DECISION OF A TRIBUNAL OF SOCIAL SECURITY COMMISSIONERS

1. In Case No CDLA/2879/2004, we allow the claimant's appeal and set aside the decision of the Wakefield appeal tribunal dated 27 May 2004. We direct that the case be remitted to be heard by a differently constituted tribunal, in accordance with our directions set out in paragraph 150 below.

2. In Case No CDLA/2899/2004, we allow the claimant's appeal and set aside the decision of the Birmingham appeal tribunal dated 7 June 2004. We direct that the case be remitted to be heard by a differently constituted tribunal, in accordance with our directions set out in paragraph 170 below.

REASONS

Introduction

3. By section 73(1)(a) of the Social Security Contributions and Benefits Act 1992 ("the 1992 Act") a person is entitled to the higher rate of the mobility component of disability living allowance ("DLA") for any period throughout which "he is suffering from physical disablement such that he is either unable to walk or virtually unable to do so...".

4. In each of the appeals before us the claimant claims entitlement to that higher rate. In the first appeal the claimant (Mr B) contends that severe low back pain substantially limits his ability to walk. In the second appeal the claimant (Mrs H) contends that severe vertigo and dizziness does so. In each case the appeal tribunal decided that the claimant was not entitled. In Mr B's case this was on the ground that, even if there was something physically wrong with his back, there was no physical reason for the severe degree of pain that he experienced, and psychological problems might well be contributing to his walking difficulties. In Mrs H's case the tribunal's decision was on the ground that her vertigo and dizziness did not have a physical cause, the implication being that these were psychological in origin. The claimants now appeal those decisions.

5. The appeals raise an important issue as to whether difficulty in walking which is due to pain (in Mr B's case) or dizziness (in Mrs H's case) which is found to have no identifiable physical cause falls within section 73(1)(a) of the 1992 Act. The number of previous decisions by Commissioners dealing with this issue - more than twenty were cited to us - and the divergence of views expressed in them amply demonstrates not only the difficulty of the issue but also its practical importance.

6. At the hearing of the appeals Daniel Kolinsky of Counsel (instructed by the Child Poverty Action Group) appeared for Mr B, Baljinder Bajwa of the Sandwell Metropolitan Borough Council's Welfare Rights Unit appeared for Mrs H, and James Maurici of Counsel (instructed by the Solicitor to the Department for Work and Pensions) appeared for the Secretary of State. We are grateful to all of them.

The Statutory Provisions

7. DLA is a non-contributory benefit for people who are so disabled that they need help to cope with their disability. There are two components, designed to assist with care and

mobility respectively. There are three rates of the care component, and two rates of the mobility component.

8. Section 72(1)(a), (b) and (c) of the 1992 Act specifies the basic conditions of entitlement in respect of the three rates of the care component. Each sub-paragraph requires the claimant to be "so severely disabled physically or mentally" that certain specified conditions are fulfilled.

9. Section 73 sets out the conditions of entitlement for the mobility component. It provides (so far as directly material)

> "(1) Subject to the provisions of this Act, a person shall be entitled to the mobility component of a disability living allowance for any period ... throughout which -
>
> (a) he is suffering from physical disablement such that he is either unable to walk or virtually unable to do so; or
>
> (b) ...
>
> (c) ...
>
> (d) he is able to walk but is so severely disabled physically or mentally that, disregarding any ability he may have to use routes which are familiar to him on his own, he cannot take advantage of the faculty out of doors without guidance or supervision from another person most of the time.
>
> ...
>
> (5) ... [C]ircumstances may be prescribed [by the Secretary of State] in which a person is to be taken to satisfy or not to satisfy a condition mentioned in subsection (1)(a) or (d) ... above."

10. Regulation 12(1) of the Social Security (Disability Living Allowance) Regulations 1991 (SI 1991 No 2890) (which has effect as if made under section 73(5)) provides:

> "A person is to be taken to satisfy the conditions mentioned in section 73(1)(a) of the Act (unable or virtually unable to walk) only in the following circumstances -
>
> (a) his physical condition as a whole is such that, without having regard to circumstances peculiar to that person as to the place of residence or as to the place of, or nature of, employment -
>
> (i) he is unable to walk; or
>
> (ii) his ability to walk out of doors is so limited, as regards the distance over which or the speed at which or the length of time for which or the manner in which he can make progress on foot without severe discomfort, that he is virtually unable to walk; or

(iii) the exertion required to walk would constitute a danger to his life or would be likely to lead to a serious deterioration in his health; or

(b) ...".

11. Fulfilment of the conditions in section 73(1)(a) of the 1992 Act, as amplified in regulation 12(1)(a) of the 1991 Regulations, entitles a claimant to the higher rate of the mobility component (currently £42.30 a week). There are other routes to the higher rate, but they are rarely relied upon and these appeals are not concerned with them. Fulfilment of the condition in section 73(1)(d) entitles the claimant to the lower rate (currently £16.05 a week).

12. There is therefore a contrast between the language used in relation to the care component and the lower rate of the mobility component on the one hand and, on the other, that used in relation to the higher rate of the mobility component. As regards the former, it is sufficient that the claimant is "so severely disabled *physically or mentally*" that the relevant qualifying conditions are fulfilled. As regards the latter, section 73(1)(a) requires that the claimant be "suffering from *physical* disablement such that he is either unable to walk or virtually unable to do so", and regulation 12(1)(a) requires that "his *physical* condition as a whole is such that" the relevant consequences follow.

13. In sections 72 and 73(1)(d), the words "physically or mentally" are words of inclusion not exclusion - they show that entitlement to the care component and lower rate mobility component is not limited to some types of disability alone (CDLA/1721/2004, at paragraph 38). The omission of any reference to "mental" disablement in section 73(1)(a) (and to "mental" condition in regulation 12(1)(a)) can only be construed as some form of restriction on the types of disablement that will satisfy the conditions of entitlement for the higher rate mobility component. This appeal concerns the extent of that restriction.

The Parties' Submissions in Outline

14. Put briefly, the submission by Mr Kolinsky for Mr B, which was adopted by Mr Bajwa on behalf of Mrs H, is that the restriction is defined in terms of the *manifestation* of the disability, the only exclusion from the entitlement criteria being of what Mr Kolinsky described as "pure" mental disablement, i.e. mental disablement which does not have physical consequences in terms of the claimant's ability actually to put one foot in front of the other. Symptoms having a physical manifestation (e.g. pain or dizziness) are sufficient to satisfy the criteria, whatever their cause might be.

15. Mr Maurici for the Secretary of State contended that the restriction must be defined in terms of the *cause* of the disability, thereby restricting entitlement to the higher rate of the mobility component to cases in which the inability or virtual inability to walk has a physical (i.e. organic) *cause*. For this purpose symptoms such as pain and dizziness which are mental or psychological in origin are insufficient for entitlement. Mr Maurici submitted that this is the proper construction of the relevant statutory provisions but, in any event, it is the construction adopted by the Court of Appeal in *Harrison v Secretary of State for Social Services* [1987] (reported as an Appendix to (R(M) 1/88) and that we are bound by that decision.

The Commissioners' Jurisprudence

16. As we have already indicated, there is a considerable volume of Commissioners' cases bearing on the issue before us. We need not refer to all of these, but we should give an indication of the spectrum of opinions expressed.

17. Mr Kolinsky for the claimant Mr B relied in particular on CDLA/948/2000 and CDLA/3323/2003. These authorities concentrate upon the effects or manifestation of the claimant's medical condition as the relevant criteria for the test. In the former case Mr Deputy Commissioner Mark, after reviewing the authorities, said (at paragraph 22):

> "If a person is in such pain that she cannot bear to be touched and cannot put one foot in front of another without agony, I find the greatest difficulty in seeing how this can be said not to be part of her physical condition because there is no physical cause for the pain. I consider that a physical symptom, if genuine, is part of a person's physical condition as a whole even if caused by psychological factors, whether it is pain, paralysis or something more mundane such as a skin rash... It therefore appears to me that..., as a matter of law, construing section 73 and regulation 12, genuine physical pain is part of a person's physical condition even if caused by, or a symptom of, psychological factors."

In CDLA/3323/2003, Mr Commissioner Rowland said (at paragraph 15):

> "Like Mr Commissioner Walker in CSDLA/265/1997 I have difficulty seeing how pain or paralysis cannot be part of a person's physical condition even if they are induced by a mental disorder. "

18. Mr Maurici for the Secretary of State relied in particular upon a decision of Mrs Commissioner Parker in CSDLA/894/2001 as setting out broadly the correct approach. In paragraphs 56 to 60, the Commissioner said (under the heading, "The Correct Test"):

> "56. At its most basic level, "physical" means "of or concerning the body" and "mental" means "of or in the mind". It is difficult to see how any restriction in walking does not have *a* corporeal element. Even the agoraphobic is physically affected by the psychiatric condition. He or she may be able to move freely when indoors but cannot move out of doors. It goes without saying that a claimant's complaint has to be genuine. The person who fakes pain or breathlessness or paralysis unarguably does not succeed. But a scientific basis for a contrast between psychosomatic pain and mental, illusory or imaginary pain is hard to comprehend, insofar as the results affect walking. If the mental problem is unrelated to a bodily symptom or function then it is not psychosomatic, but equally it cannot affect walking which is a physical activity.
>
> 57. What then is meant by "physical disablement" as a limiting factor for higher mobility? In the context of physical disablement such that the claimant is unable or virtually unable to walk, as compared with a mental disablement having the same result, it seems imperative that there is current organic abnormality, objectively verifiable, which is a necessary link in the causal chain which restricts the claimant's walking to the required degree.

> 58. This fits with *Harrison v The Secretary of State for Social Services*. It underlies the change in opinion with respect to conditions like autism. The immediate cause of restricted walking in such claimants is usually behavioural problems, such as lying down, holding on to an object, refusing to walk. In the past, such claimants failed to be awarded higher mobility. Now, however, it is recognised that autism is due to a chromosomal abnormality so that the necessary physical disablement is accepted.
>
> 59. Alternatively, a claimant may for example have physical back problems and also depression. If depression is due to her physical condition, at least in part, or if her physical condition is a material cause limiting her walking, albeit exacerbated by unconnected depression, then a tribunal is entitled to find that any resultant walking difficulties are due to her "physical condition as a whole."
>
> 60. It follows that, provided a clinical abnormality is an essential link in the chain of difficulties which result in restricted mobility, and still exists, it does not matter at which stage of the chain it comes...."

This case (like R(M) 2/78) consequently focuses upon the cause of the condition resulting in the disability, rather than the effects or manifestation of that condition.

19. Whilst most cases broadly come down in favour of one approach or the other, some have attempted a middle course. For example, in CDLA/5463/99 Mr Commissioner Jacobs seems to have taken what amounts to something of a hybrid view in holding that, while physical effects of a mental disorder do generally qualify as "physical disablement", pain is not physical disablement for this purpose.

The Construction of the Relevant Statutory Provisions in the absence of *Harrison*

20. For the reasons we set out below (paragraphs 86 to 101), we consider that we are bound by *Harrison* to hold that the Secretary of State's submission (set out in paragraph 15 above) is correct. However, before explaining why that is so, we shall consider the conclusion to which we would have come in the absence of *Harrison*. We consider that it is important to do so for three reasons. First, consideration of the merits of the relative arguments enables the question of what exactly was decided in *Harrison* to be better addressed. Second, on the footing that *Harrison* does determine the outcome of the main issue, other issues (relating primarily to causation) potentially arise, on which guidance needs to be given, both in the present cases and more generally. Third, these appeals may go further, in which case the court may find our views of assistance.

21. We deal with the relevant issues under seven headings (A-G below).

A. History of the Current Provisions

22. In support of their contentions, each party relied to some extent on the history of the current provisions.

History of the Current Provisions: Genesis

23. Attendance allowance, the forerunner of the *care* component, was introduced by the National Insurance Act 1970. From the outset, the legislation included a requirement that the claimant be "so severely disabled physically or mentally" that a particular test was satisfied.

24. Assistance for people with *mobility* needs was originally provided in kind rather than in money (see generally The Law of Social Security, Ogus & Barendt, 1st edition (1978), pages 183-5). From 1946, in exercise of his powers under the National Health Service legislation, the Minister of Health made a single seat three-wheeler invalid carriage available to a disabled person who came within any of the following categories (the criteria being set out in a DHSS Circular):

> (i) loss of both legs, one being amputated above or through the knee;
> (ii) defects in the locomotor system, or a severe chronic lung or heart condition such that, to all intents and purposes, he was unable to walk; or
> (iii) a disability which was slightly less severe but which still seriously limited walking ability, and as a result he needed personal transport to get to and from work.

25. From 1968 the relevant power was contained in section 33 of the Health Services and Public Health Act 1968 (later replaced by section 5(2)(a) of the National Health Service Act 1977) which gave power to the Minister to "provide invalid carriages for persons appearing to him to be suffering from severe physical defect or disability ...".

26. These provisions came to be regarded as inadequate because (i) facilities were distributed inequitably (in particular, they were limited to persons who themselves were able to drive) and (ii) the three-wheeler carriage provided was itself unsatisfactory (it was dangerous, noisy, uncomfortable, liable to break down, and could not carry a passenger). Following various proposals, a flat-rate non-contributory allowance was introduced as an alternative to the three-wheeler. This mobility allowance, the predecessor of the higher rate of the mobility component of DLA, was introduced with effect from 1 April 1976 by inserting section 37A into the Social Security Act 1975. Attendance allowance was by then dealt with in section 35 of that Act.

