DECISION OF A TRIBUNAL OF SOCIAL SECURITY COMMISSIONERS

Decision

1. In case CI/535/2005, we formally allow the appeal, but only to the extent of varying the decision of the Cardiff appeal tribunal dated 23 August 2004 by making the statutory date of onset for prescribed

2. In case CI/1814/2005, we confirm the decision of the Swansea appeal tribunal dated 11 February 2005.

Introduction

3. These appeals are brought on behalf of former underground coal miners who were exposed to vibration from their work tools, such as drills used in preparing the coal face for shotfiring. Each has been found to suffer from vibration white finger, a prescribed disease for the purposes of industrial injuries disablement benefit ("IIDB"). Each contends that in his case the percentage disablement awarded by the appeal tribunal was too low, because the tribunal's approach to the issue of percentage disablement resulting from this condition was wrong in law. We were informed that there are numerous ex-miners with similar benefit claims and therefore, in addition to deciding these individual cases, we were urged by the claimants' representatives to lay down guidelines that will be of assistance to claimants, decision makers on behalf of the Secretary of State and appeal tribunals in dealing with these other claims.

4. At the combined oral hearing of the two appeals Keir Starmer QC, instructed by Hugh James, appeared for the claimants and Jeremy Johnson, instructed by the Solicitor to the Department for Work and Pensions, appeared for the Secretary of State. In addition to their written and oral submissions at the hearing, both Counsel later provided further material on awards made for vibration white finger in personal injury cases. Pursuant to an earlier direction of the Chief Commissioner we had the benefit of expert medical evidence in the form of an agreed joint memorandum on general issues concerning vibration white finger and hand-arm vibration syndrome by Professor C L Welsh FRCS, a specialist in hand-arm vibration conditions, on behalf of the claimants, and Professor M Aylward CB FRCP, former Chief Medical Officer, Department for Work and Pensions, and Dr S M C Reed, Medical Adviser to the Department's Corporate Medical Group and to the Industrial Injuries Advisory Council ("IIAC"), on behalf of the Secretary of State. In addition Professor Welsh and Dr Reed both provided separate reports on the details of the two cases, gave oral evidence before us and were cross-examined. We are grateful to all concerned for their assistance.

The Legal Framework

5. The statutory basis for the payment of IIDB in respect of diseases contracted at or as a result of work is found in Part V of the Social Security Contributions and Benefits Act 1992 ("the 1992 Act"). Section 108(1) provides:

> "Industrial injuries benefits shall, in respect of a person who has been in employed earner's employment, be payable in accordance with this section and sections 109 and 110 below in respect of -

(i) any prescribed disease, or

(ii) any prescribed personal injury (other than an injury caused by accident arising out of or in the course of his employment)

which is a disease or injury due to the nature of that employment and which developed after 4 July 1948."

Section 108(2) provides that a disease or injury may be prescribed in relation to any employed earners if the Secretary of State is satisfied that it ought to be treated, having regard to its causes and incidence and any other relevant considerations, as a risk of their occupations and not as a risk common to all persons, and it is such that, in the absence of special circumstances, the attribution of particular cases to the nature of the employment can be presumed with reasonable certainty.

6. By section 109, the benefits payable in respect of a prescribed disease and the conditions for receipt of benefit are save as otherwise provided by regulations to be the same as in the case of personal injury by accident, and by regulation 11 of and Schedule 2 to the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985 SI No 967 ("the 1985 Regulations") the relevant provisions of the Act relating to accidents are to be construed in disease cases as references to prescribed diseases and references to the relevant accident and the date it was suffered as references to the relevant disease and the date of its onset, determined in accordance with regulations.

7. Under Part 1 of Schedule 1 to the 1985 Regulations disease A11 is prescribed in relation to certain occupations involving the use of vibrating or percussive tools in the following terms:

"A11. Episodic blanching, occurring throughout the year, affecting the middle or proximal phalanges or in the case of a thumb the proximal phalanx, of -

(a) in the case of a person with 5 fingers (including thumb) on one hand, any 3 of those fingers,

(b) in the case of a person with only 4 such fingers, any 2 of those fingers,

(c) in the case of a person with less than 4 such fingers, any one of those fingers or, as the case may be, the one remaining finger (vibration white finger)."

Thus where a person has five digits on each hand, the prescription requires episodic blanching of at least three digits of one hand, occurring throughout the year. Though no other description or diagnostic guidance is given in the regulations, there is no dispute that the "blanching" condition so prescribed is a disturbance of the vascular system involving interruption of the blood flow (vasospasm) to the fingers, typically associated with the use of vibrating work tools. There is also no dispute that disease A11 vibration white finger was so prescribed in relation to each of these claimants by virtue of the nature of his work. We return to the prescription below.

8. Once a prescribed disease as defined in Schedule 1 to the 1985 Regulations is diagnosed in relation to a claimant any resultant loss of faculty must first be identified and his or her degree of disablement from that loss of faculty must then be assessed in percentage terms for the purpose

of determining whether there is entitlement to benefit, and if so what that entitlement may be. The assessment must be carried out in accordance with Schedule 6 to the 1992 Act, which provides (so far as relevant):

> "General provisions as to method of assessment
>
> 1. ...the extent of disablement shall be assessed, by reference to the disabilities incurred by the claimant as a result of the relevant loss of faculty, in accordance with the following general principles -
>
> (a) except as provided in paragraphs (b) to (d) below, the disabilities to be taken into account shall be all disabilities so incurred (whether or not involving loss of earning power or additional expense) to which the claimant may be expected, having regard to his physical and mental condition at the date of the assessment, to be subject as compared with a person of the same age and sex whose physical and mental condition is normal;
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> (b) ...regulations may make provision as to the extent (if any) to which any disabilities are to be taken into account where they are disabilities which, though resulting from the relevant loss of faculty, also result, or without the relevant accident might have been expected to result, from a cause other than the relevant accident;
>
> (c) the assessment shall be made without reference to the particular circumstances of the claimant other than age, sex, and physical and mental condition;
>
> (d) the disabilities resulting from such loss of faculty as may be prescribed shall be taken as amounting to 100 per cent disablement and other disabilities shall be assessed accordingly."

