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| In The First Tier Tribunal (Social Entitlement Chamber) | | Case No: | |
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| BETWEEN: | | | |
|  | MR X | | **Appellant** |
|  |  | |  |
| - 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 1 April 2019 as confirmed by the mandatory reconsideration (MR) on 19 July 2019. The decision was to refuse the claim as 0 points were scored on all descriptors.
2. The disputed descriptors are to a large extent outlined on the letter supporting Mr X’s application for his MR (**pp75-77 of the bundle**). The author of that letter, Ms Y, is a ……. by profession. She is also a former schoolteacher and taught secondary age children with special needs. She has first-hand experience of mental health problems.
   1. It is strongly arguable in the light of the above that in the context of Descriptor 9 (Engaging with People Face to Face) Ms Y is providing social support rather than mere prompting. (I will discuss this further at [21]-[21.1] below)
   2. I broadly concur with Ms Y’s observations re the Descriptors that are satisfied but I suggest that she may not have been clear enough in places and that she may have misunderstood some of the Descriptors.
   3. It seems to me that neither Mb X nor Ms Y are aware of the various aids and appliances that are available such as devices that effectively clamp vegetables like potatoes so as to enable the person to peel using only one hand. (I was not aware of such devices myself until a disability qualified member of a Tribunal brought them to my attention)
   4. Mr X’s PIP2 form might not be completely accurate in the sense that it may well be that he could complete certain daily living activities with the appropriate aids or appliances rather than assistance from another person, but I am reminded that the test is whether something may be reasonably required so as to enable the task to be carried out to an acceptable standard
   5. It is clear that Mr X is unable to carry out a number of tasks in the PIP assessment to an acceptable standard if he is completely unaided. Any perceived inadequacies or inconsistencies in Mr X’s PIP2 form should consequently not be held against him and will not be fatal to his case. I rely on CIB/1442/1996 where Mr Commissioner (as then was) Howell held at [15]-16]

15. I would emphasise that in incapacity benefit cases just as much as in other appeals coming before tribunals under the Social Security Acts, the function of the tribunal is an inquisitorial one, whose object is the ascertainment of the claimant's true entitlement and the determination of all relevant questions whether or not these have been formally put in issue before them. In the present case there was at least some cause for further question about whether the descriptors picked by the adjudication officer truly reflected the extent of the claimant's disability in view of the state of the medical evidence by the time the matter came before the tribunal at the hearing. I do not think that in all cases the tribunal should regard the scope of their enquiries as circumscribed by the boxes claimants may or may not have ticked at an earlier stage on the long and very complicated forms they are now required to fill out. That the form apparently did cause this claimant some confusion is evident from the fact that she ticked two descriptor boxes against "bending and kneeling" on page 11, one of which would have given her 15 points in its own right and the other only 3. In my judgment, the tribunal should have gone further into this question (on which the condition of the claimant's knees, shoulder and lower back was of course of crucial importance) rather than simply recording the lower scoring descriptor as "agreed" as they did on page 57.

16. By the same token, although on page 13 she had only ticked the box that indicated she had difficulty with her left arm, the comments she added about her difficulties with lifting should in my view have alerted the tribunal to the possibility that she might have equal difficulty with lifting potatoes or other things with either arm, in view of the pull this would impose on her shoulder. And although on page 8 she had ticked only the box that indicated she could not stand without having to move around for more than 30 minutes, her comment about pain in the back and knees coupled with the medical and other evidence that emerged later should in my view have alerted the tribunal to the possibility that this was a claimant who really needed to have a sit down after standing in one place for 30 minutes, rather than just to be allowed to move around, so that the other box with '30 minutes' printed against it less than 2 centimetres away on the same page of the form was the one she really should have ticked and gave a more accurate description of her condition. Similarly if only the 3 point descriptor was being awarded to the claimant for walking as the tribunal did, a proper consideration of her case should in my judgment have included whether her difficulties with her knees and back made a higher scoring descriptor applicable to her under the 'walking up and down stairs' activity, with which her original form on page 10 had indicated she had difficulty although no specific descriptor box had been ticked

* 1. I therefore suggest that if appropriate aids or appliances are made available to Mr X it is the case that (at least) the following Descriptors are met

Daily Living

Descriptor 1(b) 2 points

Descriptor 4(b) 2 points

Descriptor 6(b) 2 points

Descriptor 9(c) 4 points

Mobility

Descriptor 1(d) 10 points

Descriptor 2(b) 4 points

1. 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 Mr X’s ESA award). She 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.
2. The Respondent has not addressed the issues outlined by Ms Y in the application for MR as discussed above, nor has she addressed the issues outlined in Mr X’s 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 F of the Response)**

Although Mr X 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…..

5.1 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.

