PO-3442

Ombudsman's Determination

Applicant	Ms I
Scheme	Local Government Pension Scheme (**LGPS**)
Respondents	Bolton at Home
	Greater Manchester Pension Fund (**GMPF**)

Outcome

1. I do not uphold Ms I's complaint and no further action is required by Bolton at Home or GMPF.

Complaint summary

2. Ms I has complained that she has not been awarded ill health retirement from active service with effect from February 2005.

Background information, including submissions from the parties

Background

3. Ms I has two periods of pensionable service in the LGPS with two different employers: Bolton College (April 1977 to January 1995) and Bolton at Home (July 1995 to February 2005). Her last employment ceased on 24 February 2005.

4. The relevant regulations are the Local Government Pension Scheme Regulations 1997 (SI1997/1612) (as amended) (the **1997 Regulations**).

5. At the time Ms I's employment ceased, regulation 27 provided:

> "(1) Where a member leaves a local government employment by reason of being permanently incapable of discharging efficiently the duties of that employment or any other comparable employment with his employing authority because of ill-health or infirmity of mind or body, he is entitled to an ill-health pension and grant.
>
> (2) The pension and grant are payable immediately.

(5)[1] In paragraph (1) -

"comparable employment" means employment in which, when compared with the member's employment -

(a) the contractual provisions as to capacity either are the same or differ only to an extent that is reasonable given the nature of the member's ill-health or infirmity of mind or body; and

(b) the contractual provisions as to place, remuneration, hours of work, holiday entitlement, sickness or injury entitlement and other material terms do not differ substantially from those of the member's employment; and

"permanently incapable" means that the member will, more likely than not, be incapable, until, at the earliest, his 65th birthday."

6. Regulation 31(6) provided:

"(6) If a member who has left a local government employment before he is entitled to the immediate payment of retirement benefits (apart from this regulation) becomes permanently incapable of discharging efficiently the duties of that employment because of ill-health or infirmity of mind or body –

(a) he may elect to receive payment of the retirement benefits immediately, whatever his age, and …"

7. Under regulation 97, a member's entitlement to benefit was to be decided "by the Scheme employer who last employed him". Before making a decision under regulations 27 or 31, the Scheme employer was required to obtain a certificate from "an independent registered medical practitioner" (**IRMP**) as to whether, in his opinion, the member met the eligibility conditions. Further extracts from the relevant regulations are provided in Appendix 2.

8. In November 2004, Ms I's case was referred to a Dr Hopkins by Bolton Metropolitan Council's occupational health unit (**OHU**). Dr Hopkins was provided with copies of letters from Ms I's GP and her occupational health notes.

9. On 6 January 2005, Dr Sopher at the OHU wrote to Ms I. He said Dr Hopkins' opinion was that Ms I was unlikely to fulfil the criteria to apply to the LGPS. He said Dr Hopkins had informed the OHU that Ms I did not qualify for ill health retirement under the LGPS rules. Dr Hopkins had signed a certificate indicating that, in her opinion, Ms I was not permanently incapable of discharging efficiently the duties of her normal occupation by reason of ill-health.

[1] Paragraphs (3) and (4) were revoked, with effect from 1 April 2004, by The Local Government Pension Scheme (Amendment) Regulations 2004 (SI2004/573

10. Ms I was told that, if she wished the decision to be reviewed, there was a "lengthy process" which would be organised through her personnel department. Bolton at Home was copied into Dr Sopher's letter.

11. Ms I submitted an appeal in January 2005. This was acknowledged by Bolton at Home on 24 February 2005.

12. On 28 February 2005, Bolton at Home wrote to Ms I informing her that her employment was to be terminated on the grounds of medical incapacity with effect from 24 February 2005. The letter made no mention of ill health retirement or Ms I's appeal.

13. In June 2005, Bolton at Home wrote to the OHU saying that Ms I wished to appeal the decision not to award ill health retirement. It asked for Ms I's case to be reviewed by an IRMP and provided a job description. Bolton at Home also provided a statement in which it mentioned that Ms I had been re-assessed for state Incapacity Benefit and found to merit sufficient points. It also said it fully supported her request.

14. Ms I appealed against her dismissal at an Employment Tribunal. Her claim of unfair dismissal was unsuccessful but she succeeded with a claim for disability discrimination. She has explained that she received a telephone call from Bolton at Home to say her ill health retirement appeal could not be progressed whilst her claim for unfair dismissal was ongoing.

15. In April 2006, Ms I was seen by a consultant psychiatrist, Professor Elliott, at the request of Bolton Council. A summary of Professor Elliott's report is provided in Appendix 1, together with summaries of and extracts from other medical evidence relating to Ms I's case.

16. In October 2006, Ms I was seen by a consultant occupational physician, Dr Fox, at the request of Bolton at Home. Dr Fox was asked to provide a report for the purposes of a remedy hearing relating to her Employment Tribunal case.

