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| In The First Tier Tribunal (Social Entitlement Chamber) | Case No:  |
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| BETWEEN: |
|  | MISS M | **Appellant** |
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| - and - |
|  | SECRETARY OF STATE FOR WORK AND PENSIONS | **Respondent** |
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|  | APPELLANT’S SUBMISSIONS FOR THE HEARING  |  |

1. This is an appeal against the decision dated 4 December 2018 as confirmed by the mandatory reconsideration (MR) on 14 May 2019.
2. The decision purported to supersede an earlier decision (**pp72-81 of the bundle**). That decision was to award the daily living component at the standard rate until **24/04/2019**
3. Although the Secretary of State has purported to supersede the previous decision, it is arguable that she has not properly established any grounds for the outcome decision
	1. In MR v SSWP (PIP)[2017] UKUT 0046 (AAC) CPIP/3556/2016 Judge Wikeley held at [27]-[29]

27. It follows that the Secretary of State could only interfere with FtT 1’s decision by way of making a *supersession* decision. On the face of it this might have been undertaken in one of two ways

28. The first is under regulation 31 of the 2013 Regulations, as I noted when giving permission to appeal. However, the extensive papers before both tribunals included only the decision notice (and subsequent DWP implementing letter) from FtT 1. In the absence of both a record of proceedings and statement of reasons for FTT 1, it is difficult to see how the Secretary of State could ever have discharged the burden of showing that FTT 1 had made its decision “in ignorance of, or … based upon a mistake as to, some material fact” for the purposes of regulation 31. That was precisely the point which the Appellant had made in lay terms in her notice of appeal (see paragraph 15 above).

29. The second was under regulation 23(1) of the 2013 Regulations, which allows the Secretary of State to make a supersession decision where there had been “a relevant change of circumstances since the decision to be superseded had effect”. This was presumably the argument the Secretary of State’s response to the appeal was seeking to make, although it was not articulated as such. However, it is well established that a new medical opinion (or paramedic’s opinion) is not of itself a change of circumstances, although it might be evidence of underlying changes in a medical condition which could constitute a change of circumstances (see e.g. *Cooke v Secretary of State for Work and Pensions* [2001] EWCA Civ 734, reported as R(DLA) 6/01). In this case there was a singular absence of hard information about what FTT 1 had decided, other than the headline decision, meaning that the Secretary of State’s task in demonstrating a change of circumstances was not straightforward. In any event, the Appellant’s argument was clearly that there had been no such change and FtT 3 certainly failed to put the Secretary of State to proof. Indeed, quite the opposite

* 1. Judge Wikeley resiled somewhat in TH v SSWP (PIP) [2017] UKUT 0231 (AAC) and held that it was not necessary to demonstrate that a change of circumstances had occurred in order to establish the grounds for supersession. Judge Wikeley held at [18]

18. For the avoidance of doubt, it seems to me as a matter of principle that the two-stage test set out by Judge Mesher applies whether the original decision was made by the Secretary of State or a First-tier Tribunal. My decision in *MR v Secretary of State for Work and Pensions (PIP)* [2017] UKUT 46 (AAC) should not be read as suggesting in planned review cases, and where the previous award was by a tribunal, that a supersession is only possible for change of circumstances (regulation

23 of the D & A Regulations) or mistake of fact (regulation 31). Receipt of new medical evidence under regulation 26 remains a possibility – but the application of the principles set out in R(M) 1/96 and *SF v Secretary of State for Work and Pensions (PIP)* [2016] UKUT 481 (AAC) will need to be considered. See further the fuller analysis by Judge Wright in *PM v Secretary of State for Work and Pensions (PIP)* [2017] UKUT 37 at paragraphs 9-17.

* 1. In SF v SSWP (PIP) [2016] UKUT 0481 (AAC) CPIP/1693/2016 Judge Wikeley held at [22]

22. Thus, the principles and guidance set out by Mr Commissioner Howell QC in R(M) 1/96 are not rendered redundant by the simple fact that the Secretary of State has instigated a Planned Review, obtained a fresh HCP report and concluded that there is now no longer any ongoing entitlement to PIP, making a supersession decision to that effect. The extent to which reasons have to be given in such a case will obviously be context-dependent. However, in a case such as the present, where there was such a stark contrast between the two decisions, the FTT could not simply pretend that the award the previous year was simply a matter of ancient history and of no current potential relevance. It was incumbent on the FTT at least to express a view e.g. that there had been a significant improvement in the Appellant’s condition and functioning in the intervening 15 months. That may well have been the situation in the present case, but the FTT did not say so and certainly did not make the necessary findings of fact to support such a conclusion. I therefore allow the appeal on this ground too.