9. By regulation 11(6) and (8) of the Social Security (General Benefits) Regulations 1982 SI No 1408 ("the 1982 Regulations"):

> "(6) Where the sole injury which a claimant suffers as a result of the relevant accident is one specified in column 1 of Schedule 2 to these regulations, ... the loss of faculty suffered by the claimant as a result of that injury shall be treated for the purposes of ... the Act as resulting in the degree of disablement set against such injury in column 2 of the said Schedule 2 subject to such increase or reduction of that degree of disablement as may be reasonable in the circumstances of the case where, having regard to the provisions of [Schedule 6 of the 1992 Act] and to the foregoing paragraphs of this regulation, that degree of disablement does not provide a reasonable assessment of the extent of disablement resulting from the relevant loss of faculty. ...
>
> (8) For the purposes of assessing, in accordance with the provisions of [Schedule 6 to the 1992 Act], the extent of disablement resulting from the relevant injury in any case which does not fall to be determined under paragraph (6) ..., the Secretary of State or, as the case may be, an appeal tribunal may have such regard as may be appropriate to the prescribed degrees of disablement set against the injuries specified in the said Schedule 2."

10. The prescribed degrees of disablement in Schedule 2 to those regulations begin with an injury consisting of the loss of both hands, or amputations higher up the forearm, for which the prescribed degree of disablement is 100%; and include lower prescribed amounts for various cases of amputation affecting the upper limbs and hands, such as 30% for the loss of a thumb without its metacarpal bone, 50% for the loss of four fingers of one hand, 14% for the loss of a whole index finger, middle finger 12% and ring or little finger 7%; and for the guillotine amputation of the tip without loss of bone 5% for an index finger, 4% for a middle finger and 2% for a ring or little finger.

Prescribed Disease A11

11. The prescription of the disease in the terms set out above (see paragraph 7) is thus entirely dependent upon a vascular phenomenon involving some form of restriction of the blood flow or vasospasm to the fingers. It has applied, in relation to persons such as these claimants who had been employed in certain specified occupations involving the use of powered or percussive machinery, at all material times from 1 April 1985.

12. The prescription in that form was introduced following the recommendations of the IIAC report of September 1981 on "Vibration White Finger" (Cmnd 8350) in which the condition was described as follows:

> "White Finger
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> 10. White Finger is the common name for the well-known phenomenon of transient attacks of blanching of the fingers. Medically it is described as episodic digital ischaemia or Raynaud's phenomenon. Three categories of the condition are recognised: primary white finger, secondary white finger, and vibration white finger.
> ...
>
> 13. Vibration white finger is the occupational form of the condition, brought on by the use of vibratory tools. It has been recognised since 1911 ..."

13. The report referred to the work of Professor Taylor and Dr Pelmear in classifying the progress of the condition into five stages of increasing severity, and recommended that the more severe forms of the condition as then understood, corresponding to the more advanced stages on the scale where the patient experienced episodes of blanching on a year-round basis, should be prescribed as an industrial disease for occupations involving particular tools and processes identified as presenting most risk. Those recommendations were accepted and implemented in the legislation.

14. Taylor and Pelmear's work (Taylor W and Pelmear PL, eds. Vibration White Finger in Industry, London Academic Press) was published in 1975. Their assessment of the severity of the condition was according to a combination of the condition of the digits and the interference with work and social activities. Both vascular and sensorineural symptoms were included in a single scale, reflecting the assumption that these would develop together as the condition as a whole progressed; however in the more severe stages of the scale (those relevant for benefit) only the vascular symptoms are measured.

15. However the agreed medical evidence before us was that the Taylor-Pelmear scale is obsolete; in particular because it fails adequately to reflect the neurological element of what is now recognized as a more complex syndrome referred to generally as "Hand Arm Vibration Syndrome" (or "HAVS": though there is no universal definition of this term). As currently understood this may involve vascular, neurological and musculo-skeletal symptoms arising as a consequence of damage to tissues caused by vibration: the neurological or sensorineural aspects of the condition may develop independently of (or at a different rate from) the vascular element. The system of classification now in most general use is that devised and adopted in 1986 at a scientific meeting in Stockholm (the "Stockholm Workshop scale") which evaluates vascular and neurological elements separately as follows:

Vascular component

Stage	**Grade**	**Description**
0		No attacks.
1V	Mild	Occasional attacks affecting only the tips of one or more fingers.
2V	Moderate	Occasional attacks affecting distal and middle (rarely also proximal) phalanges of one or more fingers.
3V	Severe	Frequent attacks affecting all phalanges of most fingers.
4V	Very severe	As in stage 3, with trophic changes in the fingertips.

Neurological component

Stage	**Description**
0SN	Vibration-exposed but no symptoms.
1SN	Intermittent numbness with or without tingling.
2SN	Intermittent or persistent numbness, reduced sensory perception.
3SN	Intermittent or persistent numbness, reduced tactile discrimination and/or manipulative dexterity.

16. With these advances in medical knowledge it has become increasingly accepted by those expert in this field that it is illogical for the IIDB prescription of disease A11 to recognise only the vascular effects of the syndrome. In its report of May 1995 on "Hand Arm Vibration Syndrome (Vascular and Neurological Components Involving the Fingers and Thumb)" (Cmnd 2844) the IIAC said, under the heading "Defining the disease":

> "Clinically, there is general agreement that HAVS can have at least two separate components - the vascular and the neurological. An affected individual may exhibit one or both system effects. The vascular effects of blanching with extension of the areas affected with time and continued exposures are already prescribed. The

neurological effects of numbness, tingling, reduced tactile discrimination and loss of dexterity are not currently included in the prescription. There is universal agreement that they should be. Indeed the internationally agreed Stockholm Classification (1986) is now the most widely used method of grading HAVS ...."

The Council on that occasion recommended that the prescription of disease A11 be extended to include the peripheral vascular and neurological effects of HAVS using the Stockholm scales, but this recommendation was not implemented.

17. In its further report of July 2004 on "Hand-Arm Vibration Syndrome" (Cmnd 6098), the Council recorded that:

> "Sensorineural disease
>
> 32. Sensorineural symptoms are well recognised to occur in individuals with VWF in association with episodes of blanching and recovery. These symptoms are currently taken into account in the assessment for disablement in diagnosed cases of VWF. However, it is now appreciated that the typical symptoms of the sensorineural component of HAVS - numbness, tingling, impaired dexterity and grip - can arise independently of blanching. The sensorineural component of HAVS usually predates the vascular part in onset....
>
> 35. More disability appears to be experienced from nerve injury than from finger blanching ....
>
> 39. ... [T]here is broad consensus that the Stockholm scales... provide a useful basis for grading the frequency, extent, and impact of HAVS."