27. Section 37A provided for the mobility allowance to be payable to a person "for any period throughout which he is suffering from physical disablement such that he is either unable to walk or virtually unable to do so" (that is, the same wording as now governs the primary condition for the higher rate of the mobility component). Further, power was given to prescribe by regulations the circumstances in which a person was or was not to be "treated as suffering from such physical disablement". Regulation 3(1) of the Mobility Allowance Regulations 1975 (SI 1975 No 1573), in its original form, provided:

> "A person shall only be treated, for the purposes of section 37A, as unable to walk or virtually unable to do so, if his physical condition as a whole is such that, without having regard to circumstances peculiar to that person as to place of residence or as to place of, or nature of employment, -
>
> (a) he is unable or virtually unable to walk; or

(b) the exertion required to walk would constitute a danger to his life or would be likely to lead to a serious deterioration in his health."

Whereas the statutory power was to prescribe the circumstances in which a person was or was not to be treated as suffering from physical disablement such that he was unable or virtually unable to walk, the original form of regulation 3(1), read literally, merely prescribed the circumstances in which a person was to be treated as unable or virtually unable to walk. It is therefore arguable that regulation 3(1) left untouched the statutory requirement that the claimant be suffering from physical disablement, so that the combined effect of the two provisions was that the claimant must be "suffering from physical disablement such that his physical condition as a whole is such that, without having regard to circumstances ...".

History of the Current Provisions: R(M) 2/78

28. The Chief Commissioner, Sir Rawden Temple, considered these provisions in R(M) 2/78, only the second reported Commissioner's decision in relation to mobility allowance.

29. The claimant was a 12 year old boy who suffered from Down's syndrome (then described as "mongolism") with a mental age of 2 years such that, although he was able to walk, he was (according to the findings of the medical appeal tribunal) "liable to run, stop, lie down and refuse to go further". A later report of the case suggests that the boy had never in fact walked more than 30 yards (see paragraph 5 of the 1979 National Insurance Advisory Committee Report referred to below).

30. The medical appeal tribunal held that Down's syndrome, although it impaired the claimant's mental functioning, was a physical disorder because it was due to faulty genetic inheritance (i.e., as the tribunal said when refusing leave to appeal to the Commissioner, the physical malformation of chromosome 21), and that it was the boy's reaction to this physical condition that stopped him walking. Therefore the claimant was virtually unable to walk because of *physical* disablement. On appeal to the Commissioner, the Secretary of State conceded that the claimant had a physical disorder but submitted that "physical disablement" meant an inability to execute a physical movement and not merely "disablement which has a physical factor in its causation". The claimant submitted that consideration had to be given to his physical condition as a whole and the test was satisfied if his virtual inability to walk was attributed to "the physical condition as a whole, regarding the condition as causative in its entirety, and as disabling".

31. The Chief Commissioner dismissed the appeal. He said that the medical tribunal had found that the claimant's physical disorder (Down's syndrome) was directly responsible for "reaction" which seriously impaired his mobility and continued:

> "No doubt it was open to the medical appeal tribunal to have decided that what effectively prevented Robert from exercising any physical ability to walk was attributable to a mental state, stemming from but operating independently of any disabling physical condition. They did not do so. In so far as there was any mental element which prevented Robert from walking (he has an accepted mental age of 2 years) they attributed his virtual inability, not to conscious volition or mental disability, but to "reaction" itself directly due to his physical condition. I read their decision as concluding that a physical factor was present throughout in the causation of his inability to walk.

I think it is plain that the medical appeal tribunal regarded Robert's physical condition as a whole as being a disabling condition, preventing him from doing the particular action of walking. The weight to be attached to physical and mental disablement in cases where both factors may be present is for the medical authorities to decide, and the answer to the question whether the one or the other, or both, are responsible for an inability or virtual inability to walk is for their decision as a medical question. I do not consider that the medical appeal tribunal misapprehended what physical disablement means, or that it can be said that they were wrong in law in concluding from their findings that it was physical disablement which was responsible for his virtual inability to walk."

32. The Chief Commissioner thus appears to have adopted a test of looking at the effective cause - or an effective cause - of the difficulty in walking, and held that the medical appeal tribunal had been entitled to regard the effective cause as being the physical defect in chromosome 21, rather than the mental impairment to which that gave rise. But he indicated that he did not consider this to be a test case, and did not consider it to be decisive in any other case. It is consequently of limited value in the interpretative exercise now before us.

History of the Current Provisions: The 1979 Report of the National Insurance Advisory Committee

33. In 1979, amendments to regulation 3 of the 1975 Regulations were proposed and a draft prepared upon which the National Insurance Advisory Committee ("the NIAC") was asked to comment. The Committee described the background as follows in paragraphs 5 to 8 of its Report (Cmnd 7491):

"5. We have been informed by the Department that the main provisions of the amending regulations were drafted as a result of doubt about the entitlement to the allowance of a number of people who, although apparently physically able to walk cannot, or do not, do so to any significant extent because of a mental handicap which results from their physical condition. Guidance was then sought from the National Insurance Commissioner in one case, that of a boy, aged 12 at the time, who because of Down's syndrome had a mental age of 2, was physically strong but had never walked more than 30 yards. The Chief Commissioner allowed the particular case but emphasised that he did not regard the case as being decisive of any other. Following the promulgation of the decision, it was thought desirable to clarify the issue by making regulations....

6. The Chief Commissioner in his decision indicated that the weight to be attached to the physical and mental disablement where both factors may be present is for the medical adjudicating authorities to decide. The Department have told us that, after taking into account legal and medical advice, they subsequently concluded that the amending regulations should relate to the effect of a disabling condition, rather than its causation.

7. We see no reason to dissent. None of the representations we received took exception to such an approach and one or two positively supported it.

8. The first draft of the main provisions of the amending regulations, therefore, in seeking to clarify the position regarding the effective inability to walk of certain people

with severe mental handicap, amended regulation 3(1) of the principal regulations by providing that the qualifying conditions for the allowance would be satisfied if, because of a physical condition, a person:- (a) was unable to make the physical movements of his body necessary for walking, or alternatively that his ability to move on foot was so severely impaired that he was unable to make any real progress; or (b) ...."

34. The report then went on to explain that the NIAC had felt that there was a danger that the revised wording, in seeking to cover a small number of particular cases, would restrict the criteria for the generality of claimants, and that it had invited the Department to produce a further draft "retaining as far as possible the wording of the existing regulation 3(1) but expanding illustratively the phrase "virtually unable to walk"".

35. The amended draft was enacted with effect from 21 March 1979 by the Mobility Allowance Amendment Regulations 1979 (SI 1979 No 172). The amended regulation 3(1) was in substantially the same terms as the present regulation 12(1)(a) of the 1991 Regulations. The substance of the amendment was therefore to set out a list of factors (distance, speed etc) by which virtual inability to walk was to be judged. However, it also altered the terms of the deeming provision so that, if the conditions of the regulation were met, a claimant was deemed not just to be unable or virtually unable to walk, but also to be suffering from physical disablement such that he was unable or virtually unable to walk. Therefore, if the regulation 12(1)(a) criteria are met, all of the conditions in section 73(1)(a) are deemed to be met, including the condition of suffering from physical disablement.

36. It is notable that both the original regulation 3(1) and the amended version (which, as described above, has been carried through into the current regulation 12) state that the claimant's "physical condition as a whole" must be such that he is unable or virtually unable to walk. In paragraph 7 of its Report, the NIAC said that it agreed with the Department's view that "the amending regulations should relate to the effect of a disabling condition, rather than its causation". In R(M) 3/86, a Tribunal of Commissioners (in paragraph 5) expressed the view that this meant that the amending regulations had left untouched the requirement in R(M) 2/78 that the effective cause be physical and should concentrate simply on seeking better to define what degree of diminution in the ability to walk would suffice.

37. However, we do not consider the meaning of paragraph 7 of the Report to be clear. It could be said that the widening of the effect of the deeming in regulation 3(1)(a) (from a deeming of merely inability or virtual inability to walk to a deeming of suffering from physical disablement such that...) did indicate a positive intention to affect the requirement that the effective cause of inability to walk be physical and that that wider intention was acknowledged in paragraph 6 of the NIAC Report. It might also be said that paragraphs 14 and 15 of the Report point the same way. It was noted there that some respondents had suggested substituting "functional" for "physical" in the regulation, but that the Department had assured NIAC that the suggestions added nothing legally to the revised draft. However, the difference in the width of the deeming could merely have been to bring the terms of the regulation into line with the terms of the statutory power in section 37A(2), without any intention to alter the substance. And it would have been curious, if such a fundamental change had been intended, for it not to be signalled more clearly in the NIAC Report.

38. Therefore, whilst on its face the NIAC Report suggests that the intention of what is now regulation 12 was to focus on "the effect of a disabling condition, rather than its cause", we are able to attribute only limited significance to the report in construing the current regulation

12, for two reasons. First, as we have indicated, the critical words "physical condition as a whole" were not in fact amended by the 1979 Regulations. Secondly, the meaning the Committee attributed to those words is itself open to different interpretations.

History of the Current Provisions: The Introduction of DLA

39. With effect from 6 April 1992 (by amendments made to the Social Security Act 1975 by the Disability Living Allowance and Disability Working Allowance Act 1991), attendance allowance (save for those over 65) and mobility allowance were respectively replaced by the care and mobility components of DLA. At the same time, the 1975 Regulations were replaced by the Social Security (Disability Living Allowance) Regulations 1991.

40. At this time two substantive amendments of note were made. First, the lower rate of the mobility component was introduced, in order to assist persons such as the blind claimant in *Lees v Secretary of State* [1985] 1 AC 930 who, although physically able to walk (and therefore, it was held in *Lees*, not entitled to mobility allowance), require guidance or supervision when walking out of doors in order to make use of that ability. The lower rate of the mobility component is available to a person who is "so severely disabled physically or mentally" that he requires such guidance or supervision.

41. Second, an additional category of entitlement to the higher rate of the mobility component was introduced (now found in section 73(1)(c) and (3) of the 1992 Act). It applies where a claimant (a) is severely mentally impaired and (b) displays severe behavioural problems and (c) fulfils the conditions of entitlement to the highest rate of the care component. For this purpose a person is severely mentally impaired "if he suffers from a state of arrested development or incomplete physical development of the brain, which results in severe impairment of intelligence and social functioning" (regulation 12(5) of the 1991 Regulations).

42. *Harrison* had been decided in 1987. The 1991 Act and the 1991 Regulations in effect re-enacted the provisions that were at issue in *Harrison* (and whose successors - i.e. section 73(1)(a) and regulation 12(1)(a) - are now in issue before us). It is therefore clear that the 1991 legislation did not intend to alter the meaning (whatever it may properly be considered to be) which the Court of Appeal gave to those provisions in *Harrison.* Whether Parliament, by re-enacting the provisions in (in substance) identical form, can be said to have *affirmed* the construction of them arrived at in *Harrison* is a different question. It is one which does not concern us, because the ratio of *Harrison* is of course binding on us. That question would only become material should this case go further.

43. The provisions in the Social Security Act 1975 relating to DLA were then consolidated, without amendment, in the 1992 Act, with regulation 12 of the 1991 Regulations having continued effect as if made under that Act. With that consolidation the present position was reached.

B. The Purpose of Higher Rate Mobility Component

44. Mr Kolinsky submitted that it is difficult to conceive of any rational policy reason for excluding from the higher rate of the mobility component persons who, by reason of a mental condition, suffer physical symptoms such as to render them unable or virtually unable to walk. The purpose of the benefit is to assist in coping with functional difficulties. Those

whose physical symptoms derive from a mental condition are just as deserving as those whose similar symptoms derive from a physical condition. Mr Maurici did not suggest that there was any rationale for such a distinction. We agree that it is not apparent why claimants who are in fact unable or virtually unable to walk should be treated less favourably because their disability is mental rather than physical in origin.

45. However, the benefits system sometimes does define broad categories of entitlement that inevitably exclude the apparently deserving from particular entitlement. It may have been that the test of physical disablement or physical condition as a whole was thought (as it appears, over-optimistically) to provide a broad and relatively straightforward way of identifying a group which ought to qualify while recognising that equally deserving individuals would be excluded. In terms of assisting us to construe the relevant statutory provisions, we do not consider that this submission carries particular weight.

46. Nevertheless, the overarching purpose of DLA (i.e. to assist people with disabilities to cope with those disabilities insofar as they affect their functional ability to care for themselves or be mobile) is not in our view irrelevant. It was an important factor in the significant Tribunal of Commissioners' decision CDLA/1721/2004, which bears on the issue now before us and which we consider below (paragraphs 62 to 65).

C. The Relationship between Section 73(1)(a) and Regulation 12(1)(a)

47. The relevant provisions are set out in full in paragraphs 9 and 10 above. Section 73(5) provides that "circumstances may be prescribed in which a person is to be taken to satisfy or not to satisfy a condition mentioned in subsection (1)(a) or (d) above". Regulation 12(1) provides that "a person is to be taken to satisfy the conditions mentioned in [section 73(1)(a)] only in the following circumstances (a) his physical condition as a whole is such that... he is unable to walk...[etc]".