5.2 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

5.3 I have attached a copy of a Tribunal Decision Notice which shows that the Tribunal hearting Mr X’s ESA case on 24 November 2017 and I ask this Tribunal to note that 15 points were awarded on Descriptor 17(b) and 9 points on Descriptor 1 (c).

5.4 I will concede that reference in Mr X’s notice of appeal to being in the Support Group was an error and it is the case that he in in the Work-Related Activity Group.

5.5 Mr X informs me that his work-related activity is limited to telephone consultations and he has not been required to attend group meetings

5.6 I submit that the points awarded by the Tribunal in Mr X’s ESA case are relevant. The Tribunal’s decision was not challenged by the Respondent, and I suggest that the decision supports my submission that Daily Living Descriptor 9(c) and Mobility Descriptor 2 (b) are net in the present case

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 F of the Response**.

The Health Professional is an independent trained disability analyst and assessed Mr X’ss 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 Mr X who gave a full account of a typical day

I consider the Health Professional’s report is objective and accurately reflects Mr X’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(4) page E 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

6.3 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.

7.1 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.

7.2 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).

7.3 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

7.4 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 (**p49 of the bundle**) that Mr X was” well nourished””

8.1 The HCP has not been helpful because she did not measure Mr X’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 Mr X’s shoulder abduction (170 degrees). I simply ask whether the HCP used a protractor to measure the angle of Mr X’s shoulder abduction but on the other hand did not have a set of scales or a tape measure to measure Mr X’s waist or had the means to measure Mr X’s height.
  2. It is arguable that HCP’s should not be using vague terminology such as “well nourished “without defining what is meant by such terms
  3. Mr X is 5’10” (177.8cm) tall and weighs 9st (57.27Kg) His Body Mass Index (BMI) is therefore 18.1Kg/m2 Mr X is underweight according to the World Health Organisation (WHO)’s criteria (A person of Mr X’s height who was only 1.9 Kg less than Mr X (*i.e who weighed no more than 55.37Kg*) may well meet the criteria to be treated for anorexia
  4. The HCP has clearly grossly over estimated Mr X’s weight
  5. **I suggest that this gross inaccuracy undermines the credibility of the whole report and that** (**contrary to what the Respondent asserts at S4(5) page E of the Response where she asserts that “***There are no clinical findings and medical opinion to case doubt on the findings already accepted in the decision under appeal”* ) **a couple of simple measurements cast grave doubt on those findings**

1. I also note at this point that Mr X is a regular user of cannabis. He has stated that he uses it to relieve pain, but there is some evidence to suggest that he may have developed a level of dependence on the drug. I discuss this further at [15]-[18.2] below, but for the moment I focus on the fact that cannabis is an appetite stimulant and users often describe “getting the munchies” after taking it.

9.1 Mr X remains underweight despite this and I suggest this supports what he reports in his PIP2 at p12 of the bundle, although I will concede that no points might be awarded on Descriptor 2 on the basis of the PIP2 because Mr X indicates that he may in fact not need prompting to eat most days

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)

10.1 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 remarks. 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.”*

12.1 I suggest that if the above authorities are followed, the remarks by the Respondent (**S4(7)of the Response Page F**) that “*The Health Care Professional considered Mr X’s abilities on the majority of days rather than exacerbations in his 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 [13] 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(5) page D of the Response**) that there was “no evidence of pain throughout the assessment” and also that “Mr X is not prescribed any pain medication”. He is “not under a specialist for his mental health”
   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 Mr X when she made them and Ms Y ( who was present at the assessment) will also confirm that 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 over estimation of Mr X’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 remined 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 Mr X’s daily living and his mobility and I ask the Tribunal to consider it in the light of the PHE report and the authorities I have cited.**

1. The HCP reports that Mr X takes no prescribed pain relief but Mr X states that he uses cannabis for pain relief. Mr X is reported to say that it helps
   1. The use of cannabis for pain relief is to say the least controversial and in Mr X’s case I will concede that it is illegal.
   2. I have nevertheless attached a copy of a scientific paper (*Whiting et al. Cannabinoids for Medical Use A Systematic Review and Meta-analysis Journal of the American Medical Association JAMA.2015;313(24):2456-2473.* ) I can only say that whilst it must be conceded that the controversy continues, there is scientific evidence that cannabis can be an effective painkiller.
2. Ms Y notes (**p76 of the bundle**) that Mr X uses both cannabis and alcohol to cope with social situations and that Mr X ’s GP is aware of his “daily use of cannabis and alcohol”
3. The (long term) daily use of psychoactive drugs such as prescribed tranquilisers, alcohol, or cannabis can (just as with prescribed painkillers) lead to dependency.
4. It is not the role of this Tribunal to make a medical diagnosis as to whether or not Mr X has a drug dependency (*whether the drug in question is cannabis or* *alcoho*l), but it is clear that Mr X’s “ self-medication “ has caused him problems (Cf Ms Y’s reference to the concerns of Mr X’s GP and the fact that Mr X has been refused entry onto public transport on account of his excess alcohol consumption – **p76 of the bundle** ).
   1. I am also nevertheless reminded of what the Tribunal of Commissioners held in R (DLA )6/06. The Commissioners held (allowing the appeal) that: *(any emphasis is mine*)