17. On 10 April 2007, Ms I wrote to Bolton at Home saying she was still waiting for it to advise her as to the progress of her appeal. Bolton at Home acknowledged this letter on 18 April 2007. On 21 June 2007, Ms I's union, GMB, wrote to GMPF in support of her case.

18. GMPF asked Bolton at Home to review Ms I's case under the two-stage internal dispute resolution (**IDR**) procedure. After further correspondence, Bolton at Home informed GMPF that Ms I's case had not been progressed because she had decided to postpone her stage one appeal. GMPF then accepted Ms I's case for review under stage two of the IDR procedure.

19. On 14 April 2009, GMPF's appointed referee notified Ms I that he had asked Bolton at Home to refer her case to an IRMP.

20. Ms I was seen by an IRMP, Dr Ormerod, on 1 June 2009. He completed two certificates: one for an active member and one for a deferred member. In both cases,

he said, in his opinion, Ms I was not permanently incapable of discharging efficiently the duties of her employment with Bolton at Home. Ms I was notified of Dr Ormerod's opinion on 8 June 2009.

21. Copies of Dr Ormerod's certificates were also sent to GMPF's stage two IDR referee. In response, he wrote to Bolton at Home stating that the intention had been that it would re-visit its stage one decision (*sic*). Bolton at Home subsequently wrote to Ms I saying that, in the light of Dr Ormerod's decision, it felt that the decision not to agree to the release of her benefits on the grounds of ill health was correct. Ms I was told that she could appeal.

22. Ms I submitted a stage two appeal in January 2010. GMPF's appointed referee referred Ms I's case to another IRMP, Dr Trafford. Ms I and her GMB representative prepared a bundle of documents for the IRMP, including letters from her GP and Professor Elliott.

23. The GMPF's appointed referee issued a decision, on 11 August 2010, overturning Bolton at Home's decision. He determined that, on the basis of the IRMP's opinion, Ms I's deferred benefits should be paid with effect from 1 April 2008.

24. In his decision letter, the appointed referee referred to Ms I's stage two IDR application and said she had stated her dissatisfaction with Bolton at Home's decision not to agree to the early payment of her deferred benefits on the grounds of ill health. He said, in particular, Ms I did not feel she had been given the opportunity to raise issues concerning her health with Dr Ormerod and that his examination had been insufficient for the purposes of establishing her capacity for carrying out her duties. The appointed referee said he had asked to see any report provided by Dr Ormerod but had not received a satisfactory response. He said he had, therefore, commissioned his own report from a Dr Trafford.

25. The appointed referee said Dr Trafford had stated that: "[Ms I has] developed a chronic depressive state which has not been treated". He said Dr Trafford had commented that, in 2005, "it was perfectly reasonable to suppose that was she referred for specialist treatment … one would have expected a recovery from her illness". The appointed referee said that the problem was that Ms I had not been treated. He said Dr Trafford had stated that he could not agree that there was good medical evidence for him to recommend permanent incapacity in 2005.

26. With regard to the effective date of payment, the appointed referee said Dr Trafford had certified that Ms I had been permanently incapable of discharging efficiently the duties of her former employment since 1 April 2008. He quoted Dr Trafford as follows:

> "She has had no specialist assessment and no significant treatment for her depression and I am afraid I do not count so many years of person centred counselling as sufficient treatment, it is very difficult to decide on a date at which she might have become permanently incapacitated. I have therefore had to decide a date pragmatically after which I feel it would be unreasonable to expect sufficient improvement to return to her former employment."

27. The appointed referee said he had relied on Dr Trafford's advice in coming to his decision. He said he had decided to uphold Ms I's appeal and overturn Bolton at Home's first stage IDR decision.

28. The 1997 Regulations had been revoked in April 2008. As at 11 August 2010, the IDR provisions were contained in The Local Government Pension Scheme (Administration) Regulations 2008 (SI2008/239) (as amended) (the **2008 Regulations**). Stage two decisions were covered by regulation 61 (see Appendix 2). Among other things, regulation 61 provided that the decision notice issued by GMPF should set out the extent to which it "confirmed or replaced" the decision given by Bolton at Home.

29. GMPF subsequently wrote to Ms I on a number of occasions asking her to complete a form and supply documents to enable it to pay her benefits. Ms I was advised by GMB not to complete the form while her appeal was ongoing.

30. GMB wrote to GMPF's appointed referee, on 15 September 2010, saying it wished to appeal the effective date from which Ms I's deferred benefits were to be paid. It also said it wished to appeal the decision to only release her benefits with Bolton at Home. In response, the appointed referee referred to Dr Trafford's opinion. In particular, he referred to Dr Trafford's statement that:

> "I cannot agree that there was good medical evidence to recommend permanent incapacity in 2005 on the basis that I have stated."