48. In his skeleton argument Mr Maurici submitted that, although regulations made under section 73(5) could limit the scope of section 73(1)(a), they could not extend it. We note, in this connection, that in *Lees v Secretary of State for Social Services* [1985] AC 930 at page 933D Lord Scarman described the power in what is now section 73(5) (which he found "startling", although "by no means unprecedented") as a power "to set a limit to the scope of an enactment". However, Mr Maurici accepted in oral argument, in our judgment rightly, that it would have been within the section 73(5) power to make a regulation expressly stating that physical manifestations resulting from a mental condition should be regarded as physical disablement for the purpose of section 73(1)(a). Section 73(1)(a), in referring to "physical disablement such that...", does not so clearly exclude physical manifestations resulting from a mental condition that a regulation expressly stating that they should be treated as physical disablement would be *ultra vires*. In our view, therefore, if the phrase "physical condition as a whole is such that" in regulation 12 includes physical symptoms resulting from a mental condition, no objection could be taken on the ground of *vires*. We therefore do not need to consider the merits of the specific submission made in Mr Maurici's skeleton argument.

49. We consider the relationship between section 73(1)(d) and regulation 12 to be as follows. First, in our view it is the wording of regulation 12(1)(a) (i.e. "his physical condition as a whole is such that .....") which governs qualification. That follows from the terms of section 73(5) and of the opening words of regulation 12(1)(a). A claimant is to be taken to satisfy the conditions in section 73(1)(a) when the conditions in regulation 12(1)(a) are met.

That conclusion is also arguably supported by the history of the Mobility Allowance Regulations 1975 before their replacement by the Disability Living Allowance Regulations 1991 (discussed in paragraphs 33 to 38 above). However, in construing regulation 12(1)(a) regard may be had to the fact that it was made in order to set out the circumstances in which a person is to be taken to "suffer from physical disablement such that...".

50. Turning to the substance of regulation 12, the history of the provisions again becomes relevant. The original form of the predecessor of regulation 12(1)(a) (i.e. prior to its amendment in 1979: see paragraph 27 above) qualified the then equivalent of section 73(1)(a) in only three respects. First, it used the phrase "his physical condition as a whole is such that" but only in the course of defining when a claimant was to be treated as unable or virtually unable to walk. It did not expressly touch the test for physical disablement. Second, it added the requirement that, in determining ability to walk, one should ignore circumstances peculiar to the claimant, such as place of residence. Third, it provided that a claimant should be regarded as unable or virtually unable to walk if the exertion required to walk would constitute a danger to his life or would be likely to lead to a serious deterioration in his health. The second and third of those qualifications were clearly by way of mere clarification of the statute, rather than any form of restriction - the statutory wording could have been construed in the manner prescribed by the regulations in any event.

51. With regard to the first qualification, the regulation could simply have remained silent or have repeated the expression "suffering from physical disablement such that" used in the statute, but instead it used different wording from that in the primary legislation (then section 37A of the Social Security Act 1975). However, it is far from clear in what way, if at all, the meaning was intended to be different. The 1979 amendment raised additional issues (discussed in paragraphs 33 to 38 above).

52. The phrase "physical condition as a whole" in regulation 12(1)(a) is in our view ambiguous. Like the phrase "physical disablement", it could be interpreted either as referring to the cause of the disablement (i.e. it has to be shown that there is something wrong with the claimant's physical condition) or as referring to the functional ability that is impaired (i.e. the physical ability to make progress by putting one foot in front of the other). The background to the 1979 amendments (see paragraphs 28 to 38 above) tends towards the latter interpretation, but in our view far from decisively.

D. Significance of the absence of reference to mental disablement or condition

53. Mr Maurici submitted (and Mr Kolinsky accepted) that the difference in wording between section 73(1)(a) and regulation 12(1)(a) (which contain no reference to mental disablement or to the claimant's mental condition) on the one hand, and section 72(1) and section 73(1)(d) (which use the words "so severely physically or mentally disabled") on the other, must have some significance. Whereas the type of disability covered by the latter is unlimited, the statutory provisions intend *some* limit on the types of disability that will give entitlement to higher rate mobility component.

54. We remind ourselves that, as a matter of history (see paragraphs 23 to 26 above), when mobility allowance (i.e. the predecessor of section 73(1)(a)) was first introduced in 1975, attendance allowance (with the wording "so severely disabled physically or mentally that .....") had been in existence for some 5 years. Mobility allowance was introduced by introducing section 37A into the Social Security Act 1975, attendance allowance being by

then in section 35. Further, the contrast between what is now section 73(1)(a) and what is now section 73(1)(d) did not then exist, because lower rate mobility component was not introduced until the creation of DLA in 1992. Further, while attendance allowance had required that a person be "so severely disabled physically or mentally that", the mobility allowance provisions used the wording "suffering from physical disablement such that", rather than the wording "so severely physically disabled that...". It is therefore not necessarily correct to regard the mobility allowance provisions as having been drafted directly by reference to the attendance allowance provisions, but with mental disablement simply excised.

55. Nevertheless, we agree with the parties' submission that the absence of any reference to mental disablement or to the claimant's mental condition in section 73(1)(a) and regulation 12(1)(a) must indicate *some* limit on the types of disability which can give rise to entitlement to higher rate mobility.

56. As we have indicated (paragraph 14 above), Mr Kolinsky submitted that only those with a mental disablement which does not have physical manifestations (what he described as "pure mental disablement") would be excluded. He cited as examples a person with agoraphobia or, perhaps, schizophrenia who can walk perfectly well indoors but will not walk out of doors; or a person with seasonal affective disorder who will not leave the house at certain times of the year; or a person with depression who is physically able to walk but lacks all interest in doing so and consequently does not do so.

57. However, Mr Maurici submitted that such a limitation would be no limitation at all, because in practice it would exclude no one with a disability from entitlement to higher rate mobility component. Persons with a mental illness such as agoraphobia which is sufficiently severe to render them virtually unable to walk out of doors would almost certainly suffer some physical manifestations (such as breathlessness or palpitations) if they were to attempt to do so. Mr. Maurici submitted that because Mr Kolinsky's suggested limitation would not in practice exclude anyone it must be wrong.

58. We do not agree with that submisson because we consider that Mr Kolinsky's limitation excludes some persons who at least arguably would have been included if regulation 12(1)(a) had referred to the claimant's physical and mental condition.

59. First, there is the category of person who, although physically perfectly able to walk (in the sense of moving their legs), cannot effectively make use of that ability in order to get from A to B by reason of mental impairment. In *Lees* (see paragraph 40 above), the House of Lords gave leave to appeal on the issue whether a person who is physically able to walk but by reason of physical disability (in that case blindness and impairment of capacity for spatial orientation) cannot direct his movement towards a desired destination can be regarded as "virtually unable to walk". It was therefore clearly arguable, prior to the decision in *Lees*, that such a person was unable or virtually unable to walk within the meaning of the provisions (see the decision to that effect in R(M) 2/81). Given the importance which Lord Scarman attached to the references in the mobility allowance legislation to physical disablement and to the claimant's physical condition (see [1985] AC 930 at page 935 D-F), it would plainly have been arguable, if that legislation had referred to both physical and mental disablement (and to the claimant's physical and mental condition), that a person who, although physically able to walk, was unable to guide himself from A to B by reason solely of mental impairment, qualified for mobility allowance. The absence of a reference to mental disablement (and, in

the regulations, to the claimant's mental condition) make it clear that such a person could not qualify.

60. Second, we consider that there are persons suffering from conditions such as agoraphobia who find themselves unable to walk in particular situations (e.g. out of doors) or at particular times, and who are therefore at least arguably virtually unable to walk, but who do not suffer sufficient physical manifestations preventing them from walking to enable it to be said, even on Mr Kolinsky's construction, that their physical condition as a whole is such that they are unable or virtually unable to walk. That may have been the position in R(M) 1/80, where the finding of fact was simply that the claimant was perfectly able to walk indoors but was "in practice unable to walk outside the house." There was no exploration in the case of what physical symptoms, as opposed to mental anguish, the claimant might suffer if she contemplated walking or attempted to walk out of doors, but it is by no means clear that all claimants with that form of disorder would necessarily suffer physical symptoms such as to render them unable or virtually unable to walk. It would still be necessary for a claimant to show that the inability or virtual inability resulted from the physical symptoms rather than the mental, although we suspect that in practice the drawing of such distinctions would be very difficult (see paragraphs 102 to 116 below).

61. Therefore, whilst we would accept that the absence of any reference in section 73(1)(a) or regulation 12 to mental disablement or mental condition is intended to have some limiting effect, Mr Kolinsky was in our judgment right in submitting that that does not assist in determining what that limitation might be.

E. The meaning of "physically or mentally disabled" in relation to the care and lower rate mobility components; its significance in relation to higher rate mobility

62. The recent decision of a Tribunal of Commissioners in CDLA/1721/2004 concerned the scope of sections 72 and 73(1)(d) of the 1992 Act, and in particular the meaning of the phrase "so severely disabled physically or mentally". Having reviewed the relevant authorities and statutory background, the Commissioners drew a distinction between "disability" and "medical condition", saying (at paragraph 35):

> ""Disability" is conceptually distinct from "medical condition". "Disability" is entirely concerned with a deficiency in functional ability, i.e. the physical and mental power to do things. Of course, a diagnosable medical condition may give rise to a disability. For example, a condition that inevitably involves the loss of a sense or a limb would give rise to an obvious diminution in functional capacity. But entitlement to DLA is dependent upon a claimant's inability to cope with care and mobility without assistance and with his consequent reasonable care and mobility needs; and not upon the diagnosis of any medical condition. Even if a person has a serious medical condition in the sense that his life is imminently threatened - perhaps some asymptomatic heart condition - that person is not entitled to either component of DLA if the condition has no adverse impact on his ability to care for himself and be mobile without assistance. Conceptually and in ordinary language usage, "disability" cannot be equated with "medical condition"; and a "severe disability" is not the same as a "serious medical condition"".

The Commissioners went on to hold that there was nothing in sections 72 or 73(1)(d) that required "disability" to have any meaning other than its usual meaning, and that "disability"

in the context of those provisions meant simply "functional deficiency" (paragraph 42). For the provisions to apply, the Commissioners said (at paragraph 39):

> "... [T]he claimant must be disabled, i.e. have some functional incapacity or impairment. He must lack the physical or mental power to perform or control the relevant function."

63. Mr Kolinsky submitted that CDLA/1721/2004 strongly supports the claimants' case in these appeals. He submitted that on the basis, as there held, that the words "so severely disabled physically or mentally that..." in sections 72(1) and 73(1)(d) focus not on cause but on functional incapacity, it would be strange if that were not also the case in relation to section 73(1)(a) and regulation 12(1)(a).

64. In our view that submission has considerable force, especially as DLA is a single benefit with two components. However, it cannot be conclusive. First, the view of the Commissioners in that case (see paragraph 38 of CDLA/1721/2004) was that "the words "physically or mentally" are intended to show that entitlement to care component and lower rate mobility component, *unlike higher rate mobility component,* is not limited to some types of disability alone. In our judgment they are words of inclusion, not exclusion." As the words which we have emphasised recognised (see also paragraph 23 of that decision), and as is common ground in these appeals (see paragraph 53 above), the fact that section 73(1)(a) and regulation 12(1)(a) refer only to physical disablement and the claimant's physical condition respectively means that those references have an exclusionary purpose, and the issue is as to precisely what is excluded.

65. Second, as we have already noted (see paragraph 54 above), the provisions relating to higher rate mobility have an independent history, and of course they use different language: neither section 73(1)(a) nor regulation 12(1)(a) used the wording "so severely physically disabled that...".

F. Adjudication difficulties which arise if a physical cause is required

66. It is the Secretary of State's contention that in order to obtain an award of the higher rate of the mobility component a claimant must show that his difficulty with walking has a physical cause. Mr Kolinsky submitted that this would give rise to such difficult questions of law and fact in distinguishing between causative physical and mental conditions that this cannot be correct. He submitted that it could not have been Parliament's intention to make the decision making process so difficult. We have considerable sympathy with these submissions.

67. Whatever the criteria might be, decision making on many DLA claims will be difficult. Even on the claimants' case, findings of fact would have to be made in respect of a claimant's physical symptoms and their effect upon his functional ability. Such findings are often far from easy, but fall within the broad fact-finding scope of decision makers and appeal tribunals identified by Lord Hoffmann in *Moyna v Secretary of State for Work and Pensions R(DLA) 7/03;* [2003] 1 WLR 1929 (at paragraph 20).

68. However, if the Secretary of State's submissions in these appeals are right, we consider that the difficulties for decision makers and appeal tribunals would be substantially increased in some (although probably only a small proportion) of cases in which the higher rate of the

mobility component is in issue. Decision makers and appeal tribunals would have to consider not only the extent to which the claimant's ability physically to make progress on foot is impaired (which they would of course have to do on either submission), but also (if the Secretary of State's submissions are correct) the issue of the cause of that impairment. Causation has given rise to notoriously difficult issues of law and fact in other branches of the law and the issues arising here would be no less difficult.

69. One of the fundamental difficulties is the lack of certainty, on the basis of current medical and scientific knowledge, as to whether any proper distinction can be made between mental and physical conditions.

70. In *Harrison*, in a passage approved by O'Connor LJ, Mr Commissioner Monroe said (at paragraph 6):

> "[I]t may be that in the last analysis all mental disablement can be ascribed to physical causes. But, if so, it is obvious that the Act, in drawing the distinction between physical and mental disablement did not mean this last analysis to be resorted to."

However, it may be that, with advances in medical science enabling chemical or other changes in the brain which are responsible for (or are at least a feature of) mental illness to be detected, it is becoming increasingly difficult to deny Mr Kolinsky's submission that mental illnesses should properly be regarded as a feature of a person's "physical condition".

