CAS-43195-Y1J6

Ombudsman's Determination

Applicant	Mrs L
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Service Authority (**NHS BSA**)

Outcome

1. I do not uphold Mrs L's complaint and no further action is required by NHS BSA.

Complaint summary

2. Mrs L has complained that NHS BSA incorrectly decided to decline her application for payment of ill health early retirement (**IHER**) benefits in the Scheme.

Background information, including submissions from the parties

3. The Scheme is governed by the NHS Pension Scheme Regulations 1995 (as amended) (**the NHS Regulations**).

4. Regulation E2(1) states that:

> "A member to whom this regulation applies who retires from pensionable employment because of physical or mental infirmity that makes him permanently incapable of efficiently discharging the duties of that employment shall be entitled to a pension under this regulation if he has at least 2 years' qualifying service..."

5. Mrs L was employed by the NHS on a part time basis in a clerical role.

6. In January 2007, Mrs L applied for IHER benefits in the Scheme using form AW33E (**the Form**). The Form showed that she was suffering from a medical condition called "Generalised Pruritis (itching)".

7. On 23 February 2007, NHS BSA informed Mrs L that her IHER application was unsuccessful because it accepted the recommendation made by one of the Scheme's Medical Advisers (**SMA**) who had said that:

> "This case has been assessed using the medical evidence provided with the application along with further medical evidence requested from Dr G A Johnston (Consultant Dermatologist) on 12/2/07 and received on 20/2/07.
>
> The applicant is suffering from widespread itching which has been diagnosed as dermographism. As Dr Johnston's letter points out this is a condition that can last from several months to several years. It is likely that the condition will resolve before her normal retirement age (**NRA**) (that is, within the next 10 years). In addition, Dr Johnston's assessment is that sufferers are "invariably able to engage in a full and active life and employment".
>
> Under these circumstances, it is felt that the criteria for IHER are not seen to have been met."

8. Based on the evidence presented, NHS BSA therefore concluded that Mrs L was not permanently incapable of efficiently carrying out the duties of her NHS employment because of ill health until the Scheme's NRA of 60.

9. Mrs L left NHS employment on 24 May 2007.

10. Mrs L disagreed with the decision made by NHS BSA and lodged an appeal.

11. In its letter dated 20 August 2007, NHS BSA informed Mrs L that her appeal was unsuccessful because it agreed with the advice given by a different SMA who had said that:

> "In support of this lady's appeal, detailed letters have been received from her GP and her Occupational Physician. This has been considered along with the existing evidence…
>
> This…clerical officer suffers with intense itching despite treatment…
>
> This is affecting her quality of life and…she is developing secondary mental health issues. There is no doubt of the strength of feeling from the occupational physician and GP but this assessment for IHER has to consider the whole period to age 60 years. In that context it is not unreasonable to expect that there may be a benefit from further treatment options such as specialist psychological involvement particularly where the issue is one as important as the potential loss of her career.
>
> In such cases of chronic distressing symptoms, psychological support can be very effective in supporting sufferers and helping them come to terms with their symptoms. Such support together with adaptation over time can allow a return to work, which can also be very therapeutic for dealing with chronic symptoms. It is not clear what benefit retiring from work would achieve in this case.
>
> The natural history of symptomatic dermographism is unpredictable. In many patients, this condition gradually improves and clears after several years.

> Notwithstanding the GP and Occupational Physician's opinion, and with no disrespect to either medical colleague, it has not been established that the condition is permanent and therefore likely to result in a permanent inability to work for the next 10 years.
>
> It is therefore advised that the medical criteria for IHER are not met.
>
> The GP also reports…other medical conditions…It is assessed that there is insufficient evidence to suggest that these conditions are a basis for permanent incapacity."

12. Mrs L was unhappy with this decision and made another appeal to NHS BSA.

13. In its letter dated 13 December 2007, NHS BSA informed Mrs L that her second appeal was unsuccessful because it accepted the advice of a SMA who had said that:

> "This medical adviser has not had any previous involvement with this case, and he has reviewed the medical evidence already held and has considered the letter of appeal and the report from the GP and Specialist in Dermatology.
>
> It is considered that the applicant cannot be accepted as being permanently incapable of efficiently discharging the duties of her current employment as a Clerical Officer due to Pruritis and Dermographism as it is considered that with appropriate treatment that this condition would not preclude work.
>
> In fact, it is noted that the Professor of Dermatology who saw her is reported to have said that "she should go to work to distract her from her pruritic symptoms."
>
> It is also considered that her condition could improve or even resolve in the nine years to age 60.
>
> Therefore, the criteria for IHER are not met."