31. The appointed referee said he had no reason to depart from Dr Trafford's "determination" or the basis upon which it was made since it used the best medical evidence available. He said he did not uphold this part of the appeal. With regard to Ms I's benefits arising from her employment with Bolton College, the appointed referee said the college had the discretion to release these and suggested that GMB contact the college.

32. In subsequent correspondence with GMB dated 5 January 2011, the appointed referee quoted further from Dr Trafford's report and confirmed that he had taken account of the reports from the GP and consultant psychiatrist. The appointed referee quoted Dr Trafford as follows:

> "The psychiatric report from Dr Elliott is very helpful. It confirms that she was suffering from a moderate depressive episode and, indeed, I carried out a hospital anxiety and depression score when I saw her and she still scores moderate anxiety and depression. Professor Elliott commented on the fact that psychological therapy (cognitive behavioural therapy) and anti-depressant medication might improve her symptoms. However, over the course of the last eight years since she has been off sick, she has taken anti-depressants for a matter of a few months only. She has had continued person centred counselling every fortnight for about the last six years. It seems that at no point in the period of time has anybody suggested referring her to specialist services, even though she was considered by her GP to be permanently

unable to work and has been assessed for incapacity benefit etc. I found it staggering that she has not received any specialist advice or assessment.

[Ms I] is of the opinion that her thyroid condition makes her feel unwell and compounds any depression. It is extremely rare for thyroid problems such as hers to cause ongoing symptoms once the condition is diagnosed and treated. I really do not think that her under active thyroid can be considered a reason for permanent incapacity from her work. What has clearly happened, however, is that she has developed a chronic depressive state which has not been treated.

My opinion is that in 2005 when she was dismissed, it was perfectly reasonable to suppose that was she referred for specialist treatment with full dosage anti-depressant medication and cognitive therapy, one would have expected a recovery from her illness. Depression is a very treatable condition.

The problem then arises in that she has not been treated and I note Dr Fox's report where he comments on the reduced likelihood of her making a full recovery even with full treatment and I believe his report was part of the Employment Tribunal process, which means it will date from around 2006. We are now four years further on.

While therefore I cannot agree that there was good medical evidence to recommend permanent incapacity in 2005 on the basis I have stated, i.e. that depression is a very treatable condition and that she had not been referred for any specialist assessment and had not commenced any treatment which one would have expected to have made her better. This is particularly the case as she still states now that it was not work which was the major issue but the fact that she felt too ill to do the work."

33. The appointed referee said he was content with the decision he had reached in August 2010 and referred to Ms I's right to apply to the then Pensions Advisory Service (**TPAS**) and the Ombudsman.

34. In February 2013, Ms I contacted TPAS. It contacted GMPF and was informed that Ms I had two deferred pensions: one in respect of her service with Bolton College and one in respect of her service with Bolton at Home. GMPF confirmed that it had been agreed that the latter should be paid from April 2008 but it required Ms I to complete the necessary documentation.

35. Ms I submitted an application to the Pensions Ombudsman (**TPO**) on 5 December 2017.

Ms I's position

36. Ms I submits:-

- Although she has been awarded early payment of her deferred benefits, she is of the opinion she should have been awarded ill health retirement from active service, with effect from 24 February 2005.
- She has lost the extra benefits which would come with an award of ill health retirement from active service.
- She has suffered financial hardship because she has had to exist on welfare benefits.
- She has suffered the stress of having to fight her case and this has taken a toll on her health.
- She is now over 64 and has been unable to work since 2002.
- Her state of health had begun to deteriorate prior to her taking sick leave. The OHU had placed her on an ill health rehabilitation plan, in 2000, and granted her two courses of counselling with a psychotherapist.
- Dr Sopher sent Dr Hopkins an incorrect job description and did not mention the correct medical conditions in his referral letter. In addition, no appointment was arranged for her with Dr Hopkins.
- Dr Hopkins was provided with incorrect information about her entitlement to Incapacity Benefit. She had successfully appealed and her benefits were reinstated.
- She attended a meeting with Bolton at Home, in March 2005, and was told her appeal for ill health retirement would be supported. Bolton at Home subsequently wrote to the OHU supporting her appeal.
- She was subsequently informed by Bolton at Home that her appeal could not be processed before her case for unfair dismissal and disability discrimination had been heard. She did not postpone her appeal.
- Her claim for disability discrimination succeeded. The Disability Discrimination Act 1995 defines a "Disabled Person" as a person with "a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities".
- At a remedy hearing held in October 2006, a barrister acting for Bolton at Home specifically referred to her accrued pension rights. However, Bolton at Home did not progress her appeal and she had to write to its personnel department in April 2007. This is at odds with its previous support for her appeal.

- It took a further two years for an appointment with an IRMP to be arranged. The appointment took place more than eight years after she commenced sickness absence and more than five years after her employment was terminated. It was also more than four years after Professor Elliot had written his report.

- She was not offered the opportunity to raise issues concerning her health with Dr Omerod or to ensure that he had the correct information.