71. This issue was discussed, in the context of the meaning of the words "bodily injury" in the Warsaw Convention, in *Morris v KLM* [2001] 3 All ER 126 at page 136, by Lord Phillips MR:

> "... [I]t is possible that every mental illness may, in time, be shown to be accompanied by and consequent upon some change to the physical structure of the body, so that mental illness can properly be described as a type of physical injury. That stage has not yet been reached, however...."

However, in the House of Lords Lord Hobhouse said ([2002] 2 All ER 565 at paragraph 154) that that statement of Lord Phillips was:

> "... in truth a statement about medical science. It is contentious and needs to be made good by qualified expert evidence.... [T]here is respectable medical support for the view that, for example, a major depressive disorder is the expression of physical changes in the brain and its hormonal chemistry. Such physical changes are capable of amounting to an injury and, if they do, they are on any ordinary use of language bodily injuries."

72. It was common ground before us that the fact that a condition emanated from the brain was not determinative as to whether a condition was "physical" or "mental" for the purposes of regulation 12. Mr Maurici accepted, as must be correct, that where a person suffers physical trauma to the brain any resultant difficulty in walking would be a consequence of his "physical condition as a whole" for this purpose. A similar example would be that of brain damage at birth which causes behavioural problems which in turn cause difficulties in walking (as in R(M) 3/86).

73. If that be so, where can any line rationally be drawn? Would the same apply in the case of arrested or incomplete development of the brain resulting from something other than physical trauma? CDLA/1721/2004 concerned a claimant with general learning disability, but in the context of care component and lower rate mobility component, neither of which required a distinction to be made between physical and mental disablement. The evidence on behalf of the Secretary of State was that general learning disability was due to an arrested or incomplete development of the *mind*, but that it is usually accepted by decision makers as a *physical* disablement: by contrast, specific learning difficulties are treated as mental disablement (see paragraph 23 of that decision).

74. In R(M) 2/78 (see paragraphs 28 to 32 above), it was held by the Chief Commissioner that the medical appeal tribunal had not erred in law in finding that Down's syndrome was a physical disorder because it was due to faulty genetic inheritance. We were told by Mr Maurici on instructions that the Secretary of State regards Down's syndrome as a *physical* disorder. In CSDLA/894/2001, Mrs Commissioner Parker held that limitations on walking ability resulting from autism are to be regarded as due to physical disablement because autism is due to a chromosomal abnormality. These cases took the analysis right back to the level of genes and chromosomes. Once the level of genes, chromosomes and chemical changes affecting the brain is reached, it may well be that, if the relevant criterion is cause rather than manifestation, any mental illness could be categorised as a feature of the claimant's physical condition as a whole.

75. The difficulty in distinguishing between the physical and the mental was a major reason for the effective abandonment of the distinction between physical and psychiatric injury in the context of tortious liability. As long ago as 1943, Lord Macmillan said in *Bourhill v Young* [1943] AC 92 at page 103:

> "The crude view that the law should take cognisance only of physical injury resulting from actual impact has been discarded, and it is now well recognised that an action will lie for injury by shock sustained through the medium of the eye or ear without direct contact. The distinction between mental shock and bodily injury was never a scientific one, for mental shock is presumably in all cases the result of, or at least accompanied by, some physical disturbance in the sufferer's system. And a mental shock may have consequences more serious than those resulting from physical impact."

More recently, in *Page v Smith* [1996] 1 AC 155 at page 188, again in the context of liability for negligence, Lord Lloyd said:

> "In an age when medical knowledge is expanding fast, and psychiatric knowledge with it, it would not be sensible to commit the law to a distinction between physical and psychiatric injury, which may already seem somewhat artificial, and may soon be altogether outmoded. Nothing will be gained by treating them as different "kinds" of personal injury, so as to require the application of different tests in law."

76. It is not for us to attempt to resolve all these issues. For the present purpose, the important point is that there appears to be no logical or consistent stopping place, short of Mr Commissioner Monroe's "last analysis", in following back mental or psychological factors to an ultimate physical cause

77. However, it is right that we point out that, in the benefits field, as recently as 1995, Parliament made use of the distinction between physical and mental in the context of the all work test (now called the personal capability assessment) for determining incapacity for work for the purposes of social security benefits (principally incapacity benefit and income support). Under that test, a claimant is only able to obtain points for difficulty in performing physical activities (such as, for example, walking) if his incapacity "arises... from a specific bodily disease or disablement", and can only obtain points under the mental health descriptors if his incapacity "arises... from some specific mental illness or disablement" (regulation 25 of the Social Security (Incapacity for Work) (General) Regulations 1995 (SI 1995 No 311)). However, it is perhaps noteworthy that the references are not simply to "disablement", but to "bodily disease" and "mental illness" as well.

78. If the inability or virtual inability to walk must have a physical cause, a further fundamental difficulty in adjudicating on claims is that of determining the cause of the claimant's walking problems as a matter of fact. This difficulty can become particularly acute where, as is often the case, a claimant has some conventional physical disorder (e.g. a disc problem), but owing to psychological problems (or "psychogenic overlay") experiences physical symptoms to a substantially greater extent than would otherwise have been the case. The appeal tribunal in Mr B's case before us found that that might well be so in his case. Below we consider further the difficult issues of causation which potentially arise where there are concurrent physical and mental causes below (see paragraphs 102 to 121).

79. It may be an inevitable consequence of the system of social security adjudication that different decisions are made about claimants in identical circumstances, because of the necessary areas of judgment given to decision makers and appeal tribunals in the evaluation of evidence as to the effects of a claimant's disablement and in the application of loosely defined conditions of entitlement (see the speech of Lord Hoffmann in *Moyna* at paragraph 20, and paragraph 67 above). But it is quite another matter to contemplate differences in result between claimants in identical circumstances depending on differing views taken by different decision makers and appeal tribunals on matters of general medical and scientific theory and on issues bordering on the philosophical.

80. Further, there are potential practical and ethical problems in requiring a claimant to undergo medical investigations - which may be intrusive - purely for the purpose of obtaining evidence to satisfy the conditions of entitlement to benefit.

81. There is therefore a substantial issue as to whether Parliament could have intended that the satisfaction of conditions of entitlement to benefit should depend on the results of sophisticated and possibly intrusive medical investigations, and on the chance of whether such investigations have been carried out for any particular claimant.

G. Conclusions

82. As we indicated in paragraph 49 above, we consider the governing wording to be that of regulation 12(1)(a), i.e. that "a person is to be taken to satisfy the conditions mentioned in [section 73(1)(a)] only in the following circumstances (a) his physical condition as a whole is such that... he is unable to walk... [etc]". However, the phrase "physical condition as a whole" is to be construed against the background that regulation 12(1)(a) specifies when a claimant will be considered to be suffering from "physical disablement" such that he is unable or virtually unable to walk.

83. We acknowledge that, looking simply at the natural meaning of regulation 12(1)(a) as one of impression, it is arguable that physical manifestations of a mental condition are not part of a person's "physical condition as a whole" (and do not constitute "physical disablement"). That, indeed, seems to have been what led the Court of Appeal in *Harrison* to reach the conclusion that, although the claimant's hysteria rendered him physically incapable of walking more than a few steps, he did not qualify for mobility allowance.

84. However, in the absence of *Harrison*, in the light of A to F above we would have considered the intention and effect of regulation 12(1)(a) to be that the inability or virtual inability to walk must be the result of an impairment of the claimant's physical functional capacity and that it is not necessary for the claimant to show that the impairment has an identifiable physical cause. Given that the phrase "so severely disabled physically or mentally" in sections 72 and 73(1)(d) focuses on the claimant's functional capacity and not the precise medical cause of that incapacity, we would have been reluctant to conclude that a different approach is adopted in the references to "physical condition as a whole" and "physical disablement" in regulation 12 and section 73(1)(a) respectively (see Section E above). The factors discussed in Sections B and F above also favour that conclusion, with those in A and C being in our view broadly neutral, although if anything pointing the same way (see paragraphs 38 and 52 above).

85. Thus, in the absence of *Harrison*, where a claimant suffers from physical symptoms or manifestations of a medical condition (whether that condition be physical or mental), we would have held that it is unnecessary for him to show an identifiable physical cause for those symptoms or manifestations to satisfy the conditions for entitlement to higher rate mobility component of DLA under section 72(1)(a) of the 1992 Act and regulation 12 of the 1991 Regulations.

Is *Harrison* Determinative?

86. However, Mr Maurici submitted that, whatever our own view of the construction of the relevant statutory provisions might be, we were bound by the Court of Appeal decision in *Harrison*. It was pointed out to us that the decision of the Court appears to have been *ex tempore*, but that is of no moment. If the case adjudicated upon the issue before us, we are of course bound by it.

87. None of the accounts of the claimant's disability is detailed, but O'Connor LJ summarised it as follows:

> "The appellant had an accident in 1979 when he fell off a crane and sustained a severe injury to his back. As a result of that, after a year or so he had to have a laminectomy on lumbar 4/5, but he was left thereafter with a disability, namely that he had a "bizarre gait", as it was described in the medical reports, and he was in a wheelchair. He could move a few yards with the help of two sticks."

88. The claimant was initially awarded mobility allowance until 1983, but his renewal claim was refused by a medical board, whose decision was upheld on appeal by a medical appeal tribunal. The appeal tribunal found, crucially, "that the restriction in the claimant's ability to walk is not due to a physical cause but is hysterical in origin."

89. Mr Commissioner Monroe dismissed the claimant's appeal. On the ground relevant for us, it was submitted for the claimant that even if his condition was hysterically based it was still a manifestation of his physical condition as a whole. As to that, the Commissioner said (at paragraph 6):

> "It may be that in the last analysis all mental disablement can be ascribed to physical causes. But, if so, it is obvious that the Act in drawing the distinction between physical and mental disablement did not mean this analysis to be resorted to. In the case of the subject of Decision R(M) 2/78 a medical appeal tribunal were concerned with a claimant who suffered from Down's Syndrome, sometimes called mongolism. The effect of the condition on that particular claimant was that he often refused to walk. The medical appeal tribunal decided that the nature of Down's syndrome was such that it was a form of physical disablement and held that the claimant satisfied the medical conditions for an award of mobility allowance. The Secretary of State appealed but the Commissioner held that it was for the medical appeal tribunal to determine what was a physical, and what was not a physical, cause of inability to walk and that their decision could not be disturbed. A converse case where a medical appeal tribunal decided that agoraphobia was not a physical condition occurred in Decision R(M) 1/80 and again it was held that the medical appeal tribunal decision could not be disturbed. I do not see how I can reach a different conclusion in relation to hysteria. This does not mean that in every case of hysteria the medical authorities are bound to hold that a claimant's hysteria is not a manifestation of his physical condition as a whole; but it does mean that if they do so find it will be impossible to disturb their decision on the ground that they ought to have found it to be a manifestation of the claimant's physical condition."

90. The claimant's appeal against that decision was dismissed by the Court of Appeal. O'Connor LJ delivered the leading judgment (with which both Lloyd and Stocker LJJ agreed). He began by indicating that the short point raised by the claimant was "whether his inability to walk, about which there is no doubt, which is due to hysteria, falls within the provisions of the legislation. The Medical Appeal Tribunal, agreeing with the Medical Board, came to the conclusion that this man's inability to walk was due solely to hysteria and therefore did not fall within the provisions of the relevant statutory wording."

91. He then summarised the factual background (in the terms noted above), set out the statutory provisions and quoted extensively from the Commissioner's decision under appeal, concluding with the whole of the passage from paragraph 6 which we have set out above. O'Connor L.J. said: "For my part I agree with the approach which the learned Commissioner made to this problem. It seems to me that he directed himself on the facts of this case entirely correctly." Then, having said that nothing in the *Lees* case touched on the problem in this case, O'Connor L.J. continued:

> "Mr Herbert, who has put his argument very effectively, has submitted that here is a man who is in a wheelchair. If one asks oneself, "Is that a physical disability?" he says the answer would be, "Yes. He has got a disability that he cannot walk." "Is walking a physical activity?" "Yes, it is." "Is he unable to walk as a result of a physical disability?" He submits that the answer should be "Yes", no matter what the underlying reason of his inability to move his legs may be.

> In my judgment that is not the correct interpretation of the words of the statute. Section 37A, as I have already said, requires that the person should be suffering from "physical disablement" such that he is either unable or virtually unable to walk. The inability to walk is not itself the physical disablement. There must be some physical disablement such that he is unable to walk. In the present case on the evidence before them the Medical Board and the Medical Appeal Tribunal held that this man was not suffering any physical disablement: he was suffering from a functional disablement. That was a matter which was entirely for them, and neither the Commissioner nor this court can possibly interfere with the finding.
>
> That is sufficient to dispose of the appeal. It should be said that, subsequent to the decision of the Commissioner, the matter went before an adjudicator who granted the applicant mobility allowance for life from a date in 1985 because he had in front of him the report of the psychiatrist giving a physical cause to the hysteria and thus bringing the man within the statutory provisions. Thus the present appeal is really confined only to an attempt to achieve a payment during the period 1983 to 1985."

92. Stocker LJ, having cited the last sentence of paragraph 6 of Mr Commissioner Monroe's decision (set out in paragraph 89 above) said:

> "That sentence seems to me to encapsulate the position and constitutes a refinement of the findings of the Medical Tribunal. Hysteria is not itself a physical condition, since physical and hysterical conditions are often used as contrasting terms, and in my view correctly so. The Commissioner points out, however, that where hysteria is itself a consequence of a physical condition, it is open to a Tribunal or Medical Board, as a matter of medical opinion, to find that where hysteria is caused by a physical condition, (for example, due to pain due to some spinal condition), the inability to walk may itself be caused by that same physical condition. It may be, though we do not know, that it was on that basis, that is to say the basis of the psychiatrist's report, which was not before the Medical Board or the Medical Appeal Tribunal, to the effect that the hysteria was caused by pain caused by a physical spinal condition, that the adjudicator was persuaded to grant a mobility allowance for the future."