The Council again recommended that the terms of prescription of prescribed disease A11 be extended to recognise both the vascular and the sensorineural elements, with the two components prescribed as alternatives to reflect the fact that claimants might have only the vascular or only the sensorineural element of HAVS, or both. However that recommendation too remained (and remains) unimplemented.

18. The terms of the prescription in its original form therefore remain unaltered. They thus constrain both departmental decision-makers and tribunals (including those with whose decisions we are concerned); and the aspects of the disease and any resulting disablement that can be taken into account for benefit purposes have to be restricted accordingly.

19. This point must be emphasised because in this respect the benefits system for claimants suffering from disease A11 vibration white finger is narrower in scope than, for example, the court system in making general damage awards for the effects of HAVS or the compensation scheme for former mineworkers suffering from the latter condition, administered by the Department of Trade and Industry ("DTI"), in succession to the National Coal Board. The compensation awards that have been obtained by and on behalf of former miners under that scheme have understandably stimulated interest in the pursuit of industrial disease benefit claims for vibration white finger as well, but have also given rise to a good deal of misunderstanding and ultimate disappointment among benefit claimants because of the differences between the benefits and compensation schemes. For benefit purposes, both the conditions of entitlement

and the system of assessment are significantly different from those of the DTI scheme. Indeed, even if the most recent recommendations of the IIAC were accepted that would still be the case, as the Council itself emphasised in the final paragraph of its 2004 report:

> "79. Medical assessment reports from the DTI coal workers compensation scheme and legal reports may be considered by decision makers during the assessment of claims for IIDB. However, the diagnostic criteria being considered must be in accordance with the criteria used to assess claims for IIDB. Qualification for HAVS under the more lenient DTI scheme will not inevitably satisfy the terms of prescription for the prescribed disease PD A11 (HAVS). The Council wishes to emphasise that in such cases, claimants would not be refused because they do not have HAVS, but that they do not qualify for the prescribed disease under the terms of prescription for IIDB."

The Facts

20. The claimant in the first case (CI/535/2005) is a man now aged 71 who was an underground face worker at Abercynon and Lady Windsor collieries for some 38 years until the latter closed in 1988.

21. The claim that gave rise to this appeal is the third he has made for prescribed disease A11. The first two, made in 1999 and 2000 respectively, resulted in adverse decisions by tribunals on 26 November 1999 and 26 March 2001 confirming departmental determinations that the claimant was not and had not been suffering from the disease in terms of the prescription at all as, although he had some vibration damage to his hands, the required degree of episodic blanching stipulated by the regulations was not shown to have been present.

22. His third claim made on 10 July 2003 was again turned down by the Secretary of State on those grounds, but that was reversed by an appeal tribunal sitting at Cardiff on 23 August 2004. After hearing his evidence the tribunal recorded decisions (as reissued incorporating a correction) that (i) the claimant was suffering from prescribed disease A11 or from a sequela of that disease and had so suffered since 1 April 1985; and (ii) he had from that date a loss of faculty identified as impaired upper limb function resulting in disablement from the prescribed disease, that disablement as finally assessed by the tribunal being 7% for the period from 14 July 1985 for life.

23. The claimant appeals against that assessment as erroneous in law. He does not of course appeal against the decision on the question of diagnosis, which was in his favour. However the Secretary of State, while not bringing any appeal of his own against the decision on diagnosis, reserves the right to reopen that aspect of the matter at any rehearing if the tribunal decision is set aside. Otherwise, he supports the claimant's appeal to the extent only of pointing out a technical error in the stated "date of onset" of the disease, and agreeing that the reasons for the award of 7%, which he considers too high on that evidence, were inadequately stated - the reasons falling "just short" of being adequate, in his view. He asks for the decision to be set aside and the case sent back to another tribunal for redetermination.

24. The claimant in the second case (CI/1814/2005) is sadly no longer alive, having died at the age of 69 after the tribunal had heard and decided his case. His appeal is pursued for the benefit of his estate. He too had worked for many years underground as a coal face worker, deputy and

shotfirer at Ystalyfera, Pwllbach, Cefn Coed and Blaenant collieries, a total of 33 years down to the end of 1985. From at least ten years before he stopped underground work the claimant had developed tingling in the fingers of both hands with some attacks of whiteness, particularly when cold.

25. He too had made a previous claim on the basis of prescribed disease A11 on 26 June 2000. On 4 January 2001 a tribunal confirmed the Secretary of State's decision to reject the claim on the ground that he had not been shown to be suffering from disease A11 in the terms required by the prescription.

26. The present appeal arose out of a further claim submitted on 23 October 2002 through the solicitors now acting for him. Following a medical examination this claim too was rejected by the Secretary of State on the ground that although the claimant had some vibration damage the evidence did not establish that his condition amounted to prescribed disease A11 with the episodic blanching required by the regulations. That decision was reversed in his favour by the tribunal at Swansea on 11 February 2005, when it was determined that (i) he was suffering from prescribed disease A11, and had been since 1 April 1985; and (ii) he had a loss of faculty from the disease identified as impaired function of both hands, with a resulting disablement as finally assessed by the tribunal of 4% from 91 days after 1 April 1985 for the remainder of his life.

27. The claimant's appeal against that assessment as erroneous in law is pursued on behalf of his estate by the same solicitors as are acting in the first appeal, the grounds advanced being for practical purposes identical with those relied on in that case. The Secretary of State does not support this appeal but makes the same reservation about reopening the question of diagnosis on any rehearing if the tribunal decision is set aside.

Scope of these Appeals

28. An appeal to a Commissioner against the decision of an appeal tribunal may only be brought on the ground that the decision of the tribunal was erroneous in point of law (sections 12 and 14 of the Social Security Act 1998).

29. The classic summary of what may amount to an error of law in reference to this jurisdiction is that given by the late Sir Rawdon Temple QC in case R(A) 1/72: a decision may be held erroneous in law if it contains a false proposition of law *ex facie*, or is supported by no evidence, or if the facts found are such that no person acting judicially and properly instructed as to the relevant law could have come to the determination in question, or if there has been a breach of the obligation to act according to the demands of natural justice, or failure adequately to observe the requirement to set out the reasons in writing.