- Dr Trafford concentrated primarily on the mental health aspects of her condition despite the fact that she continues to suffer from many physical conditions: enduring fatigue, sleep problems, carpel tunnel syndrome, recurrent shingles and vertigo.

- Dr Trafford was informed about the antidepressant medication she had taken previously and that she had been unable to tolerate them. She believed they had worsened her symptoms of anxiety and depression. Dr Trafford was also aware that she had been granted two courses of counselling, including cognitive behavioural therapy (**CBT**). He found the strategies and therapies prescribed to manage her condition unacceptable. As a result, he chose a date over three years after the termination of her employment as the date at which she became permanently incapacitated.

- This date was challenged by her union. Her union representative raised the fact of her ongoing medical condition and questioned whether the chosen date was supported by factual evidence. He pointed to evidence of her ill health prior to dismissal and said that it was a matter of conjecture as to whether different treatment options would have resulted in improvement.

- Dr Fox, in his October 2006 report, had said that the longer the condition persists, the smaller the chance of full recovery.

- The National Institute for Health and Care Excellence (**NICE**) has recommended patient choice in the treatment of depression. In May 2019, the Royal College of Psychiatrists issued a statement saying that anti-depressants can cause side-effects lasting for months. This concurs with her own negative experiences and her preference for alternative management.

- The ability to undertake gainful employment was not a condition she had to satisfy, in order to qualify for ill health retirement, under the Regulations which applied at the time of her appeal.

- She obtained legal advice (copy provided) which found the decision made by GMPF under the IDR procedure to be incorrect. The advice is summarised as follows:-

- The decision to release her benefits from April 2008 was incorrect because her employment was terminated on the grounds of her inability to work due to ill health in 2005.

- The IDR referee had made a finding of fact that she was permanently incapable of returning to work by April 2008. This was based upon the availability of treatment which she was not offered and did not benefit from. The decision was therefore irrational and should be set aside.

- The decision to only release her deferred benefits was incorrect on the basis of the finding of fact that she was permanently incapable of returning to work by April 2008. Under the LGPS Regulations, there was an arguable case for her being awarded a full ill health retirement pension, on the basis that it had been determined that she had no reasonable prospect of being capable of gainful employment before age 65. Her benefits should be based on the membership she would have had if she had stayed in the LGPS until age 65.

- The IDR referee should have ordered Bolton College to release the benefits accrued by reference to her employment with it, rather than advising her to write to the college. She had accrued benefits under the LGPS in respect of both periods of service, over which the same referee had jurisdiction, and there was no reason why they should be treated differently.

GMPF's position

37. GMPF has confirmed that it has nothing to add to the stage two IDR decision.

Bolton at Home's position

38. Bolton at Home has stated that GMPF has confirmed to it that Ms I's service from 4 July 1995 to 24 February 2005 was used to calculate the benefits which became payable from 1 April 2008. It has stated that GMPF has confirmed that Ms I has service from 25 April 1977 to 31 March 1995 but this service relates to a different employer. It has stated that GMPF has confirmed that it has no outstanding benefits to be paid to Ms I.

Adjudicator's Opinion

39. Ms I's complaint was considered by one of our Adjudicators who concluded that no further action was required by Bolton at Home or GMPF. The Adjudicator's findings are summarised below:-

    - At the time Ms I's employment with Bolton at Home ceased, the relevant Regulations were the 1997 Regulations. In order to receive benefits under Regulation 27, Ms I had to have left her employment because she was permanently incapable of discharging efficiently the duties of

that employment, or any other comparable employment, because of ill-health. Permanently meant the incapacity would, more likely than not, last until her 65th birthday.

- In the first instance, it was for Bolton at Home to determine whether or not Ms I was entitled to benefits under Regulation 27. Regulation 97 (see Appendix 2), required it to seek an opinion from an IRMP before making its decision.

- It was not the role of the Ombudsman to review the medical evidence and come to a decision of his own as to Ms I's eligibility for payment of benefits under Regulation 27. The Ombudsman was primarily concerned with the decision-making process. The issues considered included: whether the relevant Regulations had been correctly applied; whether appropriate evidence had been obtained and considered; and whether the decision was supported by the available relevant evidence.

- Medical (and other) evidence was reviewed in order to determine whether it supported the decision made. However, the weight which was attached to any of the evidence was for Bolton at Home or GMPF, as appropriate, to decide (including giving some of it little or no weight[2]). It was open to Bolton at Home or GMPF to prefer evidence from their own advisers; unless there was a cogent reason why they should not or should not have without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant Regulations by the medical adviser. If the decision-making process was found to be flawed, the appropriate course of action was for the decision to be remitted for Bolton at Home or GMPF to reconsider.