93. Mr Maurici submitted that that case is effectively on all fours with the appeals before us now. Mr Kolinsky submitted that *Harrison* does not determine the answer to the issue before us, for three reasons.

94. First, Mr Kolinsky submitted that it was not argued before the Court of Appeal that the claimant's hysteria in that case had physical manifestations which rendered him unable to walk, and therefore the Court of Appeal's decision cannot be regarded as deciding the point. This is the basis on which *Harrison* was distinguished in CDLA/948/2000 and CDLA/3323/2003, in passages on which Mr Kolinsky relies. In the former Mr Deputy Commissioner Mark said:

> "... [I]t does not appear from the report [of *Harrison*] that there was any physical factor which arose as a result of the hysteria which itself led to the limitations on the claimant's mobility. [*Harrison*], therefore, is authority only in a case where there is no physical cause for the mental state and no resulting physical factor which limits the claimant's mobility."

In CDLA/3323/2003 Mr Commissioner Rowland, having stated that the claimant's argument in *Harrison* had been that even if his condition was hysterically based it was still a manifestation of his physical condition as a whole, continued:

> "The Court of Appeal upheld the Commissioner's decision that that was a question of fact for the tribunal. Given the way the case was argued before the Court, their decision is unsurprising. What does not appear to have been argued is that the claimant's inability to walk more than a few yards, which he could manage with two sticks, was necessarily a reflection of his physical condition and that the question whether the underlying cause was hysteria or not was immaterial. It may be that the evidence that had been before the tribunal did not allow such an argument to be advanced and that there was, for instance, evidence of a more complicated psychiatric background."

95. However, we consider that this is to ignore the reality of what was in issue in the Court of Appeal in *Harrison*. The appeal tribunal found that the claimant was unable to walk more than two yards, with the aid of two sticks. Whilst it is true that the reports do not expressly indicate what precisely then stopped the claimant from walking further, the overwhelming implication is that he was complaining of physical symptoms such as pain which prevented him doing so. It was not a case where he simply would not walk owing to fear of the possible consequences, because it is clear from the findings that, with the aid of two sticks and with a bizarre gait, he was able to walk about two yards. In finding, as it did, that the claimant was unable to walk further, the appeal tribunal can only have been finding that he genuinely suffered physical symptoms, but that "the restriction in the claimant's ability to walk is not due to a physical cause but is hysterical in origin."

96. It is against that background that the summary by O'Connor LJ of the argument put by Mr Herbert on behalf of the claimant (set out in paragraph 91 above) must be viewed. The argument in substance appears clearly to have been that the physical symptoms which prevented the claimant walking were sufficient to qualify as physical disablement, regardless of the underlying cause. In stating, in the next paragraph of his judgment, that:

> "... the inability to walk is not itself the physical disablement. There must be some physical disablement such that he is unable to walk..."

O'Connor LJ was in our judgment expressly rejecting that argument and holding that it was necessary to look at whether the underlying cause of the physical symptoms was mental or physical. That is the whole tenor of the Court of Appeal judgments. We therefore reject Mr Kolinsky's first submission.

97. Second, Mr Kolinsky submitted that in any event O'Connor LJ (and therefore also Lloyd LJ, who agreed) did not base his decision on the proposition that it is necessary that the underlying cause of the claimant's inability to walk be a physical disorder of some kind. In his submission that appears from the fact that O'Connor LJ expressly approved the approach taken by Mr Commissioner Monroe, which was simply that, the medical appeal tribunal having found as a fact that the claimant's hysteria was not a manifestation of his physical condition as a whole, the Commissioner could not disturb their decision. He relies particularly on Mr Commissioner Monroe's statement that "this does not mean that in every case of hysteria the medical authorities are bound to hold that a claimant's hysteria is not a manifestation of his physical condition as a whole; but it does mean that if they do so find it will be impossible to disturb their decision on the ground that they ought to have found it to

be a manifestation of the claimant's physical condition." Mr Kolinsky submits that that approach, expressly approved by O'Connor LJ, leaves it open for the fact finder to find that, although the disabling condition may be mental in origin, its physical manifestations mean that the claimant's physical condition as a whole is such that he is unable or virtually unable to walk. He submits that it was only Stocker LJ who focused on a need to find some physical underlying cause for the claimant's difficulty in walking; but, in doing so, Stocker LJ misunderstood what Mr Commissioner Monroe was saying, and indeed understood it in a different sense from that in which O'Connor LJ had done. The crucial sentence in Stocker LJ's judgment, for the purpose of this part of Mr Kolinsky's submission, is the following:

> "The Commissioner points out, however, that where hysteria is itself a consequence of a physical condition, it is open to a Tribunal or Medical Board, as a matter of medical opinion, to find that where hysteria is caused by a physical condition, (for example due to pain due to some spinal condition), the inability to walk may itself be caused by that same physical condition."

Mr Kolinsky submits that Mr Commissioner Monroe was not contemplating the possibility of the fact finder identifying a physical cause for the hysteria, but rather the possibility that the hysteria has physical manifestations such that the claimant's physical condition as a whole is such that he is unable or virtually unable to walk.

98. We must reject this submission also. In our judgment it is clear that the basis of the reasoning of O'Connor LJ (and therefore also Lloyd LJ), as well as of Stocker LJ, was that it was necessary to look at the underlying cause of the claimant's walking difficulty, and that for this purpose the physical symptoms are to be equated with the walking difficulty, so that what one is looking for is the cause of those symptoms. We do not agree with Mr Kolinsky's submission that, in approving the approach taken by Mr Commissioner Monroe, O'Connor LJ indicated otherwise. In our judgment, whatever Mr Commissioner Monroe may in fact have meant when he stated that the medical authorities would not necessarily be bound to hold that a claimant's hysteria is not a manifestation of his physical condition as a whole, O'Connor LJ probably read it as meaning (as Stocker LJ expressly said that he read it as meaning) that if the hysteria was itself caused by a physical condition, that might be sufficient. That O'Connor LJ in fact read it in that way seems to be confirmed by the last paragraph of his judgment.

99. Third, Mr Kolinsky submits that the Court of Appeal focused on the wording of what is now section 73(1)(a), and that its decision is therefore not authority on the meaning of regulation 12(1)(a) which is in fact the governing provision.

100. It is true that O'Connor LJ, in the crucial penultimate paragraph of his judgment, appears to have regarded the words which required to be construed as being those of what is now section 73(1)(a), rather than those of what is now regulation 12(1)(a). But that can only have been because he did not consider that there was, for the purpose of the case before the Court of Appeal, any real difference of substance between the expressions "suffering from physical disablement such that" and "his physical condition as a whole is such that". He had cited both provisions earlier in his judgment, and had approved the approach of the Commissioner, who at the end of his decision did regard the crucial question as being whether the hysteria was a manifestation of the claimant's "physical condition as a whole". This submission of Mr Kolinsky could only stand up if it warranted the conclusion that *Harrison* was decided *per incuriam*. For the reasons which we have just given, that is clearly not so.

101. We do not regard *Harrison* as without difficulties. However, for the reasons given above, in our judgment *Harrison* is authority binding on us that, contrary to the construction which we would have adopted if we had been free to do so, where a claimant suffers from physical symptoms or manifestations of a medical condition (whether that condition be physical or mental), it is necessary for him to show an identifiable physical cause for those symptoms or manifestations to satisfy the conditions for entitlement to higher rate mobility component of DLA under section 72(1)(a) of the 1992 Act and regulation 12 of the 1991 Regulations.

The Proper Approach to Causation

102. Our conclusion as to the effect of *Harrison* means that guidance is necessary, for the benefit of the new tribunal in Mr B's case and to decision makers and appeal tribunals generally, in relation to issues concerning the proper approach to causation, and in particular issues which arise where a claimant's inability or virtual inability to walk has both physical and mental causes. For example, commonly a claimant has some physical disorder (e.g. a disc problem), but owing to psychological problems (or "psychogenic overlay") experiences physical symptoms to a substantially greater extent than would have been expected as a result of the physical disorder alone.

103. A number of potential issues arise.

(i) If the psychological condition is itself a direct result of a continuing physical condition, it would seem logical that the claimant's virtual ability to walk should be found to be a consequence of his physical condition as a whole. However, is that also the case where the original physical cause of the psychological condition has resolved, but the psychological condition endures?

(ii) What if the psychological disorder arose independently (i.e. was not caused by the physical condition)? Is it then necessary, in determining whether the claimant's inability or virtual inability to walk has a physical cause, to attempt to strip out that part of the walking difficulty which results from the psychological disorder, and if so how?

(iii) Perhaps even more problematically, what is the position where the psychological condition was partly a result of the physical condition and partly of independent origin (often the case when a psychologically fragile person suffers from a physical condition)?

104. These issues raise the more general question of what test should be applied in determining whether the inability or virtual inability to walk has a physical cause. Neither section 73 of the 1992 Act nor regulation 12(1)(a) of the 1991 Regulations supplies any obvious guidance, and neither is *Harrison* of any assistance.

105. Before us, there was considerable debate about the application of the traditional "but for" test for factual causation. Such a test would mean that, in order to succeed, it is necessary and sufficient for the claimant to show that he has (or possibly once had) a physical disorder but for which he would not have been unable or virtually unable to walk. Fairness and common sense would suggest that such a test may need to be modified in at least the (admittedly unusual) situation where the claimant has a physical and a mental disorder, each

of which on its own would have caused him to be virtually unable to walk. A claim for the higher rate of the mobility component should not fail merely because he would in any event have been virtually unable to walk by reason of his psychological condition. More importantly, however, the test would involve the difficulty of attempting to determine whether the claimant would have been virtually unable to walk had he not had the physical disorder.

106. In the light of the wording "his physical condition as a whole is such that..." in regulation 12(1)(a), an alternative approach would be to ask whether, if the claimant was suffering from only the physical condition and any psychological consequences of it, he would still be virtually unable to walk. A further alternative would be to ask, adopting a broad-brush approach, whether the claimant's virtual inability to walk is predominantly the result of his physical or his mental condition, and to award higher rate mobility only if it was predominantly the result of his physical condition.

107. However, like the "but for" test, these further possibilities would involve attempting to undertake an analysis of the relative causative potency of physical and mental conditions which might well be interacting with each other. In many cases, evidence relevant to this analysis would not be available. Often, the claimant's condition will not have been investigated in the necessary detail. In a significant number of cases, such evidence would simply be impossible to obtain, given the current state of medical knowledge.

108. On this aspect of the appeals, before us there was evidence from Dr Pamela Ford of the Department for Work and Pensions Corporate Medical Group, which we found of considerable assistance. She said:

> "3. The fact that a symptom such as dizziness cannot be directly linked to a physical diagnosis or disorder does not mean that the symptom is not physical, or that it is therefore, almost by definition, a symptom of a mental disorder. In addition it does not mean that the symptom is necessarily imaginary or fictitious. Many commonly described symptoms do indicate the presence of a physical disorder. But it is also true that some people with mental health disorders may describe bodily or somatic symptoms that mirror those of purely physical conditions.
>
> 4. Physical and psychological symptoms may co-exist in those with clearly diagnosed mental health disorders. The fact that the physical symptom lacks a firm diagnosis does not mean that it is necessarily a symptom of the mental disorder. For example a complaint of back pain in a person with schizophrenia is most likely to be due to a physical condition of the lower back rather than a symptom of the schizophrenia. A less well defined symptom like dizziness may still be due to a physical cause rather than the schizophrenia, but could be a manifestation of the mental health condition.
>
> 5. People with clearly defined physical problems e.g. lumbar disc prolapse, often suffer from psychological symptoms such as low mood and anxiety. The symptom of low mood may be attributed to the pain arising from the physical disorder or may arise from a separate mental health condition. Even if the latter were not formally diagnosed, it does not mean that it is not a genuine psychological symptom.
>
> 6. Assessing medically unexplained symptoms in respect of making a clinical diagnosis is often problematic for the clinician. Both physical and psychological

causes have to be considered and some symptoms may be attributed to one aetiology and some to the other. Even if the symptoms and resultant functional restrictions seem out of proportion to the proposed disorder it does not necessarily mean that the cause is always psychological and never physical.

7. Evaluating the disability that arises from medically unexplained symptoms in an individual case may be even more difficult. It is likely in such cases that physical examination will be normal and that special investigations such as scans, blood tests etc. are normal. The fact that no definite pathological basis for the symptom has been identified to date does not mean that one does not exist, or that the symptom has no physical basis whatsoever.

8. In many cases where there is a clear physical cause for disabling symptoms psychological factors may come into play. Indeed such factors may be the main reason for much of the disability observed. ...."

109. On the basis of this evidence, Mr Maurici submitted in his skeleton argument:

"Where a claimant's inability or virtual inability to walk is caused by a combination of physical and mental factors the bottom line is that in many cases it is not possible in terms of medical analysis to separate the factors out in order to determine which is the effective cause of the inability or virtual inability to walk."

110. We are satisfied that the analytical exercise required by the three tests of causation we have referred to (including the "but for test") would in most cases be unrealistic in that the decision maker or tribunal would not have evidence which would be necessary to enable the analysis sensibly to be carried out. Mr Kolinsky and Mr Maurici each submitted, in our judgment with compelling force, that Parliament could not have intended a test for causation which would often be incapable of practical application.