14. NHS BSA notified Mrs L that she had one final opportunity to appeal and suggested that she only use it when:

- fresh medical evidence came to light which clearly demonstrated the permanence of her medical condition and her inability to effectively carry out the duties of her job; or

- there was a change in her medical or mental disability.

15. In April 2008, Mrs L successfully applied for payment of the Actuarial Reduced Early Retirement (**ARER**) benefits available to her in the Scheme payable from 25 May 2007.

16. In May 2019, Mrs L asked NHS BSA to reconsider its decision to decline her application for IHER benefits on the basis that her medical condition had still not resolved, and the permanence of her condition remained. She said that:

- although her condition had improved with appropriate treatment, it was not completely resolved and had prevented her from working since leaving NHS employment; and

- the opinion expressed by NHS BSA in its letter dated 13 December 2007 was therefore clearly incorrect.

17. NHS BSA informed Mrs L at both stages of the Scheme's Internal Dispute Resolution Procedure (**IDRP**) during 2019, that, as she was already in receipt of ARER pension benefits from the Scheme, it was unable to review its decision in accordance with the NHS Regulations.

18. Following Mrs L's complaint made to the Pensions Ombudsman, NHS BSA decided that it would be appropriate to allow her one final appeal against the decision to decline her IHER application and it would be considered under Stage Two IDRP.

19. In its Stage Two IDRP decision letter dated 8 October 2020, NHS BSA informed Mrs L that her IHER application remained unsuccessful because it accepted the advice given by one of the SMAs that she did not satisfy the conditions laid down in Regulation E2(1) of the NHS Regulations for payment of IHER benefits.

20. NHS BSA said that:

> "The SMA has explained that in his clinical opinion, as at the date of termination of employment…you were not permanently incapable of efficiently discharging the duties of your NHS employment. As such you are not entitled to IHER benefits.
>
> In reaching this recommendation, Dr Evans (the SMA) has explained that further treatment options were available at the time you left NHS employment which would have benefitted you to the extent to allow a return to your NHS role in the period up to age 60. Such treatment options would have included treatment as referred to within the report from the Dermatology clinic appointment on 30 May 2007…
>
> With regards to your impaired mental health, Dr Evans has noted that at the time you left NHS employment you were not receiving any treatment for depression. It is therefore considered that there would have been scope for psychological intervention and anti-depressant medication either alone or as combinations of two drugs or in combination with a mood stabilising agent. It is Dr Evans' clinical opinion that appropriate medical treatment was likely to have improved your depression sufficiently to allow a return to your NHS employment before age 60.
>
> Dr Evans has noted the differing views provided by the GP, Occupational Health Physician, and the Dermatologists. He has explained that in providing his recommendation he had given greater weight to the information provided by Professor Camp who is a Dermatologist. This is on the basis that as a

Dermatologist, it is likely that Professor Camp will have had more experience of your skin condition than either a GP or Occupational Health Physician. Professor Camp has also provided a clear opinion on 30 May 2007, a date which is more contemporaneous to your last day of employment, that your condition did not warrant IHER.

Having very carefully considered the comprehensive recommendation and rationale provided by the SMA*, I can see no reason to disagree with his conclusion…"

* the relevant paragraphs of the SMA's medical opinion have been reproduced in the Appendix.

The position of NHS BSA

21. It refutes any allegation of maladministration by Mrs L. It says that it has correctly considered her application for IHER benefits at the date her NHS employment ended on 24 May 2007, allowing for all available relevant evidence, and weighing it appropriately. In making its decisions it has sought and considered the advice of its SMAs.

22. Evidence which post-dates a member's last day of employment will be taken into consideration but only to the extent that it relates to, or provides an insight into, the medical condition and circumstances as at the date employment terminated.

23. Any deterioration to a medical condition after the date of termination of employment cannot be taken into consideration.

24. The fact that a medical condition may not have followed the course that would have been anticipated at last day of employment also cannot be taken into consideration.

25. In matters medical, decisions are seldom black or white. A range of opinions may be given from various sources, all of which must be considered and weighed. However, the fact that Mrs L does not agree with the conclusions drawn and the weight attached to various pieces of evidence does not mean that any conclusion is necessarily flawed.