- The evidence indicated that, in 2005, Bolton at Home failed to make a decision as to Ms I's eligibility under Regulation 27. Ms I's case was referred to an IRMP, Dr Hopkins, as required by Regulation 97. Dr Hopkins provided a certificate indicating that, in her opinion, Ms I was not permanently incapable of discharging the duties of her employment with Bolton at Home. Ms I was notified of Dr Hopkins' opinion and told that she had informed the OHU that Ms I did not qualify for ill health retirement. This was not Dr Hopkins' decision to make. It was for Bolton at Home to decide whether Ms I was entitled to benefits under Regulation 27. Its decision might be informed by Dr Hopkins' opinion but Bolton at Home was not bound by her opinion.

- Bolton at Home must follow the proper procedure when making decisions about ill health retirement benefits. However, not all procedural failings meant that a decision could not be allowed to stand. For example, if procedural failings occurred at an early stage in the process and the impact of the failing was corrected later, the Ombudsman might take the view that the procedural failings did not invalidate the final decision.

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

- Although the failure to make a decision in 2005 amounted to maladministration on the part of Bolton at Home, it was necessary to consider whether any injustice suffered by Ms I had been redressed by subsequent events.

- The history of Ms I's case was not straightforward and had taken place over an extended period of time. The evidence indicated that some, at least, of the delay in reaching a final decision had been the result of events in Ms I's personal life and not as the result of delays by Bolton at Home or GMPF.

- Ms I appealed the decision not to pay her benefits under Regulation 27 in January 2005. This had been acknowledged by Bolton at Home in February 2005 but little seemed to have happened until 2007. The Adjudicator noted that Ms I had also initiated a claim at the Employment Tribunal at the same time. Bolton at Home had stated that Ms I had decided to postpone her appeal. The Adjudicator said she had not seen any evidence indicating this to be the case.

- In 2007/08, GMPF became involved when Ms I and her union raised the matter through the IDR process. Bolton at Home was asked to review the decision not to pay Ms I ill health retirement benefits. It referred her case to Dr Ormerod.

- Dr Ormerod appeared to have reviewed Ms I's case both on the basis of retirement from active service and early payment of deferred benefits. He had signed certificates to the effect that Ms I was not permanently incapable of discharging efficiently the duties of her former employment. It was not clear whether or not he had provided any covering report explaining his reasons for reaching this conclusion. The Adjudicator noted that Bolton at Home had failed to provide such a report for the appointed referee at stage two of the IDR procedure. This suggested Dr Ormerod had not provided an explanatory report with his certificates.

- Bolton at Home informed Ms I that, "in light of the decision from Dr Ormerod", it felt that the decision not to pay her ill health retirement benefits was correct. Again, there was no evidence of Bolton at Home coming to a decision itself.

- Ms I's case was reviewed by an appointed referee acting for GMPF. He referred her case to another IRMP, Dr Trafford. On the basis of the advice received from Dr Trafford, the appointed referee had determined that Ms I had not been eligible for ill health retirement under Regulation 27 in 2005. Under Regulation 61 of the 2008 Regulations (see Appendix 2), the appointed referee could come to a decision as to Ms I's eligibility. Regulation 61 made reference to the appointed referee's decision either confirming or replacing an earlier stage one decision.

- It was open to GMPF's appointed referee to accept the advice he received from Dr Trafford unless there was a good reason why he should not. Having

reviewed the correspondence from the appointed referee, the Adjudicator was of the opinion that both he and Dr Trafford were aware of and had applied the correct interpretation of Regulation 27. In addition, they both also appeared to have understood that they were required to consider what the situation had been in 2005.

- In order to receive benefits under Regulation 27, Ms I had to meet the eligibility criteria in February 2005; when her employment with Bolton at Home ceased. Consequently, Dr Trafford and the appointed referee were required to consider what the likely prognosis would have been for Ms I's medical conditions in 2005. The evidence indicated that this was the approach they took.

- Dr Trafford was of the view that, in 2005, it would have been expected that Ms I's medical condition would have improved with treatment such that she might have been capable of undertaking her former duties or comparable employment with Bolton at Home. This view did not appear to be inconsistent with those of Dr Littlewood, Professor Elliott and Dr Fox (see Appendix 1). The fact that Ms I's medical condition may not have improved as expected over the period from February 2005 to August 2010 was not relevant for the purposes of determining her eligibility in 2005. The key was whether, in 2005, she would have been expected to recover sufficiently before normal pension age.

- The Adjudicator said she had not identified any reason why GMPF's appointed referee should not have relied upon Dr Trafford's advice in reaching the decision that Ms I did not meet the eligibility conditions for ill health retirement benefits in 2005.

- In the Adjudicator's view, any injustice arising out of Bolton at Home's failure to make a decision as to Ms I's eligibility under Regulation 27 had been redressed at stage two of the IDR procedure.

40. Ms I did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Ms I provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Ms I for completeness.