30. More recently in *R (Iran) v Secretary of State for the Home Department* [2005] EWCA Civ 982, [2005] INLR 633 the Court of Appeal considered the jurisdiction of an appellate tribunal to correct errors of law in immigration cases and gave some examples of commonly encountered errors of law in terms that can apply equally to other appellate legal tribunals. Those relevant for the purposes of these appeals were summarised, with an important caveat as to materiality, in the judgment of Brooke LJ at paragraphs 9-10 as follows:

> "(i) making perverse or irrational findings on a matter or matters that were material to the outcome ('material matters');

(ii) failing to give reasons or any adequate reasons for findings on material matters;
(iii) failing to take into account and/or resolve conflicts of fact or opinion on material matters;
(iv) giving weight to immaterial matters;
(v) making a material misdirection of law on any material matter;
(vi) committing or permitting a procedural or other irregularity capable of making a material difference to the outcome or the fairness of proceedings; ...

Each of these grounds for detecting any error of law contains the word 'material' (or 'immaterial'). Errors of law of which it can be said that they would have made no difference to the outcome do not matter."

31. The difference between an error of law in one of the above senses and a disputed judgment of degree on a question of fact is particularly important to bear in mind in appeals such as the present, where the decisions complained of concern only the percentage of functional disablement shown to be suffered by a claimant on the evidence in his or her individual case. That is of course essentially a factual and medical assessment for the tribunal hearing and seeing that evidence to make; not a matter for us as an appellate body concerned with questions of law to offer or impose a substituted view of our own. We can only interfere if it is shown that the tribunal's decision is in some way erroneous in point of law. The first issue we must therefore address is whether either or both of the tribunals in the appeals before us is or are shown to have fallen into any error of law as claimed.

Perversity

32. Although the underlying aim of these appeals might at some points have been thought to imply that the percentages being awarded by these and other tribunals were inherently unreasonable or "perverse", it was not contended on behalf of either claimant at the hearing that (independently of the other grounds referred to below) the percentages awarded in these cases were in error of law as being perverse, in the sense that no tribunal properly directing itself could have lawfully awarded so low a percentage on the evidence in the case.

33. In our judgment, Mr Starmer was right not to pursue perversity or irrationality as an independent point in view of the material before us in these cases. As he accepted, it could add nothing of substance to the other grounds of appeal he pursued on behalf of the claimants.

34. As we have already indicated (paragraph 31 above), the assessment of disablement for the purposes of the industrial injuries and prescribed diseases benefit schemes is essentially a factual question for the judgment of the tribunal, which includes an appropriately qualified medical member and is the particular body charged under the legislation with making it. There was no basis on which it could be said (independently of the other specific grounds of appeal pursued) that either award was below the band of what could be described as reasonable for such a body on the evidence in the particular case. That is the proper test for an error of law for this purpose: is the award "so wildly wrong" that it can be set aside (*Murrell v Secretary of State for Social Services*, reported as Appendix to R(I) 3/84, per Sir John Donaldson MR at page 223G, citing *Edwards v Bairstow* [1956] AC 14); or is the conclusion drawn by the tribunal "an impossible conclusion" on the evidence (*Murrell* at page 226E per Browne-Wilkinson LJ). In *R (Iran)* cited in paragraph 30 above it was stressed that perversity is a "very demanding concept" - "a very high hurdle" (paragraph 11).

35. Nothing in the jointly agreed statement of the medical experts before us, or their individual evidence, suggested an error of anything like that nature. Professor Welsh, who is an internationally recognised expert on HAVS – he has many years' experience as a consultant vascular surgeon, and himself was a participant in the Stockholm Workshop referred to in paragraph 15 above - made it clear so far as his own evidence was concerned that he was not addressing the assessment of functional disablement from vibration white finger for benefit purposes at all. He did not purport to be an expert on that subject, and had not considered the relevant legislative provisions. Dr Reed, whose experience and expertise does lie in this particular area of disablement assessment - she holds Diplomas in Occupational and Disability Assessment Medicine, is an adviser to the IIAC and has been closely involved with the working of this legislation on behalf of the Secretary of State - provided no support whatever for any suggestion that either of the tribunal assessment awards was unreasonably low. On the contrary she considered the 7% award in the first case to be on the high side, and somewhat generous to the claimant.

36. In neither case therefore is there any basis for saying that the percentage awards themselves demonstrate without more that the tribunals must have fallen into some error in reaching them. They are each within the band of what a tribunal properly directing itself could reasonably have awarded on the evidence before it.

37. With that we now turn to the four grounds of appeal upon which each of the claimants did rely.

The Grounds of Appeal: Introduction

38. What was said on behalf of the claimants was that each tribunal decision was erroneous in law for four specific reasons, formulated in all but identical terms in the notices of appeal in each case. The grounds in CI/535/2005 are set out below, with the differences in CI/1814/2005 shown in square brackets:

> "(i) The tribunal failed to explain clearly what was the basis of the award of 7% [4%].
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> (ii) The tribunal did not make clear whether their assessment included the effect of both vascular and neurological symptoms following the Commissioner's decision in CI/14532/1996.
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> (iii) The tribunal failed to have proper regard to judicial guidelines on assessment as advised in Commissioner's decision CI/2553/2001.
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> (iv) Although the tribunal accepted the opinion expressed in the report of Dr D Entwistle [Dr M E B Jones], the assessment of disability at 7% [4%] is inconsistent with the report of Dr Entwistle [Dr Jones] which assessed the staging of [the claimant's] condition as follows: Left sensorineural 3SN, right sensorineural 3SN. Left Vascular 3V [2V], right Vascular 3V [2V].

The sensorineural staging is at the maximum on the Stockholm Workshop Scale. The symptoms of tingling, numbness, loss of manual dexterity and weak grip are permanent and will cause [the claimant] a significant disability."

39. The four alleged errors of law are thus in essence the same for both cases, and we take them in turn.

The Grounds of Appeal I: Inadequate Reasons

40. The first ground is that the tribunal in each case failed to explain clearly the basis of the percentage disablement award.

41. The tribunal in the first case (CI/535/2005) recorded in its statement of reasons that the appellant gave oral evidence that he had in his fingers tingling since 1978 and pain and aching, giving him problems with fine jobs and such things as handling coins. He said the tingling was there all the time but varied in severity, and he had real pain if his fingers went white, though this was related to cold and was intermittent. It could last an hour or more but he had never experienced an attack which lasted all day. His symptoms were tingling all day and aching and pain when the fingers were white. He had problems picking things up and sometimes sleeping, and the tribunal recorded his evidence of further examples of things with which he had difficulty. The tribunal, which had also previously referred to the report of Dr Entwistle prepared in connection with the claimant's civil claim against the National Coal Board (DTI) for HAVS, first considered the evidence and resolved the issue of diagnosis in the claimant's favour. The statement of reasons then continued (in paragraph 11):

> "The tribunal then proceeded to the assessment. The appellant in his oral evidence stated that he had tingling in both hands and pain and occasional whitening affecting the fingers. He found tasks such as handling coins and picking things up difficult. He was unable to DIY or change a bulb and sometimes had trouble dressing with things such as buttons and shoelaces and was unable to do car maintenance or hold a snooker cue. Taking into account the stated problems the tribunal considered that an assessment of 7% for life was appropriate."