Adjudicator's Opinion

26. Mrs L's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA. The Adjudicator's findings are summarised below:-

- The decision made by NHS BSA in February 2007, to refuse Mrs L's IHER application was taken only after seeking the view of one of the SMAs which had been based on "the medical evidence provided with the application along with further medical evidence requested from Dr G A Johnston (Consultant Dermatologist)".

- With the benefit of hindsight, it would clearly have been useful if the SMA had stated explicitly the medical evidence which he considered. That the SMA decided not to do this did not, however, mean that the SMA had ignored the medical views expressed by Mrs L's GP and her Occupational Physician which were in support of her IHER application. In the Adjudicator's view, the SMA had most likely considered all the available medical evidence and given more weight to the information supplied by Dr Johnston than her GP and her Occupational Physician when forming his medical recommendation.

- With the conflicting medical evidence that was before NHS BSA at that time, in the Adjudicator's opinion, it was not perverse for NHS BSA to have concluded, on the balance of probabilities, that:

  a) Mrs L's condition did not permanently prevent her from efficiently discharging the duties of her NHS employment before her NRA of 60; and

  b) the criteria for IHER in the NHS Regulations had not been met.

- When faced with a divergence of medical opinions amongst the experts consulted at the various stages of Mrs L's application on the prognosis of her illness, NHS BSA may reasonably prefer one medical view over the other. Moreover, it is entitled to give more weight to its own SMA's opinion.

- Mrs L was dissatisfied with outcome of her IHER application and exercised her right to appeal it on three occasions, twice in 2007 and a final time in 2020.

- On each occasion, after carrying out a thorough assessment, NHS BSA informed Mrs L that her appeal had been unsuccessful because it accepted the view of its SMAs that, on the balance of probabilities, she was not permanently incapable of efficiently discharging the duties of her NHS employment at the time of leaving employment.

- The fact that Mrs L has subsequently provided further medical evidence showing that she is still suffering from the same condition did not impact upon the validity of the original decision.

- NHS BSA was only expected to make its decision based on the information available to it at the time. But there is nothing improper in taking account of later medical evidence when reviewing a decision in so far as it bears on what Mrs L's condition was at the time when the original decision was made. Caution needs to be taken however, in revisiting earlier decisions made based on contemporary material at the time of reconsideration, but the Adjudicator considered that this was exactly what NHS BSA did do at Stage Two IDRP in October 2020, after obtaining a comprehensive medical opinion from Dr Evans.

- The Adjudicator was therefore satisfied that NHS BSA did properly consider Mrs L's IHER application by assessing all the medical evidence available and acted in accordance with the NHS Regulations. Consequently, in the Adjudicator's view, NHS BSA had reached its decision for Mrs L's IHER application correctly in accordance with the above principles and within the powers given to it by the NHS Regulations and it was therefore within the bounds of reasonableness.

27. Mrs L did not accept the Adjudicator's Opinion and her complaint was passed to me to consider.

28. Mrs L provided her further comments which, in my view, do not change the outcome. She said that:-

- She has been unable to return to work after leaving NHS employment on 24 May 2007. Her medical condition has not improved over the years despite trying all the medical treatments made available to her.

- With the benefit of hindsight, it is clear the decision made by NHS BSA in February 2007 to reject her IHER application was perverse. NHS BSA had wrongly based its decision predominantly on Dr Johnson's medical opinion and disregarded the views expressed by her GP and Occupational Physician on her condition at the time.

- When reviewing its past decision, NHS BSA should have considered the current medical evidence of her condition including the digital photographs and given it more weight than the previous medical opinions, including Dr Johnson's, which did not support her IHER application.

29. I note the additional points made by Mrs L, but I agree with the Adjudicator's Opinion.

Ombudsman's decision

30. When considering how a decision has been made by NHS BSA, I will generally look at whether:

- the correct questions have been asked;

- the applicable scheme rules or regulations have been correctly interpreted;

- all relevant but no irrelevant factors have been taken into account; and

- the decision arrived at must not be one that no reasonable body would make.

31. Providing NHS BSA has acted in accordance with the above principles and within the powers given to it by the NHS Regulations, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Mrs L's eligibility for payment of

IHER benefits under the NHS Regulations. I am primarily concerned with the decision-making process.

32. The weight which is attached to any of the medical evidence is for NHS BSA to decide, including giving some of it little or no weight. It is also open to NHS BSA to prefer evidence from its own advisers unless there is a cogent reason why it should or should not, without seeking clarification first. For example, when an error or omission of fact or a misunderstanding of the relevant rules has been made by the medical adviser.