* 1. The principles in R(M)1/96 were set out at [ 15]-[16]

“15.It does however, seemto me to follow from what is said bythe Court of Appealin *Evans, Kitchen & Others*, that while a previous award carries no entitlement to preferential treatment on a renewal claim for a continuing condition, the need to give reasons to explain the outcome of the case to the claimant means either that it must be reasonably obvious from the tribunal’s findings why they are not renewing the previous award, or that some brief explanation must be given for what the claimant will otherwise perceive as unfair. This is particularly so where (as in the present and no doubt many other cases) the claimant points to the existence of his previous award and contends that his condition has remained the same, or worsened, since it was decided he met the conditions for benefit. An adverse decision without understandable reasons in such circumstances is bound to lead to a feeling of injustice and while tribunals may of course take different views on the effects of primary evidence, or reach different conclusions on the basis of further or more up to date evidence without being in error of law, I do not think it is imposing too great a burden on them to make sure that the reason for an apparent variation in the treatment of similar **relevant** facts appears from the record of their decision.

16. Relating this to attendance or mobility cases, if a tribunal, in a decision otherwise complying with the requirements as to giving reasons and dealing with all relevant issues and contentions, records findings of fact on the basis of which it plainly appears that the conditions for benefit are no longer satisfied (e.g. a substantial reduction in attendance needs following a successful hip operation, or the claimant being observed to walk without discomfort for a long distance) then in my judgment it is no error of law for them to omit specific comment on an earlier decision awarding benefit for an earlier period. Their reason for a different decision is obvious from their finding. In cases where the reason does not appear obviously from the findings and reasons given for the actual conclusion reached, a short explanation should be given to show that the fact of the earlier award has been taken into account and that the tribunal have addressed their minds for example to any express or implied contention by the claimant that his condition is worse, or no better, than when he formerly qualified for benefit. Merely to state a conclusion inconsistent with a previous decision, such as that the tribunal found the claimant “not virtually unable to walk” without stating the basis on which this conclusion was reached, should not be regarded as a sufficient explanation, and if the reason for differing from the previous decision does not appear or cannot be inferred with reasonable clarity from the tribunal’s record, it will normally follow in my view that they will be in breach of regulation 26E(5) and in error of law

* 1. In KB v Secretary of State for Work and Pensions (PIP) [2016] UKUT 0537(AAC) CPIP/1623/2016Judge Mesher concurred with what Judge Wikeley held in SF. Judge Mesher holds at [12]-[13]

12. The effect of regulation 26(1)(a) of the 2013 Decisions and Appeals Regulations taken on its own is relatively uncontroversial. A similar power of supersession has existed for some time for incapacity benefit (IB) and employment and support allowance (ESA) in the 1999 Decisions and Appeals Regulations. In relation to those powers, a three-judge panel of the Upper Tribunal said this in FN v Secretary of State for Work and Pensions (ESA) [2015] UKUT 670 (AAC), now reported as [2016] AACR 24:

“70. We accept this analysis [of how the pre-existing case law fitted together] and although we were not asked to consider the practical application of regulation 6(2)(g) or 6(2)(r)(i) [of the 1999 Decisions and Appeals Regulations], we re-emphasise that the purpose of both provisions is to provide that the obtaining of a medical report or medical evidence following an examination is in itself a ground of supersession and that, accordingly, there is no longer a requirement to identify a regulation 6(2)(a)(i) change of circumstances in order to supersede an IB or ESA decision. More importantly, however, we accept and endorse what was said by Mr Commissioner Jacobs in paragraph 10 of CIB/1509/2004. What both provisions do is to authorise a supersession procedure but do not determine the outcome. What determines the outcome is a decision by the decision-maker (initially) or the First-tier Tribunal (on appeal), after an assessment of all the relevant evidence, as to whether the substantive tests (incapacity for work or limited capability for work) are satisfied.”

Paragraph 10 of CIB/1509/2004 was as follows:

“10. On either approach, regulation 6(2)(g) merely authorises a supersession procedure. It does not determine the outcome. It merely recognises that evidence has been produced that may, or may not, show that the operative decision should be replaced. The outcome is determined by the conditions of entitlement for an award.”

13. In my judgment, those statements of principle apply just as much to the operation of regulation 26(1)(a) of the 2013 Decisions and Appeals Regulations in relation to PIP. Thus the tribunal of 11 March 2016 was correct in paragraph 20 of its statement of reasons in so far as it was referring to regulation 26(1)(a), but subject to the important proviso that, although it is not necessary to identify a change of circumstances in order to authorise a supersession, it may be necessary to consider the circumstances obtaining when the existing award was made and during the period of the award as part of “all the relevant evidence” and as part of an adequate explanation of the outcome if it is less favourable than the existing award that is being replaced on supersession. Although the tribunal here did plainly consider whether the substantive test for entitlement to PIP was met as from 22 July 2015, I conclude in paragraphs 27 and 28 below that there was an error of law in the inadequacy of reasons.

 And at [ 16]-[17]

16. Does regulation 11 go further than that provision of context? The notes to regulation 11 in the 2016/17 edition of Volume I of Social Security Legislation (Non-Means Tested Benefits and Employment and Support Allowance) start by suggesting that it appears to mean that a decision awarding PIP can be reviewed and superseded by the Secretary of State at any time and for any reason, although they go on to suggest that that is not the case. However, some may have interpreted regulation 11 in the first sense and it is possible that the tribunal of 11 March 2016 had such a meaning in mind in paragraph 20 of its statement of reasons. If so, it would have been wrong.