42. In its statement of reasons in the second case (CI/1814/2005) the tribunal recorded findings of fact that in the late 1960s the claimant developed a coldness in his hands and tingling on the tips of his fingers of both hands. The problems with his hands got worse after 1975 and it was then that colour changes started to occur in both hands. He experienced about six attacks of blanching (whiteness) in the winter and two in the summer. (Before us, this finding was agreed to relate to the number of attacks per week, as described by the claimant in his evidence.) The whiteness affected the tips and middle phalanges of four fingers of each hand. Episodes were triggered by cold and lasted 20 to 30 minutes. In giving the reasons for the decision the tribunal recorded that having weighed up the medical evidence and having heard the claimant's own evidence, it was persuaded on the balance of probabilities that he was suffering from vibration white finger and had done so since 1 April 1975, bearing in mind his evidence that the blanching started some time in 1975.

43. Having thus determined the diagnosis issue in the claimant's favour, the tribunal then dealt with the question of disablement as follows:

"5. In assessing the disablement resulting from the loss of faculty we took into account the guidance given in CI/2553/2001. [The claimant] told us that the main problem he had was numbness in both hands especially in the finger tips and this caused him to drop things like cold spades. He was a bit clumsy with buttons and tying a tie but otherwise was self-caring. He avoided shoes with laces. He was all right handling pans. He had a problem picking up coins and repairing household items because he was unable to handle small screws. He still drove a car. He also experienced tingling in his hands especially when working in the garden and he avoided gardening in the winter now. He was not woken by numbness or tingling at night. He experienced about 6 attacks of blanching in the winter and 2 in the summer. The whiteness affected the tips and middle phalanges of 4 fingers on each hand. These episodes were triggered by cold and could last 20 to 30 minutes. This was relieved by placing his hands in warm water. No pain was described. There was no interaction with any other loss of faculty in the upper limbs.

The DTI report indicated that neither the tingling nor the numbness were persistent (i.e. did not last for more than 2 hours) and that the tingling for [the claimant] was not as bad as the numbness. [He] told us that he had given up darts due to his poor grip. However we noted the DTI report showed his grip strength to be normal and the medical assessor (page 55) noted that grip and pincer grip was normal in both hands and he was able to oppose each thumb to finger tips. We did not accept his grip was poor in view of the medical evidence. We also took into account the DTI report showed him having a score of 3SN and 2V in both hands. There was no significant loss of dexterity.

In weighing all these factors, we also had regard to the view of the DTI doctor that [the claimant] minimised his symptoms. The condition seemed fairly stable. We found the level of disablement caused to [him] was mild, and taking into account its intermittent nature, we assessed his disablement at 4% for life."

44. In an exercise of judgment and evaluation such as is involved in the assessment in percentage terms of an individual claimant's degree of functional disablement, there is inevitably a band within which an assessment would be reasonable, and the reasons why a particular percentage has been arrived at rather than a point or two higher or lower may be impossible to state with exact precision. As on all questions of valuation or the assessment of any amount, they may be difficult to explain otherwise than by making clear the factors that have or have not been taken into account, and confirming that the result reflects the application of the tribunal's own judgment and expertise to those factors and the evidence (see *Murrell v Secretary of State for Social Services*, cited above; and R(I) 30/61 at paragraph 8).

45. We do not think the practical requirements for tribunals dealing with appeals in this area can be better stated then they were in case CI/1802/2001 by Mr Deputy Commissioner Warren, when he said (paragraphs 7 to 9):

"7. Vibration white finger is not one of those conditions for which there is a prescribed degree of disablement in Schedule 2 of the General Benefit Regulations. Those Regulations therefore state only that the tribunal 'may have such regard as may be appropriate to the prescribed degrees of disablement' when making its assessment. This indicates the very broad discretion which individual tribunals have in this type of case. In many cases it is simply not possible for a tribunal to give precise reasons for the conclusion which it has reached.

> 8. In my judgment, however, as a minimum, the claimant and the Secretary of State are entitled to know the factual basis upon which the assessment has been made; in other words what disabilities were taken into account by the tribunal in concluding that a particular percentage disablement was appropriate.
>
> 9. This can often be simply expressed. In many cases it will be enough to say that the evidence given by the claimant about the effect of a particular accident or disease on his or her daily life has been accepted. In some cases, where the claimant's evidence is for some reason found to be unreliable, it may be that the tribunal will state that it felt able to accept only those disabilities which in its expert opinion were likely to flow from problems disclosed on clinical examination. Other cases may need more detail. But if it is not possible to discern the material on which the assessment is based, then the tribunal's statement of reasons is likely to be inadequate."

46. These comments, relating directly as they do to the present ground of appeal on reasons for specific percentage assessments, are also in our judgment entirely consistent with the principles stated by the Court of Appeal in the more general context of the giving of reasons by tribunals (*Eagil Trust Co Ltd v Pigott Brown* [1985] 3 All ER 119 especially at page 122 per Griffiths LJ; *English v Emery Reimbold and Strick Ltd* [2002] EWCA Civ 605, [2002] 1 WLR 2409 particularly at paragraph 19 per Lord Phillips MR; and *R (Iran)* supra particularly at paragraphs 13-16). The Court of Appeal have stressed in these cases that elaborate or lengthy reasons are not necessary, as long as the tribunal identifies and records those matters that were critical to its decision, to enable the parties and others to understand the tribunal's thought processes when it is making its material findings.

47. Although in the first of the cases before us the tribunal's summary of its reasons in the paragraph we have already quoted (see paragraph 41 above) is admittedly succinct, we do not find the stated reasons in either of these cases leaves any room for real doubt as to the factual bases on which the decisions were given, or the precise aspects of functional disability which were taken into account in the figures arrived at.