33. If I find that the decision-making process was in some way flawed or the decision reached by NHS BSA was perverse, that is, one that no reasonable body would have taken, the appropriate course of action is for the decision to be remitted for NHS BSA to reconsider.

34. The decision made by NHS BSA, in February 2007, to decline Mrs L's application for IHER benefits from the Scheme was taken only after it had carefully considered all the available relevant evidence at the time. NHS BSA had weighed the evidence before it and considered that Mrs L was, on the balance of probabilities, not permanently incapable of efficiently carrying out the duties of her NHS employment because of ill health until the Scheme's NRA of 60.

35. I am satisfied that NHS BSA did give proper consideration to Mrs L's application at the time by assessing all the relevant medical evidence available and that it acted in accordance with the NHS Regulations and the above principles. In my view, its decision not to award Mrs L IHER benefits was therefore not one that no reasonable body would make, and it was within the bounds of reasonableness.

36. The fact that Mrs L is still suffering from the same medical condition does not impact upon the validity of the original decision. NHS BSA could only be expected to make its decision in February 2007 on the basis of the condition as it was understood at the time and to reconsider that decision in light of the medical prognosis available at each stage of the review process.

37. That Mrs L's condition may not have followed the course anticipated at the time she left employment does not in itself provide evidence that the original decision made in February 2007 was incorrect.

38. I do not uphold Mrs L's complaint.

Anthony Arter

Pensions Ombudsman
16 March 2021

APPENDIX

Pertinent Paragraphs Taken from the Medical Opinion Given by Dr Glyn Evans, one of the SMAs, as Shown in NHS BSA's Stage Two Decision Letter dated 8 October 2020 to Mrs L.

"My understanding is that I am required to provide advice as to whether the applicant was likely to have met the criteria of regulation E2(1) at the time the applicant left employment on 24 May 2007.

Regulation E2(1) states that a member to whom this regulation applies who retires from pensionable employment because of physical or mental infirmity that makes him/her permanently incapable of efficiently discharging the duties of that employment shall be entitled to a pension under this regulation if he/she has at least 2 years' qualifying service or qualifies for a pension under regulation E1 (normal retirement pension).

Permanent incapacity is assessed by reference to the normal benefit age of 60 years…

MEDICAL EVIDENCE

On this occasion I have considered:

The referral documents;

Report from GP, Dr Virdee, dated 23 November 2007;

Report from GP, Dr Ackerley, dated 16 March 2007;

Report from Ms Coltman, dermatologist specialist nurse, dated 12 August 2019;

Report from Ms Saddington, staff nurse in dermatology, dated 10 April 2016;

Incomplete report from dermatology clinic dated 30 May 2007;

Report from Dr Johnston, consultant dermatologist, dated 15 February 2007;

Report from Dr Macbeth, specialist registrar in dermatology, dated 26 September 2006;

Referral letter from Dr Das, specialist registrar in gastroenterology, to dermatology, dated 24 July 2006;

Report from Dr Das dated 24 July 2006;

Report from Dr Habbab, specialist registrar in occupational medicine, dated 10 July 2007;

Report from Dr Habbab on form AW33E, dated 29 January 2007;

Letter from Dr Habbab to GP, dated 6 December 2006;

Email from Mrs Patel's GP's practice dated 24 September 2020;

Application form for complaint to Pensions Ombudsman, dated 19 November 2019;

Letters from applicant dated 14 September 2007, 13 May 2019 and 30 August 2019;

Photographs presumed to be of scheme member.

I note that some of the medical reports post-date the applicant's last day of service. Changes in the applicant's health after the applicant left employment are not relevant to the determination of whether the applicant satisfied the pension scheme definitions at the time of leaving employment. I have therefore not taken the subsequent course of the applicant's illness into account. I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, the applicant's circumstances at the time the applicant left employment.

A number of digital photographs have recently been sent to us as supporting evidence. I presume that they are of Mrs L, though this is not explicitly stated. The photographs are not dated.