17. The precise terms of regulation 11 have to be looked at carefully. They only allow the Secretary of State to make a determination on the question of whether the claimant continues to have limited or severely limited ability to carry out daily living and/or mobility activities, not an overall decision on entitlement or otherwise to PIP. It may be that too much significance should not be placed on the use of those particular words, but examination of the provisions of the Welfare Reform Act 2012 on PIP shows many references (see in particular sections 80 and 81) to the determination of various questions (including the question just mentioned) in accordance with regulations, in contrast to provisions as to entitlement or non-entitlement, under which entitlement follows from positive determinations on a number of questions. A positive answer to each necessary question is one element (in the past sometime described as one building block) that goes towards an eventual decision on entitlement. Thus, regulation 11 does not directly allow a supersession of a decision making an award whenever the Secretary of State feels like it. To put it another way, the mere existence of a subsequent determination on one question, that the claimant does not have limited or severely limited ability to carry out daily living and/or mobility activities, cannot if itself take away the authority entitling the claimant to payment of benefit under the decision awarding entitlement. That authority can only be removed by the Secretary of State under his powers of revision and supersession in the 2013 Decisions and Appeals Regulations

* 1. Miss M contends that her condition had not improved since the previous assessment at time of the decision under appeal, and it is arguable that the burden of proof is on the decision Respondent to show otherwise in order to justify his superseding decision. (CIB/1509/2004 at [ 12]-[13], DB v Secretary of State for Work and Pensions (IB) [2010] UKUT 209 (AAC) CIB/2734/2009 at [ 17].
1. The starting point must be the PIP2 **(pp6-38 of the bundle**) as followed up by the award review form (**pp82-94 of the bundle**). Miss M reports either “ no change” or” harder” in the review form, and I suggest that there is little reason why what Miss M reports should not be accepted. I also suggest that Miss Mark’s evidence is corroborated by the evidence that is in the bundle and by the additional medical notes attached to this submission.
2. I suggest that the Respondent has not considered the evidence properly. She has, with little or no justification, rejected some evidence as supposedly irrelevant (*e.g. evidence underlying Miss M’s ESA award in the support group and the previous PIP award*). The Respondent has not applied the law properly as it relates to the Descriptors, (and has not followed the authorities). She has effectively rubber stamped an inadequate Health Care Professional’s (HCP’s) report.
3. The Respondent has not addressed the issues in the application for MR as discussed above, nor has she addressed the issues outlined in Miss M’ notice of appeal. Her Response is simply peppered with a number of formulaic stock phrases that are contained in a spreadsheet provided for her submission writers. The existence of the spreadsheet was revealed in a reply to a Freedom of Information request and published on the internet at

<https://www.whatdotheyknow.com/request/origins_of_and_list_of_stock_phr>

1. The Respondent seeks to justify her refusal to consider the ESA evidence **(S4(6) page G of the Response)**

Although Miss M is entitled to ESA, this doesn’t bring automatic entitlement to PIP which is assessed separately and under different criteria. ESA assesses fitness to work. This factor isn’t relevant to the PIP qualifying criteria…..

7.1 I suggest that the Respondent is at best over stating the case, or at worst is simply wrong because there is considerable overlap between the ESA and PIP descriptors. The Respondent’s ’s position is in any case not supported by the Upper Tribunal.

7.2 In JB v SSWP (ESA) [2017] UKUT 0020 (AAC) CE/2314/2016, Judge Hemingway allowed the ESA appeal and Directed that evidence upon which a PIP award was based should be put before the new Tribunal as it was relevant to the ESA appeal. Judge Hemingway held at [17]:

17. That said, it is the case that evidence underlying a PIP decision might be relevant to an ESA decision. Mr Hampton recognises that in saying about the PIP award “the evidence on which that award was based may be of importance and is therefore of potential relevance to an ESA claim”. In my judgment, he is right to say that. That then does raise the question of whether the tribunal ought to have at least considered adjourning for the evidence underlying the PIP award to be provided

 It is strongly arguable that the same principles will apply in the present case only in reverse, i.e. that the evidence underlying the ESA decision is relevant to the assessment of a claim for Personal Independence Payment

1. The Respondent has effectively rubber stamped an arguably inadequate HCP report and she seeks to justify this by her statement at **S4(7) page H of the Response**.

The Health Professional is an independent trained disability analyst and assessed Miss M’` functional ability based on their knowledge of her medical conditions. Their report includes clinical findings and formal and informal observations covering physical and mental health problems with Miss M who gave a full account of a typical day

I consider the Health Professional’s report is objective and accurately reflects Mr M’s ability to complete the Daily Living and Mobility activities.