Ombudsman's decision

41. In order to receive ill health retirement benefits under Regulation 27, Ms I had to meet the eligibility criteria as at the date her employment with Bolton at Home ceased; 24 February 2005. In other words, as at 24 February 2005, it would have to have been the expectation that Ms I was permanently incapable of discharging efficiently the duties of that employment, or any other comparable employment, because of ill-health. Permanently meant the incapacity would, more likely than not, last until her 65th birthday.

42. Ms I's case is not straightforward because of the length of time for which it has been ongoing. As a result of this, many of the assessments of her eligibility for benefits under Regulation 27 have had to be undertaken retrospectively. In such circumstances, it is important to avoid the application of hindsight. The question to be addressed by those making the decision was what would have been the expectation as to the future course of Ms I's health in 2005.

43. In the first instance, the decision as to Ms I's eligibility for Regulation 27 benefits was for Bolton at Home to make. It was required to seek an opinion from an IRMP before making its decision, but the decision was not for the IRMP to make. I find that Bolton at Home failed to make a decision in 2004/05. It was not sufficient for Ms I simply to be informed of Dr Hopkins' opinion by the OHU. However, I find that any injustice to Ms I arising out of this maladministration on Bolton at Home's part was redressed during the IDR procedure. GMPF did come to a decision itself as to Ms I's eligibility for Regulation 27 benefits; albeit relying heavily on Dr Trafford's opinion when it did so.

44. GMPF was entitled to rely on the advice it received from Dr Trafford unless there was a cogent reason why it should not have done. The kind of reasons I have in mind are errors or omissions of fact by Dr Trafford or a misunderstanding of the relevant Regulations. In other words, the kind of things which a lay person could be expected to notice and, where appropriate, query.

45. GMPF would not be expected to query a medical opinion as such. At most, it might be expected to seek clarification if there was an obvious difference of opinion between the IRMP and other doctors which had not been explained already in the IRMP's report. This is the approach I take myself. So far as his medical opinion is concerned, Dr Trafford does not come within my jurisdiction. He is answerable to his own professional bodies and to the General Medical Council. I am primarily concerned with the decision-making process undertaken by Bolton at Home and GMPF.

46. I find that both Dr Trafford and GMPF understood that they were to consider what the circumstances were in February 2005. Ms I has argued that Dr Trafford concentrated on her mental health and overlooked her physical conditions. She lists these as: enduring fatigue, sleep problems, carpel tunnel syndrome, recurrent shingles and vertigo. However, the situation in 2005 appears to be that Ms I's depression was the primary reason for her being unable to work and it is understandable, therefore, that Dr Trafford would focus on this. He did, however, also consider Ms I's hypothyroidism.

47. I do not find Dr Trafford's opinion to be inconsistent with those expressed by Professor Elliott and Dr Fox. These opinions have the benefit of being contemporaneous with the cessation of Ms I's employment with Bolton at Home and, therefore, reflect the situation as it was in 2005. Ms I has referred to a comment by Dr Fox to the effect that the longer her condition persisted, the smaller the chance of full

recovery. Dr Fox was, however, still anticipating recovery on Ms I's part in his 2006 report.

48. I note Ms I's reference to the fact that she had succeeded in her appeal for Incapacity Benefit and also that her disability discrimination claim succeeded. However, neither of these facts help to establish permanent incapacity for the purposes of Regulation 27 in 2005. The eligibility criteria for Incapacity Benefit are not the same as those set out in Regulation 27. In particular, there was no requirement that Ms I's incapacity should be expected to last at least until age 65. I note that her Incapacity Benefit was due for review in 2008. The definition of "Disabled Person" referred to also differs from the requirements of Regulation 27. A person may have "a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities", but still be capable of employment. Ms I's eligibility for ill health retirement benefits had to be assessed against the requirements of Regulation 27.

49. I have noted the advice Ms I says she received from her legal adviser. It appears Ms I's adviser may have misunderstood the requirements of the relevant LGPS Regulations. S/he suggests that the fact that Ms I's employment was terminated on the grounds of ill health and that she was considered permanently incapable of returning to work by April 2008 is sufficient for the purposes of Regulation 27. I have already explained that Ms I had to be considered permanently incapable of discharging her duties in 2005. The fact that Ms I's employment with Bolton at Home ceased on the grounds of ill health is not sufficient, in and of itself, to meet the requirement for her incapacity to be considered permanent.

50. I note also the reference to the decision having been based upon the availability of treatment which Ms I was not offered and did not benefit from. As I have said, it is important not to apply the benefit of hindsight. The question was what might have been the expected future course of Ms I's condition and treatment from the perspective of 2005.

51. Ms I has brought a separate, although related, complaint concerning the release of her benefits relating to her service with Bolton College. That complaint is the subject of a separate investigation and I do not propose to comment on it any further here. However, I note that Ms I was advised that GMPF should have ordered Bolton College to release those benefits as part of the IDR decision. This was on the grounds that Ms I accrued both periods of benefit under the same LGPS, over which GMPF had jurisdiction, and there was no reason for them to be treated differently.