The documents cited above include an incomplete letter from someone in the department of dermatology at Leicester Royal Infirmary dated 19 June 2007 and written following an assessment of Mrs L that took place on 30 May 2007. The document provided is incomplete in that only the first page of the document has been provided. In order not to disadvantage Mrs L I attempted to obtain a full copy of that document. Mrs L's GP practice has advised that they do not have the full document. They recommended that we contact Leicester Royal Infirmary. I understand from my administrative colleagues that Mrs L's son has contacted Leicester Royal Infirmary who have informed him that they no longer hold Mrs L's records from 2007. There would therefore be little merit in my contacting the hospital for her records.

I therefore have no way to obtain a full copy of this document. I have considered whether it is appropriate to take this document into account and have decided to do so. This is because the document appertains to a consultation with Mrs L that took place 1 week after she left employment. The document therefore represents the single piece of medical evidence that is most contemporaneous with Mrs L leaving employment. While the authorship of the document is unclear, it does appear to represent the opinions of the supervising consultant, Professor Camp, who appears to have worked in the Department of Dermatology at Leicester Royal Infirmary. Given the text on the first page of the document, it does seem unlikely that the subsequent pages would contain information that would lead to my offering different advice, though the subsequent pages would be expected to confirm who actually wrote the report.

Cases are considered on an individual basis and decisions are made on the balance of probabilities.

In considering whether the applicant's incapacity for the work in question is permanent, I would first consider whether, in the absence of future treatment, the incapacity is likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this. In considering this application I have taken into account the requirements of the relevant scheme regulations.

The medical evidence indicates that, at the time Mrs L left employment, there were divergent views as to whether she was fit for work. Writing in January and July 2007 Dr Habbab, a specialist registrar in occupational medicine, expressed the view that Mrs L was incapable of working. Mrs L's GP, Dr Ackerley, writing in March 2007, agreed. However, Dr Johnston, a consultant dermatologist, writing in February 2007 expressed the view that individuals with Mrs L's condition were, in his experience, "invariably able to engage in a full and active life and employment". Dr Johnston's opinion appears to have been shared by another dermatologist, Professor Camp, who saw Mrs L in May 2007 and recommended that she should return to work as a way of distracting herself from her symptoms.

In summary, at the time Mrs L left employment, she had a number of medical conditions, including high blood pressure, high cholesterol level, hearing loss and recurrent urinary infections. However, there is no evidence that any of these conditions were giving rise to incapacity for employment at the time Mrs L ceased work. Any incapacity for employment that may have been present was the result of her skin condition, possibly contributed to by her impaired mental health.

In summary, at the time Mrs L left employment, she had been experiencing generalised itching. This symptom had been present since either 2004 or 2005 (the reports give differing information on this point). In any event, this symptom had not responded to the treatment Mrs L had received up to that point. This appears to have consisted of antihistamine drugs, given singly or in combination. Dr Habbab indicates that the symptom had affected Mrs L's concentration and was disturbing her sleep. It had had a detrimental effect on Mrs L's mood such that her GP was considering antidepressant medication. However, there is no evidence that Mrs L had actually started antidepressant treatment by the time she left employment. Mrs L was assessed by a consultant dermatologist approximately one week after she ceased employment when she was started on additional treatment for her skin condition.

It appears from the reports provided, that the working diagnosis for Mrs L's skin condition at the time she left employment was that of dermographism urticaria. Dermographism is a term which literally means writing on the skin. In essence, firm stroking on the skin produces an initial red line followed by swelling along that line. My understanding is that this condition is generally regarded as a form of chronic urticaria. It is typically associated with itching. This can be of such severity as to significantly affect the individual's quality of life.

I do note that the more recent reports refer to Mrs L's skin condition as hypertrophic lichen planus. It is not clear when the diagnosis of hypertrophic lichen planus was made. However, the key consideration is the extant diagnosis at the time of leaving employment, which the contemporaneous documents indicate was dermographism urticaria.

The medical evidence also indicates that Mrs L's skin condition had had an adverse effect on her mental health. This was likely to have been contributing to her incapacity, though whether it would, in itself, have been sufficient to prevent her from working is not clear.

There are clearly differing opinions as to whether Mrs L's skin condition and depression did prevent her from efficiently discharging the duties of her employment at the time she left NHS service. However, I do not think it would be unreasonable to consider that this was likely to have been the case.

On the basis that Mrs L was incapable of efficiently discharging the duties of her employment as of her last day of service, the key consideration therefore becomes whether Mrs L's incapacity was likely to have been permanent.