* 1. The Respondent also seeks to justify her stance by referring to the Gray Report (**S4(5) page G of the Response)**
	2. There have been two Gray Reports. Both those reports were commissioned by the Respondent and are thus arguably not independent. They have both been criticised for their terms of reference and also because much of the evidence collected was anecdotal (statements from front line decision makers). I nevertheless could not find anything in either report that could justify the Respondent’s claims. Indeed, in Chapter 4 of the second report it is noted at [36] (the emphasis is mine)

Discussions with Tribunal Judges have however suggested that, rather than further written evidence, it is cogent oral evidence from the claimant at the hearing that is by far their most common reason for overturning decisions. **This either means that this evidence is not sufficiently well-collected during the assessment or is not convincingly analysed or written-up**. It may also mean that Tribunal Judges and Health Professionals are routinely coming to differing judgements based on the same evidence

8.3 It appears that the authors of the Gray reports are ignorant of the fact that ESA (WCA) and PIP appeals are not heard by a Judge sitting alone. ( Paragraph 4 The Practice Statement on the Composition of Tribunals provides that in PIP and DLA cases, the Tribunal will consist of “a *Tribunal Judge, a Tribunal Member who is a registered medical practitioner, and a Tribunal Member who has a disability qualification as set out in article 2(3) of the Qualifications Order*.” Paragraph 5(b), (c) and (h) of the Practice Statement provides that in ESA (WCA) cases, the Tribunal will consist of “*a Tribunal Judge and a Tribunal Member who is a registered medical practitioner*)

* 1. On 7 February 2018 the House of Commons Work and Pensions Committee published a report “PIP and ESA Assessments”. That report concluded inter alia: (*any emphasis is mine*)

Ultimately, while the Department sets quality standards, it is up to contractors to meet them. **The Department’s existing standards set a low bar for what is considered acceptable**. **Despite this, all three contractors have failed to meet key targets on levels of unacceptable reports in any single period**. In Capita’s case, as many as 56% of reports were found to be unacceptable during the contract. The Department’s use of financial penalties to bring reports up to standard has not had a consistent effect. Both Capita and Atos have seen increases in the proportion of reports graded “unacceptable” in recent months. Large sums of money have been paid to contractors despite quality targets having been universally missed. The Government has also spent hundreds of millions of pounds more checking and defending the Department’s decisions.

* 1. The Respondent’s assertions are arguably unsustainable in the light of the above.
1. The HCP who carried out the assessment was a nurse who apparently has no specialist training or qualifications.

9.1 I will concede that in JF v Secretary of State for Work and Pensions (ESA) [2013] UKUT 0269 (AAC) CIB/419/2011, Judge Ovey held (at [19]) that as a matter of law, the Secretary of State can rely on a medical report that had been prepared by a non-specialist nurse or paramedic , but Judge Ovey’s decision does not make an HCP’s qualifications (or lack of them) irrelevant.

9.2 In JH v Secretary of State for Work and Pensions (ESA) [2013] UKUT 0269 (AAC) CE/3883/2012 (at [22]) Judge Mark seems to disagree with Judge Ovey

22. Where, however, the disability analyst is a physiotherapist and the problems she is dealing with are mental health problems the opinion of the physiotherapist as to the conclusions to be drawn have no probative value whatsoever. This is because the physiotherapist has no professional expertise in mental health matters. Although the strict rules of evidence do not apply, a tribunal can only take into account evidence that has probative value, so that, for example the decision of another judge as to the facts is simply his or her opinion as to the facts and has no probative value (see AM v Secretary of State, [2013] UKUT 094 (AAC), paragraphs 19-24, and the interim decision of Judge Turnbull in CH/1168/2011 setting aside the decision of a tribunal on the ground that it had relied in part on the findings of fact of another tribunal which represented no more than the opinion of that earlier tribunal as to the matter).

9.3 Mr Commissioner (now Judge) Jacobs held in CDLA/2466/2007 (at [35])

 The tribunal has to decide whether the factual basis of the opinion was correct. To the extent that it was not and the difference is significant, the value of the opinion is undermined. If the tribunal accepts the factual basis as correct, the tribunal must decide whether to accept the opinion. In doing so, it will be relevant to know the professional background of the disability analyst. The tribunal may accept that they have all been trained and approved. But that training is supplementary to the analyst’s professional training. It cannot turn a doctor into an occupational therapist or a physiotherapist into a doctor. And the professional background may be relevant to assessing the opinion given. To take some obvious examples, an occupational therapist’s opinion on the aids that would assist a claimant may be more useful than that of a doctor, while a doctor’s opinion on the risks of injury during an epileptic seizure may be more useful than those of a physiotherapist. (In practice, I suspect that the matters referred may depend on the particular’s analyst background.) Accordingly, the tribunal will not be able to place much, if any reliance, on an opinion given by an analyst whose primary area of experience and expertise is not known

9.4 A Three Judge Panel (3JP) considered the issue in in [2015] AACR 23, but there is I submit nothing in the decision that would detract from what Judge Jacobs held in CDLA/2466/2007. (or for that matter what Judge Mark held in JH) Indeed, the 3JP held (at [ 38)]:

38 .In a assessing the weight to be given to any report addressing the functional impact of any medical condition on a claimant, a First-tier Tribunal should consider (a) the level of the author’s expertise (for example, an HCP or a consultant psychiatrist) and (b) the knowledge of the claimant possessed by the author (for example, knowledge gained from a one-off assessment or that gained as a treating clinician). Additionally, the date of the evidence, its comprehensiveness, and its relevance to the issues the tribunal has to determine are also key matters for the tribunal to consider. Importantly the tribunal should explain its reasoning for attaching weight to one type or piece of evidence rather than to another

1. The HCP who carried out the PIP assessment reported (**p105 of the bundle**) that Miss M was” average build””

10.1 The HCP has not been helpful because she did not measure Miss M’s height, or weight, even though the assessment was carried out at an assessment centre.