48. In the first case the tribunal's statement makes clear that all of the stated practical problems referred to by the claimant in his evidence were accepted by the tribunal, taken into account as contributing to the overall level of disability found to be present, and reflected in the percentage assessment reached. These included the tingling and difficulties with sensation as well as the pain associated with episodes of whiteness, and also the trouble he sometimes had fumbling with such things as buttons and his difficulties with grip, for example with a snooker cue. Read in the proper context of the evidence and findings of primary fact to which the tribunal referred, in our judgment the tribunal's statement adequately complies with the requirement to show the factors to which it was directing itself and the evidence of disability it accepted and took into account: that is to say those matters that were critical to the decision.

49. We consider this to be the case despite the respondent Secretary of State's view that the reasons of the tribunal fell "just short" of being adequate. This view was based, not upon deficiencies in primary factual findings (which he considered adequate), but the tribunal's failure to indicate the "ranking" of severity in this case, not as a percentage figure (7%), but in words. As we have said, the tribunal's reasons are succinct, and of course in many cases reasons may be given in more extended form. It may well be good practice to give fuller reasons than the tribunal gave in this case. However, we do not accept that a tribunal necessarily errs simply in

failing to describe the severity of functional disability - which is key in this exercise - in one word or phrase, as opposed to setting out the nature of that disability and then assessing the disablement as a percentage as the tribunal did, adequately, in this case. We consider the reasons given by the tribunal in this case to have been adequate.

50. The same in our judgment is true of the tribunal's reasons in the second case where the factors accepted and taken into account for the assessment were stated to be all of the difficulties described by the claimant in his evidence and referred to in the tribunal's statement, with the exception of what he had said about disability with his grip; that part of his claimed disability the tribunal did not accept having regard to the medical evidence, and therefore excluded. Again in our judgment that was an adequate explanation of the basis on which the decision had been reached, sufficient for any reasonable person to understand what had and had not been taken into account in the 4% assessment the tribunal found appropriate to the "mild" and "intermittent" disablement it judged to be shown by the evidence.

51. We therefore reject the first ground of appeal in both cases.

The Grounds of Appeal II: Failure to take into account Neurological Symptoms

52. The second ground is that the tribunal in each case did not make clear whether its assessment included the effect of both vascular and neurological symptoms, following CI/14532/1996. We also reject this ground in both cases.

53. The Commissioner's decision referred to, which is reported as R(I) 3/02, holds that, although the terms of disease A11 require that episodic blanching of the stipulated degree must be shown to be present before a diagnosis of the prescribed disease can be made, once such a diagnosis is made then all aspects of the vibration-induced condition itself (including in particular any and all loss of faculty of a neurological or sensorineural nature such as permanent tingling or numbness, not just that stemming directly from vasospasm) must be taken into account in the assessment of functional disablement. That was not disputed before us as a correct statement of the law. We consider it to be correct, and now well-settled.

54. In our view it is equally beyond doubt that in each of these cases, having found the prescribed condition present in the claimant, the tribunal did in fact take into account, and reflect in its percentage assessment, all relevant sensorineural aspects of the claimant's vibration-induced hand condition, and not just those involved in the episodes of blanching themselves. Each tribunal expressly said so: the first referring to the appellant's stated problems with tingling and handling small objects, and the second to the numbness which was the claimant's major problem as well as the tingling and clumsiness with buttons and picking things up.

55. Accordingly, we find nothing of substance in the second ground of appeal in either case.

The Grounds of Appeal III: Failure to take into account the Judicial Guidelines on Assessment of Damages

56. The third ground of appeal is that the tribunal in each case failed to have proper regard to judicial guidelines on assessment of damages, as advised in CI/2553/2001. We consider that this ground also fails. It is particularly inapposite in relation to the second appeal, where the

tribunal's reasons expressly refer to the guidance given in CI/2553/2001, and record that they have taken it into account.

57. When one looks at the actual terms of the guidance given in that case by Mr Commissioner Williams when remitting the appeal to a tribunal for rehearing, neither of the tribunals with which we are concerned did or said anything inconsistent with it. The Commissioner referred to the published Judicial Guidelines for the Assessment of General Damages in Personal Injuries Cases published and regularly updated by the Judicial Studies Board, but made clear (at paragraph 22) that he did not attempt to derive anything from the bands of damages there set out. Nor in our judgment would it be right to do so. Those guidelines are for an entirely different purpose (see *R v Medical Appeal Tribunal ex p Cable* reported as an Appendix to R(I) 11/66, quoted below at paragraph 75). The Commissioner merely directed the tribunal to take into account certain specific criteria referred to in those guidelines, namely the length and severity of the claimant's attacks and symptoms, the extent and/or severity and/or rapidity of deterioration of his condition, and his age and prognosis. While the guidelines may provide a useful list, those are of course entirely unexceptional matters for a tribunal to take into account in its assessment of functional disablement.

58. Furthermore, it is clear from their respective statements of reasons that the tribunals in the cases before us did take into account precisely these matters. Such matters can of course be taken into account on the assessment of a person's functional disablement without any express reference to the judicial guidelines.

<u>The Grounds of Appeal IV: Tribunal Decision Inconsistent with DTI Medical Reports</u>

59. The fourth ground of appeal in each case is that the percentage disablement found by the tribunal was inconsistent with the findings of medical reports prepared for a claim under the DTI scheme, and in particular with the standardised test results of the claimants' sensorineural symptoms measured on the Stockholm scale. These reports were in evidence before the tribunals. Again, we find nothing of substance in this ground in respect of either case.

60. Indeed, there was no evidence before us in support of this submission. In particular, Professor Welsh made clear in his evidence that the Stockholm scales did not focus on the measurement of functional disability. It was perfectly possible for a person to have a measurement of 3S on the Stockholm sensorineural scale and still have only mild disablement; and in any case that score, like the all of the measurements in the DTI report, was subjective in that it depended on the individual responses of the subject, there being no objective clinical diagnostic test. Professor Welsh emphasised that his own approach, and that of the Stockholm scales, was concerned with attempting to evolve a certain and transparent system of measurement of peripheral neuropathy as a clinical condition and did not focus on disability. For him and his work, such transparency and certainty were more important than the assessment of disability.

61. Dr Reed's evidence was that while a score on the Stockholm scale which depended on self-reported symptoms could certainly be taken into account by a medical assessor or tribunal in the assessment of functional disablement, they were by no means the same thing. The legislation required a practical assessment of a person's degree of impairment in the things they could and could not do, and that was not something that was measured by the Stockholm scale nor could it be obtained from it. We accept this.

