She confirmed that she had considered all the medical evidence, including the additional information recently provided.
2. After summarising Dr N’s condition she said

“From the available evidence there is no indication that all reasonable therapeutic interventions have been exhausted in this case. She is waiting for Pain Clinic input and there are treatment options available, including medication and specialist input, to help her psychological problem. Therefore permanent incapacity for teaching and any work is not supported in this case and her appeal is rejected”.

1. Dr W concluded that Dr N did not meet the criteria for ‘incapacitated for teaching’ as set out in the Regulations.
2. The NUT issued a second appeal against the decision on Dr N’s behalf. With their letter dated 8 June 2012 they enclosed further medical information in support of the appeal as follows:
   1. A letter from Leeds Primary Care Mental Health Service dated 8 February 2012 said

“I can confirm that although Mrs N responded well to the first episode of CBT based treatment for bereavement and stress as per our previous treatment summary letters. However the chronic pain following her operation have made this more recent boubt (sic) of anxiety treatment resistive and we agreed that she would need referring to a more specialist service for assessment. I have therefore referred Mrs N to Liaison Psychiatry who specialises in treating people with co-existing physical and mental health problems”.

* 1. A letter from Dr M of the Department of Liaison Psychiatry dated 24 April 2012 said

“I acknowledge that not all treatment avenues have been explored, such as treatment with SSRIs [selective serotonin reuptake inhibitors] for anxiety, but Mrs N has proved to be quite sensitive to medication and has found treatment with pregabalin and amitriptyline difficult to cope with. Stressors are ongoing and these have clearly impacted on her current ability to return to work”.

…

“I understand that from a gynaecological point of view there is no further treatment available, and the pain clinic also feel that they have explored all viable options and none of them have worked. I have met Mrs N on two occasions and I am planning to initiate a treatment plan, including both medication in the form of an SSRI for her anxiety as well as acceptance and coping therapy to support Mrs N with managing her chronic pain and hopefully improve her day-to-day functioning”.

* 1. A letter from Dr S at the Pain Management Service dated 5 April 2012 confirmed

“I do not think that there are any likely strategies available from the pain clinic, which will permanently substantially resolve the bulk of her symptoms”.

The letter also suggested that treatment with a Versatis Lidoderm patch might be beneficial, but accepted that Dr N’s GP may come to the conclusion that this treatment was not indicated.

* 1. A letter from Dr N’s GP dated 26 April 2012 confirmed that the Versatis Lidoderm patch was inappropriate and not a choice for Dr N.

1. Dr N also submitted a letter dated 25 May 2012. In this she pointed out the comments made by Mr B, the Consultant Gynaecologist, in his letter dated 20 September 2011 and suggested that Dr W seemed to have misread the sentence regarding her ability to return to work. She said

“Medication and treatments suggested by both my Consultants have been followed fully but unfortunately have not been effective. Referral to the Liaison Psychiatry Service has been engaged with and this may, perhaps, help in management of symptoms with regard to daily life as the enclosed letter from [Dr M] indicates”.

1. Dr N’s appeal was referred again to Atos Origin Medical Advisers for an independent assessment. The assessment was provided by Dr M who completed his report on 6 July 2012. He confirmed that he had considered all the medical evidence, including the additional information recently provided. However, he added that under the Scheme Rules he was not allowed to take into consideration medical evidence that was not available at the time of the initial application.
2. Dr M concluded that as no evidence had been presented which altered the position at the time of the application this led to continued rejection of Dr N’s claim
3. DfE wrote to the NUT on 18 July 2012. In that letter they said

“All appeals are considered on the basis of whether they show that the original decision arrived at following the application using the evidence available at the time of the application should not have been reached”.

1. The letter confirmed that the medical adviser had been unable to recommend that Dr N had become permanently incapable of continuing to work and that she could not be awarded ill-health retirement benefits. A copy of the medical adviser’s report was included. The letter advised what action Dr N should take if she wanted to appeal the decision.
2. DfE say that their process is built around the requirement for incapacity to be permanent despite appropriate medical treatment and that whether any potential treatment is likely to be curative was integral to the consideration of whether the criteria for ill health retirement were met.
3. In its response to my office dated 17 October 2012 DfE said that it had been satisfied that “TP had correctly adhered to the processes involved in deciding whether or not an ill health retirement application can be accepted or rejected. The Department therefore decided that it was appropriate to uphold TP’s decision to reject Dr N’s application for ill health retirement benefits”.
4. In a further submission on 8 May 2013 DfE has said that a further review of Dr N’s case file by Dr M has concluded that her original application would still not succeed because the evidence of continuing incapacity following appropriate treatment does not render the original decision, that such treatment should be tried, was wrong.
5. However, DfE has agreed to use the discretion available to it and apply “in service” test conditions and on that basis they say that Dr M has determined that were Dr N to submit a new application it would succeed. They say that the letter from Dr N’s GP dated 26 April 2012 was the crucial evidence that would show that incapacity would be permanent despite appropriate medical treatment.
6. On the basis of this DfE has agreed to award Dr N ill-health retirement from a point six months before the date of that report, i.e. 26 October 2011.
7. Dr N has agreed to submit a new application.