* 1. The HCP does purport (for example) to have accurately measured Miss M’s shoulder abduction (170 degrees). I simply ask whether the HCP used a protractor to measure the angle of Miss M’s shoulder abduction but on the other hand did not have a set of scales or a tape measure to measure Mr M’s waist or had the means to measure Mr M’s height.
	2. It is arguable that HCP’s should not be using vague terminology such as “average build “without defining what is meant by such terms
	3. Miss M’ medical notes (p23 of 32-page computer printout) show that her weight is steadily increasing and that as of 07/02/2017 she weighed 106Kg and her body mass index (BMI) was 38Kg/m2. Miss M s states that she has not lost any weight since then, but If Miss her BMI is 38 Kg/m2 and she weighs 106Kg, her height is therefore 1.67m
	4. According to the Adult Obesity Health Survey (HSE) for England 2014, the average BMI for men and women is 27.2kg/m2. I will concede that the average person in England is overweight given that the accepted threshold for being overweight is a BMI of more than 24.9 kg/m2.
	5. If average build is taken to be synonymous with a BMI of 27.2Kg/m2 and Miss M weighed around 106Kg at the time of the assessment it then become clear that the HCP underestimated Miss M’ weight by over 30Kg
	6. **I suggest that this gross inaccuracy undermines the credibility of the whole report and that** (**contrary to what the Respondent asserts at S4(7) page H of the Response where she asserts that “***I consider the Health Professional’s report is objective and accurately reflects Miss M;’s ability to complete the Daily Living and Mobility Activities”* ) **a couple of simple measurements cast grave doubt on those findings**
1. It is strongly arguable that the Respondent has had no regard for the authorities that apply to Regulation 4(2) or Regulation 4(2A)

11.1 Regulation 4 (2A) of The Social Security (Personal Independence Payment) Regulations 2013 SI 2013/377 as amended requires that the tasks can be carried out:

(a) safely;

(b) to an acceptable standard;

(c) repeatedly; and

(d) within a reasonable time period

1. It is now established beyond doubt following [2016] AACR 23 (TR v SSWP(PIP)) that a descriptor may be satisfied if a claimant is unable to carry out a task for part of the day, provided the impact on that person’s life is more than trifling. (see TR at [18] and [32] re Regulation 4(2A)(c))
2. In PM v SSWP (PIP) [2017] UKUT 0154 (AAC), Judge Gray held at [ 20]

To the extent that this definition was interpreted to exclude the appellant’s choice as to how often she would ‘move around’ (in the words of the schedule; I might use the expression ‘walk’) and replace that choice with an objective test of how often she needed to do so, that was wrong. I reiterate my observations in *EG* cited above. If the tribunal looked at the concept *‘repeatedly’* on one walk to a local shop and then back home each day, which an appellant could accomplish at one stretch, perhaps because it felt that she would be able to pick up what she needed on such an outing, that would be to assess her on an overly limited basis: she may wish to walk on to the park, or meet a friend, and why should she not? That extended walk may necessitate rest periods thus the concept of repeatedly is wider. Using Judge Jacobs point in relation to dressing, to which I also refer above, a tribunal does not need to accept the genuineness of an extreme routine put forward in an apparent attempt to “generate” points, but if it is accepted that somebody would like to walk further or more frequently, and such activity is not inherently unreasonable then that wish should be factored in to the calculation of how often the activity being assessed is reasonably required to be completed. To address this matter otherwise would be to calculate entitlement upon the tribunal’s view of what the disabled person’s activities should be. Directly in the PIP context I draw support for that proposition from the comments of Upper Tribunal Judge Hemingway in *CE-v-SSWP (PIP) [2015] UKUT 643 (AAC)* at [34*]:*

*It seems to me it makes no sense to say a person is able to perform an activity as often as reasonably required if they cannot do so for a part of the day in which they would otherwise* ***reasonably wish or need to do so****.* (my emphasis).

I pick up on a different aspect of that comment in my closing reM. I also consider pertinent the dicta of Lord Slynn of Hadley in *Secretary of State –v- Fairey (R(A) 2/98)*; although made in the context of the Attendance Allowance scheme the assessment was of attention “reasonably required”.