111. They each submitted that the following test would be both consistent with the statutory language and as workable as reasonably possible: the claimant's physical condition must be a material cause of his inability or virtual inability to walk, and it will be a material cause if it contributes to his inability or virtual inability to walk to any appreciable extent - i.e. to any extent which is more than *de minimis*.

112. Mr Maurici sought to support this submission by reference to authorities taken from the law of tort in which the "but for" test for causation was departed from, and in particular the decision of the House of Lords in *Bonnington Castings Ltd v Wardlaw* [1956] AC 613. In that case the plaintiff contracted pneumoconiosis from inhaling air at his workplace that contained silica dust. The main source of the dust was from pneumatic hammers in respect of which the employers were not in breach of duty. Some of the dust came from swing grinders for which they were responsible by failing to maintain their dust-extraction equipment. Lord Reid noted at page 621 that:

"[T]he medical evidence was that pneumoconiosis is caused by a gradual accumulation in the lungs of minute particles of silica inhaled over a period of years. That means, I think, that the disease is caused by the whole of the noxious material inhaled and, if that material comes from two sources, it cannot be wholly attributed to material from one source or the other."

On that basis Lord Reid considered that:

> "... the real question is whether the dust from the swing grinders materially contributed to the disease. What is a material contribution must be a question of degree. A contribution which comes within the exception *de minimis non curat lex* is not material, but I think that any contribution which does not fall within that exception must be material. I do not see how there can be something too large to come within the *de minimis* principle but yet too small to be material."

Viscount Simonds and Lord Somervell agreed with Lord Reid, and Lords Tucker and Keith delivered speeches to the same effect.

113. *Fairchild v Glenhaven Funeral Services Ltd* [2001] EWCA Civ 1881, [2002] 1 WLR 1052 is another example from the field of tort of the "but for test" being abandoned in favour of some other test in circumstances in which it would have been evidentially impossible to satisfy the "but for test" of causation, given the current state of scientific knowledge.

114. We doubt whether authorities from the law of tort, concerned with the issue whether a disease had been caused by the defendant's breach of duty, are sufficiently analogous to be of much assistance to us. However, these authorities do illustrate the willingness of the courts, even at common law, to look beyond the traditional test in that field where there are particular evidential difficulties in proving that test.

115. The "material cause" test was advocated by both parties before us. Counsel on behalf of the Secretary of State, on instructions after careful consideration had been given to the implications, proposed a test which appears to be as favourable to claimants as is consistent with the statutory language, and which appears to minimise the difficulties of adjudication which other (less favourable) tests would involve. In these circumstances, we consider we should be slow to reject it. We are persuaded that the test advocated by Mr Kolinsky and Mr Maurici is the correct one.

116. In our judgment, therefore, even if a decision maker or appeal tribunal considers that mental or psychological problems are the substantial cause of a claimant's walking difficulties, it should award the higher rate of the mobility component if it finds that a physical disorder contributes to the claimant's inability or virtual inability to walk to more than a minimal extent.

117. That still leaves the issue whether the claimant must currently be suffering from a physical condition which is at the date of the decision a material cause of his inability or virtual inability to walk; or whether it is sufficient that he formerly suffered from a physical condition which has abated but which itself gave rise to a psychological condition which, at the date of the decision, is the only remaining operative cause of the walking difficulty. Mr Maurici submitted that it is not enough that the claimant once suffered from such a physical condition, whereas Mr Kolinsky submitted that it is.

118. We do not consider *Harrison* to be of any assistance on this issue. In that case, the claimant's hysteria may have been due to the original injury to his back, sustained when he fell off a crane. However, the medical appeal tribunal found simply that the restriction in the claimant's ability to walk was not due to a physical cause but was hysterical in origin. It

appears to have made no finding one way or the other as to whether the hysteria had originally been caused by the accident. In the penultimate paragraph of his judgment (at page 211G) O'Connor L.J. noted that after the decision of Mr Commissioner Monroe an adjudication officer had awarded mobility allowance on the basis of a report from a psychiatrist giving a physical cause to the hysteria "and thus bringing the man within the statutory provisions". (See also paragraph 4 of Mr Commissioner Monroe's decision, referring to a report (not before the medical appeal tribunal, but which may well have been the same report as that on the basis of which mobility allowance was subsequently awarded) stating that the claimant's inability to walk was not the result of hysteria, but of pain). It would seem that the report referred to might well have been asserting a *continuing* physical cause for the hysteria. Even if the penultimate paragraph of O'Connor LJ's judgment can be regarded as approval of the basis of the adjudication officer's subsequent decision, *Harrison* itself is of no assistance on this issue

119. The majority of this Tribunal (the Chief Commissioner and Mr Commissioner Turnbull) agree with Mr Maurici's submission that, in order to prove that a functional inability is caused by a physical condition, that physical condition must be extant at the relevant time. On the footing that a physical cause is necessary - as we consider ourselves bound by *Harrison* to hold - in the view of the majority, the words of section 73(1)(a) ("... he *is* suffering from physical disablement such that") and regulation 12(1)(a) ("his physical condition as a whole *is* such that...") do not include the situation where at the date of the decision the walking difficulty is entirely due to psychological problems, even if those arose from a physical problem which has abated. The minority (Mr Commissioner Mesher) would have accepted Mr Kolinsky's submission that, in such circumstances, if the original physical disorder is accepted as having made a material contribution to the causation of the claimant's inability or virtual inability to walk (for example, through a contribution to psychological problems), that causative effect continues to exist so as to satisfy the terms of the legislation and the use of the present tense if those psychological problems continue to be a cause of inability or virtual inability to walk, even though the physical disorder itself no longer exists. It is of course the opinion of the majority that is to be followed.

120. For the avoidance of doubt, we should say that our conclusion as to the effect of *Harrison* does not mean that a claimant cannot be entitled to the higher rate of the mobility component if the origin of his walking difficulties was mental. If, for example, a claimant has, as a result of severe depression, been so inactive that his muscles have atrophied, with the result that he is virtually unable to walk, he clearly satisfies the condition of entitlement. The atrophied muscles are clearly a feature of his physical condition. We therefore agree with the general proposition formulated by Mrs Commissioner Parker in paragraph 60 of CSDLA/265/1997 that, provided a physical disorder materially contributes to the claimant's inability or virtual inability to walk, it does not matter where in the chain of causation it comes.

121. Finally, as to the proper classification of conditions such as autism, Down's syndrome and learning disabilities, and as to the extent to which mental disorders could be regarded as having a physical cause owing to genetic defects or changes in brain chemistry, those issues do not arise on the facts of the cases before us and were not the subject of any detailed submissions. For the avoidance of doubt, we should make it clear that we expressly refrain from expressing an opinion on these issues.

Summary

122. At the end of this decision we summarise our views on the legal issues of wider importance which have been raised in these appeals.

The Individual Cases

123. Having dealt with the issues of principle, we now turn to the two individual appeals before us.

CDLA/2879/2004 (Mr B's case)

124. The claimant is a man now aged 46. He suffers from lower back pain, pain in his left shoulder, anxiety and depression.

125. On 11 December 2000 he was awarded the higher rate of the mobility component and the highest rate of the care component of DLA for the period from 22 February 2001 to 21 February 2004. It appears that that was itself an award made on a renewal claim. None of the evidence on the basis of which that award was made is in the papers, but according to the decision of 11 December 2000 that evidence included a report from an Examining Medical Practitioner ("EMP").

126. In March 2002 the claimant was requested on behalf of the Secretary of State to answer some questions and to complete a further claim pack, with a view to possible supersession of his award. This seems to have been prompted by a belief that he had been claiming invalid care allowance (which the claimant stated in his answers that he had not in fact been claiming).

127. The claim pack was duly completed, and the Department also obtained a report dated 26 April 2002 from Dr Royle, a clinical psychologist to whom the claimant had been referred. There is no evidence in the papers of any decision having been taken as a result of this information, and the inference must be that it was decided not to supersede the claimant's award.

128. In the claim pack the claimant stated his illnesses and disabilities as being "severe and constant aches and pains. Arthritic pain in back and shoulders - elbow joints." He further stated that "because of my high dependency on others to support me every day I feel very depressed and lonely". As regards walking outdoors, the claimant said that owing to his pain he used walking sticks, and could walk only 8 to 10 yards before feeling severe discomfort, and that that would take 5 to 10 minutes.

129. Dr Royle gave her diagnosis of the claimant's psychiatric conditions as:

> "... clinical depression secondary to adjustment to physical pain and its consequences. Social phobia linked to above. Self-harm and parasuicidal behaviour."

She continued:

> "[The claimant] has struggled with his physical and psychological well-being since May 1995. He has struggled with (?) intractable chronic pain in his lower back which

radiates into his right leg and in his left shoulder and arm. He has secondary physical symptoms associated with his pain, including a swelling of his hands and fingers and a tremor which is exacerbated by his emotional state.

Physically, [the claimant] is significantly limited by his pain and subsequent poor mobility. Activities tend to worsen his pain and he is unsteady with balance problems, which has led to many falls. A recent fall resulted in him falling into a door and injuring his head. Falls can be a consequence of dizziness, physical balance or pain.

Psychologically and emotionally [the claimant] is struggling. He is very withdrawn with clinical depression and suicidal ideation. He has episodes of self-harm with a preoccupation with negative images of himself and death. He becomes angry, frustrated and irritated with a low tolerance of noise or any interruption to his solitude."

130. On 24 September 2003 the claimant signed a renewal claim pack. This was in very similar terms to that which had been completed in 2002. The Department obtained a report dated 13 October 2003 from his general practitioner ("GP") (to which we refer further below).

131. The Department also obtained a report from an EMP, dated 5 November 2003. The EMP commented as follows in the section relating to examination of the limbs:

"Examination had to be limited as he said that any movement was painful. He declined to rise from the bed to stand or walk. Expressed discomfort leaning forward while I examined his chest. No sign of arthritis in any joints. No muscle wasting or spasm."

132. The EMP marked the claimant as having full function of all limbs, save slight impairment of the left shoulder, and further commented as follows:

"Expressed pain on movement of left shoulder and did not raise arm past 30 degrees. Very little movement seen at legs, but no fluid on knees. I note hard callus on soles of both feet."

133. He expressed the opinion that the claimant would be able to walk only 10 metres before the onset of severe discomfort, at a very slow pace, in about 30 seconds. In relation to gait and balance the EMP said, "Not seen"; and he said that the claimant would need an arm to lean on. He considered that the claimant would need help with a substantial number of the activities involved in daily living.

134. In the section of the report headed "overall factors" the EMP wrote:

"This sort of presentation is common in DLA, but strangely I rarely see it in my practice. Appeared ill at ease, both nervous, and in pain. Breathing shallow and jerky. Unfortunately examination was more limited than I would like, but we have to be careful not to hurt people. I suspect the statement is overstated, there are no hard physical signs supporting his claims, and neither can I fit him into a diagnostic category. I am not even sure where his pain is coming from. However, it does affect him. I certainly can't disprove function affected."

135. On 18 November 2003 a decision was made on the renewal claim, awarding the higher rate of the mobility component and the middle rate of the care component, in each case from 22 February 2004 to 21 February 2006.

136. The claimant appealed, contending that he should have been re-awarded the highest rate of the care component. The decision maker sought advice from the Department's Medical Services as to the "reasonable level of night care or watching over requirements of this customer most of the time." A Medical Adviser advised as follows:

> "Substantial independence would be expected.
>
> - "no muscle wasting"
>
> - GP comments - "informs me he stays in bed".
>
> Rest is inadvisable in back pain.
>
> EMP opinions are poorly connected with objective findings and independence with all functions listed would be expected day and night.
>
> Intermittent counselling would be the most appropriate means of dealing with his mood disorder, rather than long term intensive supervision. No physical reason for severe and chronic walking problems is evident."

137. As a result of that advice, on 29 December 2003 a decision was made, by way of revision of the decision of 18 November 2003, that the claimant was not from 22 February 2004 entitled to any rate of either component of DLA. The claimant's appeal therefore continued as an appeal against the decision of 18 November 2003, as revised by that of 29 December 2003.

138. In support of the appeal the claimant's representative obtained a further report, dated 15 April 2004, from his GP, who stated his diagnosis as "chronic lower back and shoulder pain. Anxiety with depression secondary to chronic pain." In the earlier report the GP had said that the back pain had started in 1990, the shoulder pain in 1994 and the anxiety and depression in 1999. He stated that there had been an orthopaedic referral in 1995, an "MUA" under general anaesthetic in 1996, a pain clinic referral in 1997, a physiotherapy referral in 1999, referral to a rheumatologist in 2000 and referral to a psychologist in 2001. (In oral evidence to the tribunal the claimant added that there had been an orthopaedic referral in 1989).

139. The GP stated, as regards mobility, that the claimant was in discomfort at rest, walked very slowly and in pain and that he did not leave the house when bad. He stated the cause of these difficulties as "musculoskeletal pain". In the earlier report the GP had said that "back pain and shoulder pain can result in severe incapacity when he is bed bound. Anxiety and depression is also severe - requires medication and counselling. Most if not all days are bad - my opinion is based on my observations when he attends to see me. More information from [the claimant] himself will confirm."

140. The appeal tribunal, by the decision now under appeal to us made on 27 May 2004, allowed the appeal, but to the extent only of awarding the middle rate of the care component in respect of the period from 22 February 2004 to 21 February 2009 on the ground of a need

for frequent attention throughout the day. It considered that the tremor in the claimant's hands meant that the claimant reasonably required assistance with dressing and undressing and with feeding, when using the toilet and when taking a bath or shower, and with medication.