52. Ms I accrued her benefits in respect of her earlier period of service under The Local Government Superannuation Regulations 1986 (SI1986/24) (as amended). It appears that this service was not aggregated with the service Ms I later accrued by reference to her employment with Bolton at Home. The employer in relation to Ms I's earlier benefits remained Bolton College.

53. Under each set of LGPS Regulations which has applied over the course of Ms I's membership, the initial decision as to her eligibility for benefits was for her employer or, where appropriate, former employer to make. At stage two of the IDR procedure, GMPF had the authority to confirm or replace a decision. The wording of Regulation 67, which applied at the time of GMPF's decision, is given in Appendix 2. I find that the wording of Regulation 67 meant that GMPF could only make a decision in respect of Ms I's earlier benefits if there had already been a decision which it could confirm or replace. It was right, therefore, to direct Ms I to Bolton College in the first instance.

54. Therefore, I do not uphold Ms I's complaint.

Anthony Arter

Pensions Ombudsman
14 August 2019

Appendix 1

Medical evidence

Dr Littlewood, GP, 19 October 2004

55. In a letter to an occupational physician working for Bolton MBC, Dr Littlewood confirmed that he had been Ms I's GP for 20 years, with a short break between 1993 and 2002. He said he had last seen her in April 2004. Dr Littlewood went on to describe Ms I's symptoms and medication. He referred to diagnoses of hypothyroidism, carpel tunnel syndrome, possible irritable bowel syndrome, seborrhoeic blepharitis, and depression. Dr Littlewood said he had suggested antidepressants and Ms I had tried these but did not feel they helped. He said she was seeing the practice counsellor every two weeks. He said he had tried to reassure Ms I that a suggested antidepressant was not addictive "in the traditional sense". Dr Littlewood said Ms I's depression could respond to psychological treatments but these were not readily available under the NHS.

56. Dr Littlewood concluded:

> "At the moment I do not think that she is fit for work. She is tense and her concentration is poor. Her energy levels are low. Treatment for depression with antidepressants is generally effective, but sometimes medication and dosages have to be changed. If treatment fails then usually we would refer to a psychiatrist. Left untreated depression usually resolves itself, often over an eighteen to twenty-four month time scale. It is possible that deterioration can occur before an improvement. I find it difficult to state the likely length of any continued absence.
>
> On 9.6.04[3], I had notice from the Social Security Department that they had decided that [Ms I] had not met the threshold of incapacity from that date. Since then we have not been giving her sicknotes …
>
> In view of her long history of depression, which has not been helped by stress at work, I would support [Ms I] in her early retirement on health grounds … It could be that at some stage in the future [Ms I] will be able to do work of a less stressful nature."

Professor Elliott, consultant psychiatrist, 10 April 2006

57. Professor Elliott's report was requested by Bolton Council in connection with Ms I's Employment Tribunal claim. He had been asked to give an opinion as to whether or not Ms I fulfilled the criteria for disablement under the Disability Discrimination Act 1995.

[3] Ms I has explained that her Incapacity Benefit was reinstated on appeal.

58. Professor Elliott gave a history of Ms I's state of health from one year before she went on long term sickness absence to date. The information was provided by Ms I and her GP notes. Professor Elliott concluded:

> "In my opinion, [Ms I] has suffered and is still suffering from several significant psychological sequelae beginning probably around the time she developed her hypothyroidism and certainly in the months after she was initially signed off work, and continuing more or less with the same frequency and severity until the present. Depression and hypothyroidism are commonly associated.
>
> In my opinion, her symptoms represent a chronic moderately severe "Depressive Episode" as defined …
>
> In my opinion, [Ms I's] Depressive Episode was substantial and affected her life significantly, and has lasted from probably before she was originally signed off work but definitely from the time she was diagnosed by her GP in 2003, until the present."

59. Professor Elliott went on to say that Ms I had received some counselling but had not responded significantly to this. He said there were well recognised treatments for Depressive Episode which might sometimes be of considerable benefit. He referred to CBT. Professor Elliott also said that he believed that Ms I would benefit from a course of antidepressant medication. He commented that patients with less chronic histories were most likely to benefit but, in his opinion, up to two-thirds of patients would respond to some degree to a course of medication. He said drug treatment combined with psychotherapy was likely to maximise potential benefits.

Dr Fox, consultant occupational physician

60. Dr Fox had a meeting with Ms I on 11 October 2006. He had also been provided with copies of reports from Professor Elliott and Ms I's GP, and copies of Ms I's GP records. Dr Fox concluded:

> "In summary, [Ms I] had insidious onset of underactive thyroid with typical presentation including depression and fatigue. The thyroid condition was quickly treated and stabilised biochemically but she has been left with enduring fatigue and depression. She has chosen not to take any medical treatment for depression, only pursuing counselling from 2004 to date. She is currently by no means fully well and still has ongoing symptoms of depression with anxiety and fatigue. In my opinion the thyroid condition is likely to be permanent and to require long-term medication. The typical lifespan of untreated depression is about two years and obviously she has exceeded this. One would still anticipate eventual recovery, but the longer the condition persists the smaller the chances of full recovery.
>
> At this point I would suggest that further improvement is still likely but there may be a residual impairment. However, the condition may well still respond to

appropriate medical treatment, were she to pursue this. I would therefore not consider the depression to be a permanent condition.