*‘ In my opinion the yardstick of a “normal life” is important; it is a better approach than adopting the test as to whether something is “essential” or “desirable”. Social life in the sense of mixing with others, taking part in activities with others, undertaking recreation and cultural activities can be part of normal life. It is not in any way unreasonable that the severely disabled person should want to be involved in them despite his disability. . What is reasonable will depend on the age, sex, interests of the applicant and other circumstances. To take part in such activities sight and hearing are normally necessary and if they are impaired attention is required in connection with the bodily functions of seeing and hearing to enable the person to overcome his disability. As Swinton Thomas LJ in the Court Of Appeal said “Attention given to a profoundly deaf person to enable that person to carry on, so far as possible in the circumstances, an ordinary life is capable of being attention that is reasonably required.”*

13.1 I suggest that if the above authorities are followed, the reM by the Respondent (**S4(7)of the Response Page G**) that “*The Health Care Professional considered Miss M’s abilities on the majority of days rather than exacerbations in her condition”* needs to be viewed in a different light. The yardstick of a more normal life established by Fairey and the principles established in the PIP context by TR, PM, and PS (cited at [14] below) ought to be the focus for that view

1. Regulation 4(2A) requires that an activity can be carried out to an acceptable standard and I am reminded that in PS v SSWP [2016] UKUT 0326 (AAC) CPIP/665/2016, Judge Markus held at [ 11]

11. What the Appellant was saying in his written and oral evidence was that he suffered pain when he walked, that he would walk slowly for a short distance despite the pain but that it would get worse until the pain would stop him. It could not properly be assumed that, because the Appellant managed to keep going for a certain distance, any pain he experienced while he was walking was not relevant. If a claimant cannot carry out an activity at all, regulation 4(2A) does not come into play. Where a person is able to carry out an activity, pain is clearly a potentially relevant factor to the question whether he or she can do so to an acceptable standard.

1. The Respondent suggests(**S4(4) page G of the Response**) that “in keeping with *the nature and history of Miss M’ s conditions* , *findings and observations on assessment and level of prescribed treatment , it’s reasonable to state that Miss M can stand and then move more than 200 metres* “
	1. The evidence relied on by the Respondent is the disputed (and I submit now discredited) HCP report, but I am also reminded that this piece of evidence is in the main what the Respondent concedes were “informal observations”
	2. The HCP did not put those observations to Miss M when she made and it is arguable that for the reasons outlined at [10]-[10.7] above, some of the so called clinical findings such as shoulder abduction were not clinical findings at all but were also mere informal observations (arguably also wild guesses in view of the HCP’s gross under estimation of Miss M’s weight)
	3. **It is strongly arguable that the so-called informal observations routinely made by HCP’s are not acceptable unless those observations are put to claimants at the time**
	4. I submit that the above is a well-established principle that has long been supported by the former Commissioners and the Upper Tribunal. The principle was affirmed in the old Incapacity benefit context in CIB/1235/1997 where Mr Commissioner (as then was) Williams held at [7]

“….If the tribunal did use its observations….then it should, as a matter of natural justice have drawn this to the attention of the claimant or her representative so they could comment on any matter that had attracted the tribunal’s attention”

* 1. I see no reason why the standards outlined by Mr Commissioner Williams as they apply to Tribunals who stand in the shoes of decision makers should not apply equally to HCP’s who are delegated by the Respondent to make the initial assessments
	2. I am in any case reminded that Mr Commissioner Heggs noted in CM/166/1998 at [3] that pain can be born in stoic silence.

 14.7 I am also reminded that in CDLA/0902/2004, Mr Commissioner (now Judge) Jacobs held at [14]-[15])

14 “Medical experts on pain no longer believe that there is a direct and proportionate relationship between (a) a disease or injury and (b) the nature and level of pain that a person experiences. This is reflected in the definition of pain by the International Association for the Study of Pain:

‘An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.’

15 Now that those medical professionals who are expert in pain do not recognise a direct link between clinical findings and pain, it is no longer rational for tribunals to reason simply from the clinical findings on examination to the level of pain that a claimant experiences. Tribunals must investigate the evidence of the claimant’s pain and explain how they have dealt with it. As there is no direct causal link between disease or injury and pain, the only direct evidence of pain can come from the claimant

* 1. It is acknowledged that a person’s perception of pain may be increased by psychological factors such as anxiety or depression. In R(DLA) 4/06 the Tribunal of Commissioners noted at [ 102]

…. For example, commonly a claimant has some physical disorder (eg 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.”

* 1. Judge Jacobs also considered the use of pain-relieving medication and held at [24]

The claimant’s medication

24. The nature and dosage of medication may be an indicator of a claimant’s pain. If the medication is not consistent with the level of pain described by the claimant, the tribunal must investigate as far as it can. There may be a credible explanation for an apparent discrepancy. It is not unknown for claimants to dislike taking medication for a prolonged period. And some pains respond better to medication than others. On the other hand, it is also not unknown for GPs to over-prescribe.