1. physical symptoms or manifestations flowing from alcohol dependence alone do not result from an identifiable physical cause and in the light of Harrison and CDLA/2879/2004 (now reported as R(DLA) 4/06), it followed that a claimant is not entitled to higher rate mobility component if the only disability on which his claim is based flows from only such a cause (paragraph 19);

2. if a separate medical condition arises from the excessive consumption of alcohol, then any disabling manifestations of such a condition can be taken into account in assessing entitlement to the care component and the lower rate of the mobility component of DLA, whether or not the ingestion is related to alcohol dependence (paragraphs 21 to 22);

3. the transient and immediate effects consequent upon a person choosing to consume too much alcohol are not to be taken into account in determining entitlement to DLA because a claimant does not require the help contemplated by the legislation if he or she can reasonably be expected to avoid the need for attention or supervision by controlling the consumption of alcohol (paragraphs 23 to 25);

4. alcohol dependency is a medical condition, not a disability, but there is a direct causal link between dependence on alcohol and intoxication (paragraphs 28 to 30);

5. **the diagnostic criteria for dependence show that it is inappropriate to think in absolute terms of choice or uncontrollable addiction; it is more helpful to think in terms of the degree of self-control that is realistically attainable in the light of all of the circumstances, including the claimant’s history and steps that are available to him to address his dependence (paragraphs 32 and 33);**

6. a person who cannot realistically stop drinking to excess because of a medical condition and cannot function properly as a result can reasonably be said both to be suffering from disablement and to require any attention, supervision or other help contemplated by the legislation that is necessary as a consequence of his drinking and so there is no reason why the effects of being intoxicated should not be taken into account in determining his entitlement to the care component of DLA (paragraph 33);

7. there is also no reason why the possibility of the claimant’s taking advantage of professional assistance to control his alcohol consumption should not be taken into account (paragraph 36);

8. the tribunal in this case was wrong simply to exclude from all consideration the effects of the claimant being drunk (paragraph 43).

* 1. There can be no doubt following the decision of Judge Hemmingway in SD v SSWP (PIP) [2017] UKUT 310 (AAC) that the principles outlined by the Tribunal of Commissioners in R(DLA)6/06 apply equally in the ESA and PIP context and apply whether the dependency is on alcohol, street drugs or prescription drugs.
  2. The Tribunal will, in the light of the above, need to consider whether or not Mr X may be dependant on cannabis and/or alcohol and whether this may exacerbate his existing mental health condtions to the extent that the relevant Descriptors are met.

1. The Respondent **(S4(5) page E of the Response**) states:
   1. The 3JP’s decision in MH was issued (as conceded by the Respondent) on 28 November 2016. MH therefore precedes the present decision under appeal before this Tribunal by over 2 years
   2. I think it is necessary to set out the historical background to the Respondent’s statement
   3. The Respondent did not seek to appeal MH but instead decided to amend the Regulations from 8 March 2017 in order to reverse the effect of MH
   4. Her action was challenged in the High Court (RF [2017] EWHC 3375 (Admin)). Judgement was issued on 21 December 2017 and the amended Regulations were consequently quashed
   5. The Respondent decided not to appeal RF.
   6. I can see no reason why the Respondent should see fit to look at Mr X’s case again because of MH given that she chose not to appeal RF over a year before Mr X’s case was assessed. It seems to me that the Respondent’s reference to MH is yet another stock paragraph that has been copied and pasted into the Response and I suggest that this indicates that the Response when taken as a whole is not a serious attempt to answer the points of dispute raised in this appeal.
2. The Tribunal is obviously bound by MH. 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.
3. 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 Mr X requires social support in order to engage with other people

1. The Respondent **(S4(5) page D of the Response**) makes much of the fact that Mr X is not under a specialist for his mental health

22.1 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)

22.2 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.

22.3 The Respondent’s conclusions that Mr X 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. I therefore ask the Tribunal to allow the appeal for the reasons outlined above.



For the Appellant

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| Attachments |
| Copy of Tribunal Decision Notice re ESA 24 November 2017 |
| Whiting et al. Cannabinoids for Medical Use A Systematic Review and Meta-analysis Journal of the American Medical Association JAMA.2015;313(24):2456-2473. |