Conclusions

1. The responsibility for all medical decisions in relation to ill health retirement applications rests with DfE. DfE allows TP to carry out this function at the application and first appeal stages. The second and final appeal is carried out by DfE.
2. The test for incapacity under the Regulations is whether the applicant is unable to serve as a teacher due to illness or injury, despite appropriate medical treatment, and is likely permanently to be so. The task facing DfE was therefore to decide whether, as a matter of fact, based on available evidence including the advice of their Medical Advisers, Dr N met these criteria.
3. In reaching a decision, DfE must ask the right questions, construe the Regulations correctly and only take into account relevant matters. They should not come to a perverse decision, i.e. a decision which no other reasonable decision maker faced with the same evidence would come to.
4. There is no dispute that Dr N was suffering from an illness or injury which prevented her working as a teacher. The issue is whether her illness was such that, despite any appropriate medical treatment which might be available, she was likely to be unable to work again before her normal retirement date.
5. DfE sought advice on Dr N's state of health from their Medical Advisers, whose first opinion, in July 2010, was that, as Dr N was awaiting further treatment, it was not possible to say whether her current level of disability would cause permanent incapacity. The same view was taken by the Medical Advisers at subsequent reviews of Dr N's case.
6. In the final review, on 6 July 2012, the Medical Adviser said that under the Scheme Rules he could only consider information which had been available at the date of the application. Whilst I agree that reports from the Consultant Gynaecologist and the Pain Clinic were not available at the time of the July 2010 assessment it is, nonetheless, clear that there was no regard in the Medical Adviser's opinion for the fact that, in considering Dr N's condition as at May 2010, the outcome of the further treatment, which had been mentioned in the earlier rejection of Dr N's application in July 2010, was now known. That had a bearing on that decision, and should have been considered as possible further medical evidence in relation to the extent to which untried treatments might have enabled Dr N to return to teaching.
7. Even if it was still considered there was any further "appropriate" treatment to be undertaken, no regard whatsoever had been had for the practical consideration of whether such treatment was available and the likely timescale within which benefits might have been expected, if at all. All of this had a bearing on the likelihood of Dr N's condition remaining until her 60th birthday and the earlier decision taken in this respect.
8. I see nothing objectionable in principle, to an approach which requires consideration of new medical evidence on appeal which might not have been available at the date of the original decision but which has a bearing on that decision. This is particularly so where the original decision on permanence turns on the likely effect and availability of as yet untested treatments. Self-evidently, if a condition is said not to be permanent because there are such treatments available, later evidence which demonstrates that those treatments either had no effect within relevant timescales or were otherwise unsuitable, must have a bearing on the question of permanence as previously opined.
9. The question to be answered here was whether, on the balance of probabilities, the ill health which prevented Dr N from discharging her duties as a teacher was likely to be permanent. If such ill health might improve, as a result of treatment, so that she could have potentially resumed her duties, then the view might well have been taken that the ill health was not likely to be permanent. However, proper regard should be had for whether, for whatever reason, access to such treatment within the time available is possible and for the speed with which any improvement may be expected. I can see no evidence that these considerations played any part in the decision making process either at the time of the original application or on appeal. I consider the failure to consider this question to be maladministration.
10. As is not uncommon, the various medical opinions which have been obtained by one or other party are not unanimous. For the decision maker to favour one doctor's opinion over that of another is not in my judgement evidence of any perversity in the decision, but simply represents the weighing of one set of evidence against another. However, it is apparent that there were differing views over what was "appropriate" treatment for Dr N. I have seen little to suggest that this criterion was considered, and the view was taken, quite simply, that if untested treatment remained available, the condition could not be said to be "permanent."
11. I note that DfE say that their process is built around the requirement for incapacity to be permanent despite appropriate medical treatment. However, I have to say that this is not evident from the documentation provided. It appears that little consideration was given, at any stage in the process, to the extent that, even if there remained untried treatments, they would have any effect and within what timescales. Repeatedly, the Medical Advisers simply asserted, for example, that, “…both conditions await further treatment. On this basis, neither can be said to cause permanent symptoms… " (Paragraph 16 above), and "From the available evidence there is no indication that all reasonable therapeutic interventions have been exhausted in this case … Therefore permanent incapacity for teaching and any work is not supported…" (Paragraph 22 above). These observations do not demonstrate any consideration being given to the likelihood or not that the untried treatment would be successful in the timescale required. By the time of the second appeal it should have been clear that, regardless of what had gone before, an opinion expressed less than two years before somebody reaches NPA, which confirms that, despite by that time the fact that the problem had persisted for more than three years, the person might recover by the time they reach NPA because there are untested treatments, is flawed. In my view, DfE failed to give proper consideration to these factors in considering whether the view taken in July 2010 had been correct, the closer Dr N came to the age of 60.
12. DfE has said that it simply considered whether TP had correctly adhered to the processes involved in deciding whether or not an ill health retirement application can be accepted or rejected and had been satisfied that it had. In my view this is not sufficient and does not fulfil the requirements of the appeal process. It was DfE’s responsibility to consider the evidence placed before it in determining whether or not Dr N was entitled to ill health retirement benefits. I consider its failure to do so to be maladministration.
13. However, given that DfE has conceded that Dr N is entitled to receive ill-health retirement benefits from 26 October 2011 and that Dr N has agreed to this proposal I shall make my directions accordingly as set out below.

Directions

1. I direct that within 14 days of receipt of a new application from Dr N DfE shall issue a further decision to the effect that she became entitled to ill-health benefits under the Regulations, from 26 October 2011 as established in paragraph 33 above.
2. The pension shall be put into payment as soon as practicable and backdated to 26 October 2011. Simple interest, calculated in accordance with the rate declared from time to time by the reference banks, is to be paid on each instalment from the due date of each payment to the actual date of payment.
3. For the maladministration identified above DfE shall pay to Dr N the sum of £250 for the distress and inconvenience she has been caused.

**JANE IRVINE**

Deputy Pensions Ombudsman

16 June 2013