* 1. Judge Jacobs’ observations at [24] are now particularly pertinent in the light of Public Health England’s (PHE) report “Dependence and withdrawal associated with some prescribed medicines an evidence review”, (September 2019) and the subsequent guidance from the DWP to HCP’s undertaking PIP and WCA reports. The DWP issued the following guidance to HCP’s following the PHE report

1.6.35 HPs must also take into consideration the invisible nature of some symptoms such as fatigue and pain which may be less easy to identify and explore through observation of the claimant. HPs should be mindful that the level of analgesia used does not necessarily correlate with the level of pain. GPs are encouraged to avoid prescribing strong painkillers for long-term pain as the harms usually outweigh the benefits and there could also be specific reasons why painkillers are not prescribed, for example intolerance, or the use of other methods of pain relief. When pain is a significant symptom we would expect the claimant to be able to describe the location, type, severity and variability of the pain they experience and the impact it has on their daily life. The HP can assess the disabling effect of the pain by considering such description (where applicable) along with all other aspects of the case, for example disease activity/severity, effect on daily activities, treatment, pain relief, pain management strategies, examination findings and informal observations.

Source

 <https://www.gov.uk/government/publications/personal-independence-payment-assessment-guide-for-assessment-providers/pip-assessment-guide-part-1-the-assessment-process>

* 1. **The above guidance was issued after the date of the decision in the present case, but I submit that it is still relevant to the decision and should be accepted following R(DLA)2&3/01.**
	2. **Pain is a major factor affecting Miss M’s daily living and her mobility and I ask the Tribunal to consider it in the light of the PHE report and the authorities I have cited.**
1. I am reminded that the Respondent decided not to appeal (RF [2017] EWHC 3375 so consequently the Tribunal is then bound by MH v Secretary of State for Work and Pensions (PIP) [2016] UKUT 0531 (AAC). It is therefore arguable following MH that 10 points should be awarded on Mobility Descriptor 1 (d), given that it was held in MH that following a route involves more than just navigating.
2. It is also beyond doubt following the Supreme Court’s Judgment in Secretary of State for Work and Pensions (Appellant) v MM (Respondent) (Scotland) [2019] UKSC 34 that the need for social support in connection with Descriptor 9 does not necessarily mean that such support must be given within the confines of the engagement itself.( [2019] UKSC 34 at [43]). The Supreme Court (at [35]) also approved of what the Court of Session held in their Judgement at [55]

In our opinion the critical distinction between “prompting” (as defined in the Schedule) and “social support” is the fact that social support comes from a person trained or experienced in assisting people to engage in social situations. That does not mean, as the argument is somewhat unkindly parodied in some of the cases, that “prompting” qualifies as “social support” merely because the help is in fact given by a person trained or experienced in assisting people so to engage. There has to be some necessity for the help to be given by a person with this training or experience. In many cases it may well be that that is because the help is of some specialist kind which only a person trained in that specialism can deliver. For example, psychological support would normally be given by someone trained in psychology. This would clearly count as “social support”. But there may be cases where the support is in the nature of encouragement or explanation but, because of the claimant’s mental state, will only be effective if delivered by someone who is trained or experienced in delivering that type of support to that individual. In such a case there will not be a qualitative difference in the help given, but the help can be regarded as “support” because of the necessity for it to be provided by someone trained or experienced in delivering it.

* 1. It is therefore arguable in the light of MM that Miss M requires social support in order to engage with other people
1. The Respondent **(S4(4) page F of the Response**) makes much of what she considers to be the fact (sic) that Miss M is not under a specialist for her mental health

17.1 I am reminded that The Adult Psychiatric Morbidity Survey 2014 found that one adult in ten with severe common mental disorder (CMD) symptoms (Clinical Interview Schedule (CIS-R). Disorders (CIS-R 18+) asked for a particular mental health treatment in the past 12 months but did not receive it. I am also reminded that In R(DLA)3/06 the Tribunal of Commissioners held at [43] (the emphasis is mine)

43. “Those care needs have to be assessed on the basis of all the available evidence. As the authors of “Wikeley, Ogus & Barendt’s The Law of Social Security” (5th edition (Butterworths, 2002) at page 680) observe, clinical tests cannot themselves determine functional incapacity, e.g. an inability to self-care. However, we agree with Mr Commissioner Levenson (at paragraph 8 of the Common Appendix) that medical evidence, although not essential, will in many cases be important in determining whether a claimant has a disability, and, if so, in determining the extent of the care needs to which the disability gives rise. For example, some medical conditions (such as the loss of a sense or a limb) give rise to obvious functional impairment. Others (particularly psychiatric conditions) are diagnosed by reference to a constellation of symptoms, and where such a diagnosis is made one might assume (or at least expect) certain symptoms or patterns of behaviour. But that does not mean that, in the absence of a diagnosis (or even in the absence of any medical evidence), the statutory criteria will necessarily fail to be satisfied. **There will be cases in which there has been no medical diagnosis of a disabling condition for some particular reason, for example, because a person with a psychiatric condition is unwilling to undergo treatment, or perhaps because of a shortage of medical resources in a particular area**. The absence of a diagnosis does not necessarily negate entitlement to DLA, and the absence of such a diagnosis does not lift from the shoulders of a decision maker or tribunal the burden of assessing the evidence of disability such as it is. For a tribunal, in the absence of a determinative diagnosis, all of the evidence of the functional abilities of the claimant will need to be considered, relevant findings of fact made in relation to those abilities, and a decision made as to whether the disability is such as to satisfy one or more of the statutory tests in section 72(1)(a) to (c) and section 73(1)

17.2 Judge Poynter followed R(DLA)3/06 in MM v SSWP (ESA) [2018] UKUT 446 (AAC) Judge Poynter held at [34-[35]

34 The claimant’s representative comments

: “A current lack of treatment is not by itself [a reason] including the appellant did not meet the qualifying criteria. … The appellant had had the conditions and symptoms for many years. It may be that management by the GP was currently considered the most appropriate by the appellant’s own health care professional, other treatments and interventions having taken place over [preceding] years. The tribunal made no findings about prior treatments and interventions the appellant had undergone. … The tribunal should have put those concerns to the appellant and considered an adjournment to seek further evidence to address this issue.