141. The tribunal's reasons in relation to higher rate mobility component were as follows.

> "With regard to the higher rate of the mobility component, however, the Appellant must establish physical disablement leading to any problems with walking. In this case the Appellant himself has confirmed that no diagnosis of his joint pains has ever been made. He has had extensive investigation at several hospitals and numerous tests. He has also had a considerable amount of treatment. Nevertheless, although he tells us that he was told he had Arthritis, he also told us today that he was advised by one of his consultants that he had slight inflammation in his lower back which would go away. Certainly, the findings on examination by the Benefits Agency doctor who examined him in connection with the current claim do not indicate a significant physical problem. The doctor's report is difficult to interpret. He makes the point that examination of [the claimant] was very difficult because he was complaining of pain. Nevertheless he did note that there was no muscle wasting and there was no sign of any Arthritis in the joints. Indeed the doctor marked him with full function of all parts of the body apart from his left shoulder where there appeared to be little movement. In spite of this the doctor accepted that the Appellant could not walk more than 10 metres before the onset of severe discomfort. The Tribunal accept the opinion of the Medical Adviser who looked at all the evidence and stated on 22 December 2003 that there is no physical reason for severe chronic walking problems. We agree with that view. It may well be that the Appellant does not do any useful walking. He tells us that he walks across to the local park and that is as far as he goes. We must consider how far he could reasonably be expected to walk. His psychological problems are obviously considerable as outlined by the Psychiatrist whose report we have mentioned above. It may well be that his psychological problems do contribute considerably to his walking difficulties. However, looking at the physical reasons for any inability to walk we consider that these are not such as to render him virtually unable to walk out of doors taking account of time, distance, speed and manner of walking before the onset of severe discomfort. His GP does not given an actual opinion about walking except to say that his mobility is restricted. The GP does mention antalgic gait. However, overall on taking account of his physical problems we do not consider that the Appellant satisfies the conditions for an award of the higher rate of the mobility component."

142. We have, by virtue of being bound by the authority of *Harrison,* rejected the central submission on behalf of the claimant that the tribunal erred in law in assuming that genuinely experienced physical pain was not physical disablement or a feature of the claimant's physical condition as a whole, unless it had an identifiable physical cause.

143. It is, however, submitted on behalf of both the claimant and the Secretary of State that, even on the footing that the claimant's central submission is rejected, the tribunal nevertheless erred in law. Those submissions were based substantially on passages in the initial written evidence, in this appeal, of Dr Pamela Ford of the Department for Work and Pensions' Corporate Medical Group. On an appeal to a Commissioner on a point of law, it is of course not generally appropriate to introduce medical evidence which was not before the appeal tribunal. However, the Secretary of State did so in order to provide medical evidence relevant

to the issue of law of general importance before us, and in the course of Dr Ford's evidence she commented on the individual cases in terms on which the claimants then relied.

144. The particular passages relied upon on behalf of Mr B were these:

> "37. I think that the evidence available does not permit us to be certain as to whether a specific cause for his (back) pain has been identified. There are no hospital reports and the GP report provides little extra detail. However it seems to be the case that the claimant has been investigated and treated for back pain at some time in the past. I accept the available clinical findings provided by the EMP. Ideally a fuller examination of the back recording neurological findings plus observations of him standing, walking, rising etc. would have been helpful. The claimant did not however choose to cooperate fully with the examination. The physical findings as recorded in this case are persuasive but not conclusive.
>
> 38. It seems likely that this claimant has a diagnosis of mechanical back pain. This is a condition in which the person describes pain in the lower back. Investigations such as X rays, scans or blood tests reveal no abnormality. Physical examination shows a full range of spinal movement in all directions without any muscle spasm or wasting. There is no impairment of the lower limbs i.e. no wasting, joint abnormalities or neurological deficit. From the medical point of view it would be accepted that the condition does have a physical cause. However on the basis of the normal clinical findings it is reasonable to expect the person to have good mobility. This would seem to be the situation in this claimant, and I think that the tribunal reaches the correct conclusion in not awarding higher rate mobility component. Some people with this diagnosis may have psychological or social factors as discussed above that do influence their need for help to a much greater extent. This does not negate the argument that there is an underlying physical disorder that could lead to physical disablement."

145. Of relevance here is also the following later evidence from Dr Ford specifically in response to a direction made by the Chief Commissioner inviting medical evidence on the question "as to whether it is possible, and if so how likely, that there is a physical (as opposed to mental or psychological) cause for a claimant's apparently physical symptoms in a case where, despite investigation by doctors, no such physical cause has been identified - recent Commissioners' decisions suggest that this may be most likely to occur in cases of lower back pain, generalised muscle weakness and fatigue, and dizziness":

> "1. Low back pain is conventionally regarded as a physical symptom. Although the pathology of the condition is not well understood, most medical authorities would agree that the pain does arise from anatomical structures in the back such as muscles, ligaments, joints or parts of the spine.
>
> 2. If demonstrable by physical examination generalised muscle weakness is likely to be regarded as a physical symptom. Descriptions of weakness and/or fatigue could be either physical or mental symptoms. For example such symptoms occur in many types of cancers and blood disorders such as anaemia, where the ability of the blood to carry oxygen is reduced. Their presence in a condition such as chronic fatigue syndrome, where the pathophysiology of the condition is poorly understood and no special tests or investigations exist to confirm the diagnosis, may also be accepted as a manifestation of a physical symptom.

3. Most medical authorities would agree that dizziness may be a physical symptom, even though its exact pathological cause is unclear in many medical conditions in which it occurs.

4. In conclusion, if a person presents with physical symptoms, but no diagnosis has been made, or no clear physical cause has been identified, the cause could be physical, or it could be mental. It should not be assumed, that because no physical cause has been identified, that the underlying cause is necessarily mental or psychological. Symptoms such as pain, weakness, fatigue and dizziness may be due to physical causes, but in those cases where no clear physical cause is found, a mental cause should be considered. If a mental health disorder has been identified it is reasonable to presume that the cause of the symptom is psychological. Each case needs to be considered on the basis of the medical evidence. In many medical conditions the presentation is of a combination of physical and mental symptoms, albeit with a predomination of one category of symptoms. Absence of a clearly identified physical cause does not rule out the possibility that the physical symptoms have an underlying physical aetiology."

146. The effect of the evidence of Dr Ford is that the fact that no physical cause for (in particular) back pain has been identified, even after extensive examination and tests, by no means rules out the possibility that the pain does have a physical cause. (This underscores the difficulties for decision makers and appeal tribunals in relation to causation referred to above: see paragraphs 102 to 112). It seems that "mechanical back pain", without anything more specific, can for that reason be a meaningful diagnosis implying an underlying physical cause. These are not of course matters on which we can sensibly give any general guidance. They are for decision by the appeal tribunal, on the balance of probabilities, on the evidence before it in each case. We therefore make clear that we are not setting out Dr Ford's evidence with a view to it being followed by appeal tribunals. In particular, we doubt the validity of any general proposition that, where a mental health disorder has been identified, it is reasonable to presume that the cause of physical symptoms for which no clear physical cause has been found is that mental health disorder. However, it may well be, in the light of the evidence of Dr Ford, that appeal tribunals have in the past often been too ready to assume that because no specific physical cause for lower back pain has been found, despite extensive investigations, therefore the pain does not have a physical cause. An appeal tribunal may therefore need to do more, in order satisfactorily to explain its reasons, than simply to state that because no precise physical cause for lower back pain has been identified, therefore there is none.

147. The appeal tribunal in Mr B's case seems to have admitted the possibility that there may have been something physically wrong with his back. The tribunal's reasoning seems to have been that, even if there was, that defect (whatever it was) could not (owing to the lack, despite extensive investigations, of an identified specific physical cause) have been sufficiently serious to result in pain *of the degree which the claimant experienced.* We refer again, in particular, to the following sentences in the tribunal's statement of reasons:

"It may well be that his psychological problems *do contribute considerably* to his walking problems. However, looking at the physical reasons for any inability to walk we consider that these are not such as to render him virtually unable to walk out of doors taking account of time, distance, speed and manner of walking before the onset of severe discomfort." (emphasis added).

148. We do not feel able to say that the tribunal erred in law in making that finding of fact. In our judgment it was entitled on the evidence to do so, and sufficiently explained its reasons for doing so.

149. However, the tribunal's reasoning assumes that where there is an underlying physical problem, any exacerbation of the pain by reason of psychological problems must be left out of account. For the reasons set out in paragraphs 102 to 112 above, we do not consider this to be the correct approach.

150. We therefore allow the claimant's appeal and set aside the tribunal's decision. We remit the matter for redetermination by a differently constituted appeal tribunal. The new tribunal will award the higher rate of the mobility component if it finds that the claimant is virtually unable to walk and if it finds that a physical disorder (i.e. mechanical back pain) is a material cause of that inability - i.e. contributes to that inability to more than a minimal extent.

CDLA/2899/2004 (Mrs H's case)

151. The claimant is a woman now aged 41. She has suffered from severe dizziness since about 1995.

152. The claimant was awarded the higher rate of the mobility component and the lowest rate of the care component of DLA from 30 August 1996 for life.

153. On 14 July 2003 the claimant applied for supersession in order to obtain a higher rate of the care component. By a decision made on 25 November 2003 that application was refused. On the claimant's appeal, the Birmingham Appeal Tribunal by its decision made on 7 June 2004 superseded the awarding decision and replaced it with a decision that the claimant was entitled to the lower rate of the mobility component from 7 June 2004 to 13 July 2005 and to the lowest rate of the care component (on the basis both of a need for attention in connection with bodily functions for a significant portion of the day and of the main meal test) from 14 July 2003 to 13 July 2005. The ground on which it removed the award of the higher rate of the mobility component was that there was no organic cause for the claimant's dizziness. The basis of the claimant's appeal to a Commissioner is that the tribunal erred in law in removing the higher rate of the mobility component.

154. At the oral hearing, additional grounds emerged in argument. In particular, it was observed that the appeal tribunal stated that the burden of showing, on the balance of probabilities, that she satisfied the conditions of entitlement to any particular rate of either component was on the claimant. It rested its conclusion in paragraph 18 of the statement of reasons on the conclusion that she had not discharged the burden of proof. It was submitted for the claimant that, when the appeal tribunal was exercising the power of superseding the existing decision adversely to the claimant, it had to be satisfied both that there was a ground of supersession supporting such an adverse decision and that the superseding decision should be adverse to her, so that the burden of proof was not on the claimant (see paragraph 10(4) of Tribunal of Commissioners' decision R(IB) 2/04). It was also submitted that the appeal tribunal had failed to show in its statement of reasons that it had consciously exercised its judicial discretion under section 12(8)(a) of the Social Security Act 1998 to consider issues not raised by the appeal (i.e. qualification for the higher rate of the mobility component and the lowest rate of the care component) and failed to give any reasons for the exercise of the discretion in that way (see paragraph 94 of R(IB) 2/04).

155. In the part of her supersession claim pack relating to walking out of doors, the claimant stated: "I cannot go outdoors alone because of my permanent dizziness. It is constant day and night and I need someone for support at all times." She did not answer the questions as to how far she could walk before feeling severe discomfort.

156. The evidence before the tribunal included the claimant's medical notes. These included a transcript of a letter to her GP (Dr Mitchell) dated 7 February 2002 from a Dr Lopes at the City Hospital Trust, which contained the following:

> "I gather that [the claimant] has seen a number of specialists ranging from ENT surgeons to neurologists, none of whom have been able to find an organic cause for her dizziness. She does have some clicking symptoms in her temporomandibular joint and the only link that there could be with her symptoms of dizziness may be that both these symptoms are stress related...."

157. The notes also included a transcript of a letter dated 8 May 2003 to her GP from Mr Dekker, a consultant ENT surgeon. That letter included the following:

> "... [T]his lady has a problem of intractable chronic vertigo which is felt to be due to an uncompensated peripheral vestibular disturbance. She was extensively investigated in 1996/7. She saw a neurologist, ENT surgeons, and cardiologists. She had had an MRI scan, echocardiogram, and caloric tests. She saw Professor Luxon at Queens National Hospital for nervous diseases.... She underwent vestibular rehabilitation therapy at Sandwell and City Hospital. She eventually declined further treatment as vestibular rehabilitation therapy was not helping and she did not wish to have any further investigations. It is likely that she has an uncompensated peripheral vestibular disorder with psychogenic overlay. The history is not classical of benign positional paroxysmal vertigo. Unfortunately she will not allow me to do a Dix Hallpike test as she feels this may exacerbate her vertigo. In fact she claims to have been dizzy for three years following her previous caloric test. I feel this lady's interest would be best served by having a further vestibular assessment and posturography at the Leicester Balance Centre and I will be referring her."

158. There was also a letter dated 13 October 2003 from Mr Dekker to the Department, in which he stated that when he saw the claimant in 1996 he felt that the claimant had "a longstanding uncompensated peripheral vestibular dysfunction" and that Professor Luxon had "confirmed this and felt that she should have vestibular rehabilitation. She however wanted to perform further investigations before making any decisions." The letter went on to state that the claimant refused to have further investigations "and therefore it was not possible to confirm a diagnosis or indeed institute treatment." Mr Dekker then went on to state that he did not see the claimant for 6 years, until April 2003, when he referred her for further full vestibular assessment and thereafter vestibular rehabilitation therapy, but that he had heard nothing since. The letter concluded by saying that "we are unable to make a diagnosis as [the claimant] refuses to undergo any further investigation and indeed treatment. Under the circumstances I expect the prognosis for this lady's recovery is extremely poor."