The natural history of dermographism urticaria is very unpredictable. In some patients, it can persist for months or even years. In others, it can be present intermittently. A study published in the British Journal of Dermatology in 2002 on the natural history of the various types of chronic urticaria found that of the chronic forms of urticaria, dermographism urticaria had the best prognosis with the condition clearing in 51% of individuals within a 10-year period. At the time Mrs L left employment, she was approximately 9.5 years from reaching scheme pension age. Whether, at the time she left employment, Mrs L's skin symptoms would have been expected to spontaneously resolve before she reached scheme pension age was therefore finely balanced. It would not have been necessary for Mrs L's skin symptoms to fully resolve before she returned to work; the question is whether they would have been likely to improve sufficiently that they no longer prevented Mrs L from working. The probability of such partial improvement in her symptoms would have been higher than the probability that they would have fully resolved.

The natural history of depression is that it can improve over time. Given that Mrs L's skin condition was a factor in the development of her depression and that her continued skin symptoms were probably acting to maintain her depression, it would have been reasonable to consider that Mrs L's depression would not spontaneously improve while she remained incapacitated by her skin symptoms.

In summary, I think that, at the time Mrs L left employment, the question of whether she would have been permanently incapacitated in the absence of future treatment was finely balanced.

However, I think it would have been reasonable to have considered that in the absence of future treatment Mrs L's incapacity was likely to have been permanent.

At the time Mrs L left employment, further treatment options were available for both her skin condition and her impaired mental health. With regard to the dermographism urticaria, treatment is usually in the form of a type of antihistamine drug called an H1-antihistamine (which blocks a particular type of histamine receptor, the H1 receptor). Most antihistamine drugs fall into this category. However, higher than standard doses of antihistamines are often required to achieve symptom control in this condition and in some patients a combination of two different H1 antihistamine drugs are required. At the time Mrs L left employment, she was taking the H1 antihistamine cetirizine, in a dose of 20mg daily. This is double the usual maximum dose of cetirizine. Current guidance from the National Institute for Health and Care Excellence is that there are no randomised clinical trials as to the benefits of using cetirizine in a higher dose than this. Dr Johnston, whom Mrs L saw in

February 2007, had intended that a further drug, hydroxyzine, which is also an H1 antihistamine, be added. Dr Ackerley's referral letter to Professor Camp dated 21 March 2007 does not indicate that Mrs L was actually taking hydroxyzine by that time. The letter from Professor Camp's clinic on 30 May 2007 appears to indicate that Mrs L was only taking cetirizine at the time she saw Professor Camp. Professor Camp recommended that Mrs L take hydroxyzine in a dose of 100mg each night. He also recommended the addition of ranitidine. Ranitidine is also an antihistamine drug, but one that blocks the H2 receptor, not the H1 receptor. My understanding is that the addition of H2 receptor antagonists such as ranitidine in these circumstances does result in some benefit, but that this benefit is generally small. The use of ultraviolet light can be used as an adjunct to drug treatment in this condition. However, it is my understanding that the benefits of ultraviolet light therapy in this condition are short lived. Further drug treatments for this condition are now available in the form of monoclonal antibody therapy. However, such treatment would not have been regarded as appropriate medical treatment for this condition in 2007.

At the time Mrs L left employment, she was not receiving any treatment for depression. There would therefore have been scope for psychological intervention as well as the use of antidepressant drugs, either alone or as combinations of two different drugs or the combination of an antidepressant drug with a mood stabilising agent.

The above documents demonstrate that, at the time Mrs L left employment, further treatment for her dermographism urticaria and her depression were available. However, the key consideration is not the availability of future treatment; rather it is the likely benefit of that treatment.

Treatment of depression is generally beneficial. Over 70% of individuals will respond to appropriate treatment for depression. The timescale for response to treatment is generally measurable in months or a small number of years. Given the length of time remaining before Mrs L reached scheme pension age, at the time she left employment, future treatment of Mrs L's depression was likely to have alleviated any incapacity arising from depression. Therefore, any incapacity that may have been arising from her depression was unlikely to have been permanent.

With regard to the benefits of treatment for dermographism urticaria, it is reasonable to begin from the premise that Mrs L's dermatologists would not have recommended treatment unless they thought it was more likely to be beneficial than not. The report from the clinic appointment on 30 May 2007 clearly expresses optimism that increasing Mrs L's treatment would be beneficial and it was Professor Camp's view that Mrs L's skin condition did not warrant her medical retirement. Dr Johnston had previously indicated that, in his experience, although undoubtedly distressing, the symptoms caused by Mrs L's skin condition did not lead to cessation of employment. Writing in March 2007, Dr Ackerley thought it likely that Mrs L would not work in the future. Writing in January 2007, Dr Habbab expressed the view that Mrs L's condition was unlikely to improve in the near future, though expressed no view as to her long-term prognosis. However, by July 2007, Dr Habbab's view had altered and thought it unlikely that Mrs Patel would be able to engage in any form of employment in the future.