 35 I broadly agree with those observations. However, I do not agree that the tribunal should have put its concerns to the appellant. The claimant is not medically qualified and therefore lacked the knowledge to respond to any concerns the Tribunal may have had on this point. It is difficult to see how she could have commented other than to suggest that the treatment she received was a matter for her GP’s professional judgment which she was not in a position to second-guess.

17.3 The Respondent’s conclusions that Miss M has few mental health limitations is therefore not justified in the light of the Adult Psychiatric Morbidity Survey 2014, and the authorities I have cited.

1. The Respondent is in any case wrong in asserting that Miss M has no input from mental health services because the additional medical evidence flatly contradicts this

18.1 The medical notes (**p1 of 32-page printout**) show an entry dated 18/05/2018 (seen by psychiatrist”) and a note the same day (“seen by mental health counsellor”)

* 1. I also note a reference to “Greenwich Time to Talk” and I have attached a document completed by X Cognitive Behavioural Therapist at T The document is dated 20 June 2018. I note the PHQ 9 and GAD7 scores of 19 and 18 and whilst I recognise that the PHQ9 and GAD7 questionnaires are not a diagnostic tool, the high scores are an indication of severe anxiety and depression and are in stark contrast to the findings in the (arguably discredited) HCP report
	2. I also draw attention to the entry dated 31/07/2019 in the GP notes

Anxiousness -symptom managed to get seen by women trust in Stratford states nothing in locality lives alone child abuse when she was young and gets reminded when she sees her grandchildren

* 1. There is another significant entry dated 15/01/2019

Wants anntiinflammaorty (sic) and cocodamol……..**warned** **re constipation and addiction** (my emphasis) (Cf [14.9]-[14.11] above)

* 1. The issued prescriptions are on pages 9-10 of the GP notes
1. .I suggest that the evidence at **p 1 and pp9-10 of the GP notes**, along with the report from X is much to be preferred to that of the HCP. The HCP report was clearly not carried out to a high standard, and I will go so far as to say that I have proven it to be inaccurate.
2. I also note that T do not consider themselves the most suitable service for Miss M and that Miss M that her childhood traumas have “resurfaced through recent triggers”

20.1 The GP notes refer to “child abuse” and there is also a reference to agoraphobia

20.2 This all corroborates what Miss M reports in her PIP claim form and review form, but I will also say that I have been able to gain Miss M trust to the extent that she disclosed to me that the references to “ child abuse” are to physical, emotional, and sexual abuse.

1. Miss M could have arguably been one of the “one in ten” referred to in the Adult Psychiatric Morbidity Survey 2014 (if that survey was carried out today) who could not access the necessary help.
2. I notice that the first entry in Mis M’ notes that referred to a psychiatric condition was in 2004 (**p8 of the 32-page printout**). The note is dated 02/03/2004 (almost 16 years ago). The diagnosis then was “*endogenous depression first episode and panic attacks”*

22.1 **I suggest that it can be safely concluded from the above that regardless of the precise diagnoses, Miss M’s psychological conditions are long standing and have been resistant to treatment**

1. Ialso suggest that the medical evidence of Miss M’ psychiatric conditions supports my argument at [16]-[16.1] above. I also say this because I am familiar with the work of the charity QT who specialise in providing counselling to victims and survivors of child sexual abuse.

23.1 I will not go into any more specific detail (although will do so if asked by the Tribunal at the hearing) but it is strongly arguable that I am a person “trained or experienced” in providing support to someone like Mrs M I have also signposted Miss M to QT.

1. I submit that in the light of the attached medical evidence and the authorities I have cited that points could be awarded on the following Descriptors.

Daily Living

Descriptor 1(b) 2 points

Descriptor 3(b) 1 point

Descriptor 4(b) 2 points

Descriptor 5(b) 2 points

Descriptor 6(e) 4 ponts

Descriptor 9(c) 4 points

**Total Daily Living 15 points**

Mobility

Descriptor 1(d) 10 points

Descriptor 2(b) 8 points

**Total Mobility 18 points**

1. Miss M will be entitled to both components at the enhanced rate
2. I ask the Tribunal to allow the appeal for the reasons outlined above



Derek Stainsby

Welfare Rights Adviser

Plumstead Community Law Centre

For the Appellant

|  |
| --- |
| Attachments |
| Copy of Computerised GP Notes 32 Pages |
| Further 12 pages of GP Notes to 2016 |
| Med 113 (Used for ESA Assessment) |
| Referral and Report from T |