159. There was a report dated 12 November 2003 from the claimant's GP which described the diagnosis of the claimant's disabling condition as "uncompensated peripheral vestibular

disturbance." In a letter dated 15 January 2004 the GP said that the claimant had seen a number of specialists and that "no-one has been able to get to the bottom of her problems."

160. In paragraph 5 of its statement of reasons the tribunal, having stated that the medical evidence before it consisted of the report from the claimant's GP, the letter from the claimant's GP dated 15 January 2004, the letter from Mr Dekker dated 13 October 2003 and the medical notes, continued:

> "Dr Mitchell [the GP] last saw [the claimant] on 24 April 2003 and his report is dated 12 November 2003. He stated that she had suffered from severe giddiness for 5 years and that the diagnosis of the condition was "uncompensated peripheral vestibular disturbance", although at p.8 he stated that "it is likely that she has uncompensated peripheral vestibular disorder with psychogenic overlay." GP notes indicate that despite intensive investigations specialists had not been able to find an organic cause for her dizziness [and the tribunal then gave references to the letter dated 7 February 2002 from Dr Lopes and the letter dated 8 May 2003 from Mr Dekker]".

161. Paragraph 7 of the statement of reasons contained the core of the tribunal's reasoning in relation to the higher rate of the mobility component:

> "In her previous claim pack, [the claimant] said that she could not go out alone because of dizziness. Dr Mitchell [the claimant's GP] had stated that she "had difficulty leaving the house alone". She did not state either in her claim pack or during the hearing that her lower limbs were impaired. She did not say that she could not walk. During the hearing, she said that she did not go out alone, but would go out with her husband and her husband said that on Sunday afternoons they either went to the park or to a garden centre. Although the Department had not removed or reduced her award to (sic) higher rate mobility component, the tribunal found that as specialists had found no organic cause for her dizziness despite intensive investigations (paragraph 5), there was no physical disablement that could result in an award of higher rate mobility component. The tribunal found that Department had made the decision in ignorance of the material fact that investigations had not found an organic cause for [the claimant's] dizziness, as it was not in possession of GP notes until Mr McDonald sent these in with his letter of 8 March 2003. The tribunal therefore removed the award from 25 November 2003."

162. We received some helpful evidence from Dr Ford as to the nature of vestibular disorders, of which we would set out the following as being of particular assistance in understanding the evidence before the tribunal and the tribunal's reasoning:

> "13. The vestibular system is a complex part of the inner ear that plays an important role in helping the person to maintain balance. Fluid in balance organs in the inner ear (the semicircular canals) moves as the head moves; messages are sent to the brain via the vestibular nerve (the nerve of balance).
>
> 14. Maintenance of balance in the human body is complex and is coordinated in the brain. Information is received from the eyes, sensory receptors in the muscles, joints, skin and from the vestibular system in the ear. This information from the periphery (the peripheral parts of the body) is coordinated and interpreted centrally by the brain. In turn messages are sent from the brain to the eyes, joints, etc enabling balance to be

maintained. Abnormal function of any central or peripheral component may affect balance adversely. Abnormalities of the vestibular system are common.

15. Causes of vestibular disorder affecting the inner ear include:

Viral infections (labyrinthitis, vestibular neuronitis)
Benign positional vertigo
Menières disease
Head injury
Ototoxic drugs e.g. certain antibiotics
Acoustic neuroma (a tumour of the vestibular nerve)

16. Vestibular disorders may cause a number of symptoms including vertigo.... Other symptoms of vestibular disorder include dizziness, giddiness and feeling unsteady when walking....

...

20. Treatment known as vestibular rehabilitation may be recommended for people with persistent symptoms of vestibular disorder. This consists of exercises involving a coordinated set of eye, head and body movements that the person is taught to carry out 3-4 times a day. The purpose is to retrain the brain to compensate for the impaired vestibular function....

21. People with long standing vestibular disorders may become anxious and depressed, especially if simple treatment with medication does not relieve symptoms. They may become afraid that attacks of vertigo will render them incapacitated in public or in the street. They may become fearful of walking out of doors on their own. Low mood, anxiety and panic attacks in their turn may cause feelings of dizziness. Associated anxiety/depression in those with vestibular disorders may need treatment in their own right. As described above the resultant degree of functional restriction may arise from a complex interaction of biological, psychological and social factors.

22. The commonest type of vestibular disorder seen in general practice is acute labyrinthitis/vestibular neuronitis. The person presents with short lived episodes of vertigo, frequently accompanied by nausea and vomiting.... The condition resolves itself quickly over a few days or weeks and is relieved by specific medications. It is postulated that recovery occurs because the brain compensates for, or learns to adapt to, the abnormal signals that it receives from the inflamed vestibular organ/nerve....

23. You enquire what is "uncompensated peripheral vestibular disorder". In [the claimant's] case it is clear that she has consulted a number of specialists and had several relevant investigations. The description "peripheral vestibular disorder" indicates that the problem affects the balance organs or nerve in the inner ear. Central problems affecting the brain such as a tumour or stroke have been ruled out. The term "uncompensated" indicates that spontaneous recovery or resolution has not occurred. The terminology used also indicates that a specific condition like Menière's disease has not been identified. To say that "no treatable cause found" may mean that no specific diagnosis has been made, or it may mean that no treatment has been successful or that little or no recovery has taken place. It does not necessarily mean that symptoms are

psychological or imaginary, or that there is no recognised disease, or that there is no organic cause for the disabling condition. The term "psychogenic overlay" may indicate that the claimant has developed psychological symptoms such as anxiety in response to her persistent disabling symptoms, and that this is contributing to the degree of disability observed. It does not necessarily imply that there is a conscious intention to mislead or malinger.

30. In conclusion I think that [the claimant] should be considered as having an underlying physical cause for her symptoms of vertigo and dizziness. I appreciate the diagnosis of uncompensated peripheral vestibular disorder is to some extent a diagnosis of exclusion, and also a description of a conglomeration of persistent symptoms, most of which might be considered to be subjective. Nonetheless it would be recognised as a medical condition by most medical authorities and considered to have some disabling effects of a physical nature. It would also be accepted that psychological and other factors may contribute to the overall level of disability observed in some individuals, as is the situation in many more well defined physical and mental disorders."

163. In our judgment the tribunal's decision was erroneous in law in the following respects.

164. First, the tribunal ought expressly to have stated what significance it attributed to the opinion of Mr Dekker, confirmed by Professor Luxon and in effect repeated in the GP's report, that the claimant was suffering from uncompensated peripheral vestibular disorder. That, as Dr Ford's evidence makes clear, is a physical disorder of the mechanism in the inner ear, and appears to be an acceptable diagnosis even though it is unspecific as to precisely what is wrong and even though it was in this case, in Dr Ford's words, "to some extent a diagnosis of exclusion."

165. The tribunal's crucial statement in its paragraph 7 that it "found that as specialists had found no organic cause for her dizziness despite intensive investigations there was no physical disablement that could result in an award of higher rate mobility component" is clearly a reference back to the last sentence of paragraph 5. There the statement that no organic cause for the dizziness had been found is supported by reference to two entries in the claimant's medical notes. The first (in time) is the letter dated 7 February 2002 from a Dr Lopes (whose speciality does not emerge), which does state that none of the specialists had been able to find an organic cause. The second, however, is the letter dated 8 May 2003 from Mr Dekker, which contains the two references to uncompensated peripheral vestibular disturbance (or disorder). Mr Dekker was of course one of the specialists who had investigated the claimant in 1996 and 1997 and who were therefore being referred to by Dr Lopes in his letter. Although the tribunal had, in paragraph 5, quoted what Mr Dekker had said in that letter (albeit while seemingly wrongly attributing it to the GP), it did not in paragraph 7, as in our view it should have done, state what significance it attached to it. Read in the light of it, Dr Lopes' statement arguably meant merely that no specific organic cause had been precisely identified. The tribunal should have considered whether there was nevertheless, on the balance of probabilities, some disorder of the vestibular system.

166. We would make the general comment, in the light of Dr Ford's evidence, that as in the case of back pain (see paragraph 145 above) it may well be that tribunals have in the past been too ready to conclude that the fact that no specific and precisely identified organic cause for persistent dizziness has been found means that there is not in fact an organic case.

167. Secondly, apart possibly from the one reference in the letter dated 8 May 2003 from Mr Dekker to "uncompensated peripheral vestibular disorder with psychogenic overlay" there was no diagnosis of any specific mental disorder. The tribunal appear to have accepted that the claimant's symptoms of dizziness were genuinely experienced. In those circumstances the tribunal, before concluding that those symptoms did not have an organic cause, ought in our judgment expressly to have considered whether it was likely that the cause was mental or psychological. The tribunal's finding that there was no organic cause implied that that was so, but in the absence of a diagnosis of mental disorder the tribunal ought expressly to have considered the point.

168. Thirdly, the ground on which the tribunal superseded the award of the higher rate of the mobility component was that the Department had made the decision "in ignorance of the material fact that investigations had not found an organic cause for [the claimant's] dizziness, as it was not in possession of GP notes until Mr McDonald [then the claimant's representative] sent these in with his letter of 8 March 2003." That reasoning seems to betray some confusion of thought, because the decision which the tribunal was superseding must have been made in 1996 or 1997 (the date of it was not in evidence before the tribunal), and at that date the evidence in the GP notes (summarised above) as to what occurred in 1996 and 1997, and on which the tribunal relied, did not of course exist. It may well be that, at the date of the decision awarding the higher rate of the mobility component, at least some of the investigations as to the cause of the dizziness which were undertaken in 1996 and 1997 had not yet been carried out.

169. Nevertheless, the general point which the tribunal was intending to make was that the original awarding decision was made in ignorance of the material fact that there was no organic cause for the claimant's dizziness (or alternatively in the mistaken belief that there was an organic cause). However, the original awarding decision is not in the papers, and even if it had been it is unlikely that it would have contained anything specific by way of reasoning on this point. Further, the evidence which was before the original decision maker is not in the papers. The reasoning of that decision maker can therefore only be a matter of inference. Nevertheless, on the footing (as found by the tribunal) that there was no organic cause for the dizziness, it would have been open to the tribunal to find that it was likely that the original decision maker either (i) mistakenly considered that there was an organic cause when there was not or (ii) made an error of law in awarding the higher rate of the mobility component without being satisfied that there was an organic cause for the dizziness. Either of those events would have provided a ground for supersession. The tribunal did not, however, actually reason along those lines, and in the absence of such reasoning its decision was further erroneous in law. In addition, the tribunal did not in its statement of reasons indicate that it had consciously exercised the discretion in section 12(8)(a) of the Social Security Act 1998 to take into account issues not raised by the appeal (see R(IB) 2/04 at paragraph 94) and wrongly placed the burden of proof on those issues on the claimant.

170. We therefore set aside the tribunal's decision as erroneous in law and remit the matter for reconsideration by a differently constituted appeal tribunal. The new tribunal must first consider whether (viewed as at the 25 November 2003, the date of the decision under appeal) there were one or more grounds for supersession of the original awarding decision. Grounds for supersession might be (a) a deterioration in the claimant's condition since the original awarding decision (as contended in her application) and/or (b) a mistake of fact or of law in relation to the award of the higher rate of the mobility component. If the tribunal finds that there is no ground for supersession, the appeal should simply be dismissed. If there is a

ground for supersession, the tribunal must consider what the appropriate award is. It must bear in mind here that the ground for supersession must form the basis of the new decision in the sense that the original decision can only be altered in a way which follows from that ground: see R (IB) 2/04 at paragraph 186. If, therefore, the *only* ground for supersession is that the claimant's condition has deteriorated, the new tribunal could not remove the award of the higher rate of the mobility component even if it considers that the claimant's dizziness does not result in her being virtually unable to walk.

Summary of Conclusions on the Issues of Law

171. Finally, for convenience, we set out below a summary of our conclusions on the issues of law raised before us:

(i) In our judgment the effect of the decision of the Court of Appeal in *Harrison* is that pain, dizziness or other symptoms are not a feature of the claimant's "physical condition as a whole" within the meaning of regulation 12(1)(a) of the Social Security (Disability Living Allowance) Regulations 1991 unless they have a physical cause. Difficulty in walking which results from pain, dizziness or other symptoms affecting physical functions which are found to have an entirely mental or psychological cause cannot therefore qualify a claimant for the higher rate of the mobility component of DLA. Decisions of Commissioners to contrary effect, such as those in CSDLA/265/97, CDLA/948/2000 and CDLA/3323/2003, should not be followed. (Paragraphs 86 to 101 above).

(ii) Although this must be a matter for decision by each tribunal on the basis of the evidence before it, on the evidence before us (particularly that of Dr Ford: see paragraphs 145 and 162 above) it may be that tribunals have in the past been too ready to conclude that the fact that no specific identifiable cause for lower back pain and dizziness has been found, despite extensive investigation, means that there is no physical cause. (Paragraphs 146 and 166 above).

(iii) In cases where a claimant's inability or virtual inability to walk is caused by both physical and mental factors, the claimant is entitled to the higher rate of the mobility component if the physical disorder is a material cause - i.e. if its contribution to the inability or virtual inability to walk is more than minimal (paragraph 116 above). The physical cause must be one which is still current at the date of the decision maker's decision (paragraph 119), but it does not matter at what point in the chain of causation it comes (paragraph 120).

His Honour Judge Gary Hickinbottom
Chief Commissioner

John Mesher
Commissioner

Charles Turnbull
Commissioner

25 November 2005