Clearly, at the time Mrs L left employment, there were differing views as to the likely permanence of any incapacity, with the GP and the employer's occupational physician being pessimistic and the dermatologists taking a different view. On the basis that the dermatologists would be likely to have more experience of patients with Mrs L's conditions than either a GP or a specialist registrar in occupational medicine, and given the reported clear opinion of Professor Camp that Mrs L's condition did not warrant ill health retirement, particularly as this is the piece of evidence most contemporaneous with Mrs L leaving employment, I am minded to give greater weight to the views of Mrs L's dermatologists than the views of her GP and those of the employer's occupational physician. On that basis, it is my opinion that, at the time Mrs L left employment, future treatment was likely to have altered the permanence of her incapacity.

I think that there is an element of uncertainty about this application. However, given the uncertainty over the extent of Mrs L's incapacity at the time she left employment, the probability of there being at least partial improvement over the next 10 years even without treatment, the likely benefits of further treatment and the opinions of her treating specialists, I think that the weight of evidence available at the time Mrs L left employment was that her incapacity was unlikely to continue until she reached scheme pension age.

In my opinion, at the time of leaving employment, the applicant did have a physical or mental infirmity that made her incapable of efficiently discharging the duties of her employment. This incapacity was unlikely to have been permanent. The pension scheme criteria were therefore unlikely to have been met for the reasons given above.

I note Dr Habbab's support for Mrs L's application. I would, however, note that Dr Habbab's support is not made with reference to the pension scheme criteria. I have taken this into account in deciding how much weight to give to Dr Habbab's views. In doing so, I have taken into account the guidance provided by the Deputy Pensions Ombudsman in her determination in the case of Mr Y v Oxfordshire County Council in which the Deputy Pensions Ombudsman agreed with an earlier statement by an Adjudicator who said that Oxfordshire County Council was entitled to ascribe little weight to recommendations in support of Mr Y being granted ill health retirement from his specialists or GP, particularly if those recommendations were not made without reference to the criteria laid out in the scheme regulations.

I do note that Mrs L's ill health has continued since she left employment. This is most unfortunate. Mrs L has my sympathy. However, this application requires a forward-looking assessment as to the likely future course of Mrs L's condition at the time she left employment. This assessment has to be made upon information that was, or could have been, available at that time. The fact that Mrs L's condition may not have followed the course anticipated at the time she left employment does not in itself provide evidence that the initial application was incorrectly considered.

I note that one of Mrs L's concerns is that she was not seen by the SMA who considered her application. I did consider whether there would be merit in offering Mrs L a consultation. However, while a consultation would add to my understanding of Mrs L's current circumstances, it would be unlikely to provide additional information about her

circumstances in 2007. It is my understanding that there is no requirement in the scheme rules for an applicant to be seen by the SMA. It is also my understanding that the Pensions Ombudsman generally adopts the position that it is a matter for the professional judgement of the SMA as to whether he/she needs to see the scheme member before providing advice. I refer you, for example, to the determination of the Pensions Ombudsman in the case of Smart v West Berkshire Council.

Mrs L is further concerned by her understanding that the information from her employer's occupational physician and GP was ignored. I do not think her understanding is correct on this matter. The SMA who considered the original application did not specify the evidence he considered in detail, merely referring to the documents supplied with the application and a report from Dr Johnston. The SMA who considered the first appeal similarly did not specifically document each piece of evidence he considered. However, given his reference to "the GP and Occupational Physician's opinion" it is clear that he was aware of the GP and occupational physician's opinions and took them into account when he provided advice. There is a difference between considering a piece of evidence and, after consideration, deciding to give it little or no weight and not considering that piece of evidence altogether. It does appear from the previous SMA's report that he did take the GP and occupational physicians' views into account though he appears to have given less weight to them than the other reports.

CONCLUDING ADVICE

It is my opinion that relevant medical evidence has been considered in this case and, on the balance of probabilities, indicates that at the time of leaving employment:

That the applicant was not permanently incapable of efficiently discharging the duties of her employment."