62. Thus none of the expert medical evidence gave any support for the suggestion that there was any inconsistency between the tribunal's acceptance of the DTI medical reports referred to and quite properly taken into account in each case, and the levels of functional disablement actually found to exist when that and all the other evidence about the practical loss of functional ability suffered by each claimant was considered and taken together.

63. It follows that no error of law was established on this ground in either case.

Conclusion

64. The claimants' contentions against the percentage assessments of disablement therefore fail and that is sufficient to dispose of these appeals, subject to one correction which must be made in CI/535/2005 on the statutory "date of onset" of the disease and the related start of the disablement assessment period, to accord with the requirements of the legislation. As quite correctly noted by the tribunal in paragraph 8 of its statement of reasons, there had in this case been a previous determination on the claim in 1999 that the claimant had not at any time since 1980 been suffering from prescribed disease A11. For the reasons explained in case R(I) 5/04, the legislation formerly in force governing medical determinations made that conclusive for all purposes, including any subsequent claim; although that did not apply to the second tribunal decision given on 12 February 2001, when the provisions of the Social Security Act 1998 by then in force did not impose such a restriction. Those principles, entirely correctly set out in the tribunal's statement of reasons, were not however reflected in the terms of the formal decision notices, even in their corrected and reissued form; and consequently we vary them to the extent only of substituting the correct dates. Those are agreed to be 8 May 1999 for the statutory date of onset of prescribed disease A11 from which the claimant was found on 23 August 2004 to have been suffering (the earliest date the tribunal then had jurisdiction so to find) and the 91st day after 8 May 1999 for the start of the 7% disablement assessment period.

65. For these reasons, we formally allow the appeal in CI/535/2005 but only to the extent of varying the Cardiff appeal tribunal's decision by making the statutory date of onset for prescribed disease A11 to be 8 May 1999, and the start of the 7% disablement assessment period to be the 91st day after that date.

66. In CI/1814/2005, we confirm the decision of the Swansea appeal tribunal dated 11 February 2005.

Postscript

67. For the reasons given at the outset of this decision, we were pressed by the claimants to use these cases as an opportunity of making observations of a general nature on the assessment of disablement for the purposes of prescribed disease A11. The scope for doing so usefully on the basis of the material submitted to us must obviously be limited given its nature and our conclusion that it does not show any error of law in the approach of these tribunals to that question.

68. Commissioners have always regarded it as part of their function to give guidance where needed for the assistance of tribunals and departmental decision makers on the relevant principles of law to be applied in this specialised jurisdiction: this is an area where certainty and consistency of approach and an orderly development of the law are of particular importance

given the complex nature of the legislation and the very large number of individual cases potentially involved. However it is a function to be exercised cautiously, particularly in an instance such as the present where the questions of assessment of an individual's percentage level of functional disablement are not primarily matters of legal interpretation at all, but of factual judgment - including judgment on medical matters - entrusted by the legislation to the specialist tribunals best qualified to decide them. There is a danger in misinterpreting the observations of individual Commissioners on the facts of such cases as laying down additional rules of law where only helpful guidance on the fact-finding process was intended. There was some evidence of that in the way the notices of appeal before us were formulated. What matters is not whether express reference is made to some such guidance, but whether the substance of the tribunal's decision, and its statement of the factors taken into account in reaching it, demonstrates any error of law as outlined above.

69. The relevant statutory requirements are set out above (see paragraphs 5 to 10). The effect of those provisions insofar as vibration white finger is concerned - there being no special provisions in the prescribed diseases regulations for any special method of assessment of the disablement resulting from prescribed disease A11 - is that set out by Mr Deputy Commissioner Warren in the passage we have already quoted (see paragraph 45). In short, the assessment of the degree of disablement for benefit purposes in such cases is at large, for the tribunal to determine on the facts of the individual case. It must make a reasonable assessment of the extent of disablement resulting from the relevant loss of faculty identified as attributable to the prescribed disease.

70. The only specific obligation placed on the tribunal in that context is to make the assessment in accordance with the general principles set out in paragraph 1 of Schedule 6 to the 1992 Act (see paragraph 8 above). In doing so it must take into account all disabilities incurred as a result of the relevant loss of faculty to which the claimant may be expected to be subject during the period taken into account by the assessment; and taking as a starting point the mandatory evaluation of the total loss of both hands, and the other very severe conditions so prescribed in the Regulations, as amounting to a 100% level of functional disablement, it must assess other disabilities "accordingly". It "may have such regard as may be appropriate" to the prescribed degrees of disablement for which set percentages less than 100 are prescribed in Schedule 2 to the General Benefit Regulations; but is not bound to do so, if it does not consider them of assistance in making a reasonable assessment of the actual disablement in the case before it.

71. Subject to that, a tribunal is not obliged to try and force the disablement with which it is concerned into an imaginary position on the scale set out in the regulations, or on any other scale; and it would in our judgment be contrary to the intent of the legislation to attempt to construct such a scale, or to set recommended or suggested percentage levels of assessment of disability from prescribed disease A11 or any other prescribed disease where the legislation itself does not do so. Within the broad requirements of the legislation, these matters are best left to the tribunals qualified and experienced in dealing with them; and as with all matters of factual judgment on questions of degree, the mere fact that another tribunal might as a matter of judgment and professional opinion reach a different figure on consideration of the facts of a similar case, or even the same case, does not begin to demonstrate that either is in error of law.

72. There was debate before us as to whether the degrees of disablement prescribed in Schedule 2 for hand and finger conditions can be of any assistance to tribunals. Having

considered those submissions, we consider the assistance that can be derived is relatively small. Dr Reed's evidence that, in her view, the functional loss – in terms of ability to do things – is more adversely impaired by the loss of an index finger (prescribed at 14%) than by permanent vibration white finger sensorineural symptoms in all fingers of one hand resulting in an inability to pick up nuts and bolts and similar fine dexterous activities, was cogent. But, as she made clear, functional disablement depends upon the facts of an individual case; and the activities affected by the loss of one important finger are entirely different from those affected by impaired sensation in the fingertips. One is not comparing like with like.

73. It was however common ground between the experts (set out in paragraph 12 of the joint memorandum prepared after their meeting on 19 October 2005) that "only stage 4 vascular on the Stockholm scale would equate to the loss of the tips of the fingers (in the order of 10-13% each hand)". This was explained in their evidence before us to mean the most severe case of HAVS, which (they said) would be measured on the Stockholm scales as 4V 3SN. On the basis of this evidence, a theoretical starting point would be an absolute maximum of 20-26% disablement for the most severe case conceivable. However, the value of this starting point is diminished by the following:

(i) This would be for the most severe form of HAVS, involving ulceration of the finger tips and other trophic changes. Professor Welsh said that, in all of his experience in seeing perhaps 13,000 HAVS patients, he has never seen any with such severe symptoms. Such symptoms would likely arise, not from the use of vibrating machines, but from medical conditions which affect the vascular and peripheral nervous systems (e.g. scleroderma).