With regard to the failed return to work in 2004, it would appear that [Ms I] was unlikely to be able to return to her normal position because of her perceptions of the stress of the emotional demands of confrontation at that time. She would appear not to have had the stamina at that time for her normal working hours but may have been able to improve her stamina to her normal part-time hours, or thereabouts, with a gradual phased return, probably over two months or more … I do not anticipate she would have returned to her normal role but may have been able to undertake a less "stressful" role …

… [Ms I] appears to suffer from two chronic problems. Firstly, she has an under-active thyroid that requires medical treatment to stabilise and this is likely to be a long-term condition. Secondly, she is suffering from depression and has been doing so for about four years …

The thyroid problem will not disappear and should be considered as permanent … I would anticipate that the depressive condition will disappear in the long-term future, particularly if she chooses to pursue medical treatment, but after such a protracted illness it is possible there may be a degree of residual impairment …

In my opinion, making reasonable adjustments may have enabled her to return to work but it was still unlikely that she would return to her former position … She may well have been able to undertake alternative work perceived as less stressful, for example a more administrative role with less confrontation.

It is very difficult to comment specifically on her health at points in time in the past as the only corroborative evidence is the brief entries in her General Practitioner's notes at various points in time. From the level of reported symptoms documented in March and April 2004 …I expect it is unlikely she would have returned to work successfully at that time … Unfortunately her onward progress is then clouded by a perception of improvement once she was dismissed … there are no consultations for emotional health issues until her father passed away in January 2006 …

Currently she still has symptoms of fatigue and depression … However, I do consider she would be able to return to work in some capacity, even with her former employer, were she able to put the political and emotional issues around the matter to one side. Were she to do so, it would need to be with the above adjustments and would be unlikely to be in to her former role …"

Dr Mirza, GP, 1 June 2009 and 2 July 2010

61. In an open letter, Dr Mirza expressed the view that Ms I was permanently unfit for work. He said, in his opinion, Ms I was suffering from several significant sequelae

beginning around the time she had developed hypothyroidism. He said Ms I's condition had continued with more or less the same severity until the present date. Dr Mirza said Ms I was suffering from hypothyroidism for which she required medication. He said she had been suffering from depression since 2002 but had not required antidepressant medication. He said Ms I was unable to work and likely to remain so up to her retirement age, in 2020, because she was too debilitated to function.

Appendix 2

The Local Government Pension Scheme Regulations 1997 (SI1997/1612) (as amended)

62. Regulation 97, as at 24 February 2005, provided:

> "(1) Any question concerning the rights or liabilities under the Scheme of any person other than a Scheme employer must be decided in the first instance by the person specified in this regulation.
>
> (2) Any question whether a person is entitled to a benefit under the Scheme must be decided -
>
> (a) … and
>
> (b) in any other case by the Scheme employer who last employed him.
>
> …
>
> (9) Before making a decision as to whether a member may be entitled under regulation 27 or under regulation 31 on the ground of ill-health or infirmity of mind or body, the Scheme employer must obtain a certificate from an independent registered medical practitioner who is qualified in occupational health medicine as to whether in his opinion the member is permanently incapable of discharging efficiently the duties of the relevant local government employment because of ill-health or infirmity of mind or body."

The Local Government Pension Scheme (Administration) Regulations 2008 (SI2008/239) (as amended)

63. As at 11 August 2010, Regulation 61 provided:

> "(1) The appropriate administering authority must give its decision on an application under regulation 60 by notice in writing -
>
> (a) to the applicant; and
>
> (b) if that authority is not the employing authority, to the employing authority,
>
> before the expiry of the period of two months beginning with the date the application was received.
>
> (2) …
>
> (3) A notice under paragraph (1) must include -

(a) a statement of the decision;

(b) in a case where a decision was given under regulation 59, an explanation of whether and, if so, the extent to which that decision is confirmed or replaced;

(c) a reference to any legislation or provisions of the Scheme on which the authority relied;

(d) in a case where the disagreement relates to the exercise of a discretion, a reference to the provisions of the Scheme conferring the discretion;

(e) a statement that the Pensions Advisory Service is available to give assistance in connection with any difficulty with the Scheme which remains unresolved; and

(f) a statement that the Pensions Ombudsman may investigate and determine any complaint or dispute of fact or law in relation to the Scheme made or referred in accordance with the Pension Schemes Act 1993; and

(g) the addresses at which the Pensions Advisory Service and the Pensions Ombudsman may be contacted."