(ii) The experts were agreed that there was a significant drop in severity between someone classified as 4V and someone classified as 3V, although they were not agreed as to the extent of that drop (largely in our view because of (iii) below).

(iii) In any event, even if 20-26% could represent a theoretical disablement at the absolute limit, it would not follow that actual lesser disablements could be graduated down from that figure in line with the Stockholm classification, which is not related to functional disablement at all.

For these reasons, the schedule of prescribed percentage disablement for various conditions found in Schedule 2, while informing appropriate percentages for a specific case of prescribed disease A11 to an extent, is of very limited value in assessing percentages for such conditions.

74. For similar reasons we were not able to adopt the suggestion made for the claimants on the basis of Professor Welsh's evidence, of setting out guidelines for percentage awards by reference to a self-contained scale for assessing the severity of HAVS cases. The initial suggestion was to do this by simply taking 25% of the prescribed percentage for the loss of a phalanx in respect of each digit affected by blanching, and a further 25% for those affected by sensorineural symptoms. However Professor Welsh was perfectly frank in his evidence that the 25% proportions chosen had no scientific rationale, and in the worked examples in his supplemental report they resulted in degrees of disablement of 34 and even 40%: substantially higher than the total of 20-26% for the loss of all finger tips he accepted as the absolute theoretical maximum for a disablement beyond any he had ever seen (paragraph 73). In its modified form the suggestion made by Mr Starmer in reply was therefore that we should set a guideline scale by reference to the severity of the condition up to that maximum. That might have the benefit of

simplicity but it too (and any similar scheme) has the irremediable defect for our purposes that, as Professor Welsh also frankly acknowledged, his approach would not reflect functional disablement - his aim was to replace such an assessment with a certain and transparent scale, by equating condition (the presence of vascular and/or neurological changes) with disablement. Condition is not a proper surrogate for disablement and we were left unpersuaded that this could be a way of implementing the present legislation, as distinct from replacing it with something different: it would not reflect functional disablement in any proper way at all, failing to take into account (for example) the time and extent of symptoms, that would inevitably affect a person's functional ability.

75. Similarly, in reaching a valid decision on an individual claimant's functional disablement for the purposes of industrial injury or disease benefits, other scales which have been developed for entirely different purposes must also have very limited value; and, although there can be no objection to a tribunal making points relevant to the exercise they are undertaking by reference to such scales, tribunals will certainly not err if they do not make mention of such scales. Thus the Guidelines on the Assessment of General Damages in Personal Injury cases published by the Judicial Studies Board, while they do refer to vibration white finger, are of very little assistance in this field, for the reasons explained by Diplock LJ in *ex parte Cable* (cited above at paragraph 57) as follows:

> "The National Insurance (Industrial Injuries) Act, 1946, which with subsequent amendments has now been consolidated... was one of a series of statutes which inaugurated the welfare state. It operates in a field with which the law courts are only too familiar, that of industrial injuries, but introduces a concept which is wholly different from those which the courts apply in actions for damages by negligence or breach of statutory duty brought by an employee against his employer. The 'injury benefit' and 'disablement benefit' to which a claimant is entitled under the Act is not 'compensation' for injury but money payable under the terms of a statutory contract of insurance. It bears no direct relationship to the actual loss suffered by the claimant as a result of the industrial injury and in construing the Act the Court must be continually on guard against the fallacy of applying to the assessment of 'benefit' the principles applicable to the assessment of damages or compensation - a task with which it is so much more familiar. The Act and the Regulations made thereunder constitute a self-contained code dealing with the right to benefit. Cases about damages at common law throw no light upon the meaning of that code. To refer to them as an aid to construction can only mislead."

The caution against cross-referencing implicit in that passage is salutary. Any reference to other scales, such as the Criminal Injuries Compensation Scheme, would have to be the subject of similar caution.

76. Similarly while a tribunal may of course quite properly take account of an individual claimant's score on the Stockholm (or even the obsolete Taylor-Pelmear) scales as evidence of vascular and/or neuropathological changes from exposure to vibration in the workplace, it should do so only subject to the caveat that those scales are not, and were never intended as, a means of measuring the resulting degree (if any) of functional disablement for benefit purposes for the particular individual concerned. That is the tribunal's task to assess, and is a discrete exercise, applying different criteria. If there could have ever been any doubt about that, the evidence given to us by the distinguished medical experts in these cases must have removed it.

77. Finally for the sake of completeness we confirm that it is not part of the tribunal's function to apply, or even necessarily to take into account, anything contained in any internal guidance circulated by the Department for Work and Pensions to its own medical assessors or decision making staff. It is of course entirely proper for there to be such guidance within the Department in the interests of promoting clarity and consistency of approach, but nothing in it can bind or need concern a tribunal: it records only one side's view - that of the executive Government - of what the law and good practice may require. Where a tribunal does take such guidance into account at all, it must bear that in mind. For that reason we make no comment of our own on the "Medical Assessment Framework" document included among the material before us, beyond noting with approval Dr Reed's assurance of the emphasis that is given to all medical staff that nothing in the document is to fetter their own individual judgment in a particular case, and her acknowledgment that on some aspects the present version was due for a review.

78. We appreciate that these comments may disappoint potential claimants and those who represent them, who were seeking guidance for the easier disposal of the claims we have been led to believe are in the pipeline. Unfortunately, for the reasons we have given, any attempt at producing a template for such decisions would be bound to founder. In this area of the benefits regime (as with many others: see, e.g., *Secretary of State for Work and Pensions v Moyna* [2003] UKHL 44; [2003] 1 WLR 1929; R(DLA) 7/03) there is a considerable discretion left to decision makers (and, in their turn, appeal tribunals) who are charged by statute to make such decisions. It is however hoped that our comments will assist those concerned with such claims and decisions, by identifying the correct approach to such decisions in this area and also to an extent matters which should (and matters which should not or need not) be taken into account in exercising that judgment.

His Honour Judge Gary Hickinbottom
Chief Commissioner

P L Howell
Commissioner

A Lloyd-Davies
Commissioner

27 April 2006