R(DLA) 10/02

Mrs. L. T. Parker **CDLA/3908/2000**
6.9.01

Disablement – care component - whether there must be a free-standing finding of severe disablement

Care component – meaning of "continual supervision"

Care component – refusal of medical treatment – whether care needs reasonably required

The claimant had been in receipt of the highest rate care component and lower rate mobility component of disability living allowance. On renewal, the award of the care component was reduced to the lowest rate for attention during the day. That decision was reviewed but not revised by the adjudication officer. An appeal tribunal upheld the adjudication officer's decision. The claimant appealed to the Commissioner on a number of grounds which were considered at an oral hearing. The appeal was supported by the Secretary of State.

Held, allowing the appeal, that:

1. the decision under appeal was an "any ground" review under section 30(1) of the Social Security Administration Act 1992 and although it fell to be treated, under transitional provisions, as a decision of the Secretary of State under section 8(1)(a) or (c) of the Social Security Act 1998, the tribunal's jurisdiction was to consider the merits of that decision and, if necessary, correct it, having regard to the powers available to the adjudication officer when he made it;

2. there is no free-standing need for severe disablement in section 72 of the Social Security Contributions and Benefits Act 1992. There has to be a physical or mental disablement which meets the statutory criteria. The severity of the disablement is determined by the care needs which arise and not by reference to the general nature of the disablement;

3. the tribunal had erred by construing the words "continual supervision" in section 72 as equating to "uninterrupted supervision". "Continuous" meant "uninterrupted" whereas the proper meaning of "continual" was "frequently recurring";

4. care needs must be reasonably required and, in certain circumstances, an unreasonable refusal of help from medical services which could eliminate or reduce the care needs, could result in these needs not being "reasonably required".

DECISION OF THE SOCIAL SECURITY COMMISSIONER

1. The decision of the Carlisle appeal tribunal (the tribunal) held on 23 February 2000 is erroneous in point of law. Accordingly, I set it aside and remit the case for rehearing by a differently constituted tribunal in accordance with directions given below.

Background

2. The claimant's date of birth is 6 May 1958. She was in receipt of highest rate care component and lower rate mobility component of disability living allowance (DLA) from 3 March 1997 to 2 September 1999. That award followed a report by an examining medical practitioner (EMP1) on 28 July 1997 in which EMP1 listed the main conditions causing her disability as anxiety, depression, bowel problem,

agoraphobia and arthritis. EMP1 considered she could cope independently with incontinence of faeces but recorded her statement that 5 years earlier she had been admitted to hospital with suicidal thoughts and, more recently, had smashed pictures resulting in the police being called and had hit her own face sufficiently to cause a fracture. The award made by an adjudication officer (AO) on 20 August 1997 was expressly founded on the claimant's requirement for "guidance of another person whilst out of doors and she required supervision during the day and watching over at night to prevent substantial danger".

3. At issue in this appeal is the renewal claim for the period beginning 3 September 1999. In the renewal claim pack of 7 April 1999, the main complaint is of asserted problems caused by irritable bowel and her difficulty coping alone with the consequences of this, or with certain daily activities such as getting in and out of bed and washing and dressing, because of panic attacks. No information was given on any attempt at self injury or suicidal thoughts or damage to property.

4. On 6 May 1999, an AO again awarded lower rate mobility component DLA but reduced the care component to lowest rate for day attention needs, the award to run from 3 September 1999 to 2 September 2000 (both dates included). The claimant sought review on the ground that she needed care both day and night. She was then seen by a second examining medical practitioner (EMP2) on 7 July 1999. Her account of her difficulties to EMP2 was very similar to that in the renewal claim pack. EMP2 recorded:-

> "There is little objective evidence to corroborate the degree of debility claimed due to physical factors. There is good evidence on history today of severe anxiety depression (sic) with phobic anxiety features which seems to the examiner to be the primary source of incapacity".

5. In addition, EMP2 accepted agoraphobia, intermittent asthma, irritable bowel syndrome and arthritis in hands, knees and shoulders. All limb functions were slightly impaired due, in EMP2's opinion, to subjective complaints of weakness and pain. The irritable bowel syndrome led to bowel incontinence by day and night but "in examiner's opinion the customer could self care but doesn't because of psychiatric features". This conclusion led EMP2 to tick "Yes" to the question "Can the person cope independently with their incontinence problems?".

6. EMP2 thought that her psychiatric condition made it unlikely she would be able to go out and purchase food for her meals and, for that reason, she was not capable of maintaining reasonable standards of personal hygiene and nutrition. She had faints lasting for a few seconds following panic attacks. There was no evidence that she was subject to inflicting self injury or attempting suicide. EMP2's overall conclusion was of a claimant:-

> "…obviously debilitated by her psychiatric condition.
>
> I did not get the impression that the customer was trying to mislead or dissemble but the only reasonable and acceptable basis for her contention that she needs so much help and care seems to be her psychiatric illness and the effect it has upon her.

> It seems unlikely that her irritable bowel complaint would lead to incapacitating weakness even given her frequent bowel motions.
>
> The objective evidence of arthritis/asthma is not consistent with significant debility.
>
> I am of the opinion that this lady's perception of her care needs has a psychiatric basis and is in itself genuine but not founded on physical disability".

7. An AO second tier review decision on 25 August 1999 made no alteration to the renewal award and the claimant therefore appealed to a tribunal on 14 October 1999 stating that she required "attention and watching over throughout the day and sometimes at night".

Before the tribunal

8. The claimant has been represented throughout the proceedings by Mrs. Doggart, initially a Resource Advice Worker with the Carlisle Benefits Advice Centre and now Information Officer for the Disability Association of Carlisle and Eden. Mrs. Doggart put in a substantial submission at the tribunal hearing on the claimant's behalf (the tribunal submission).

9. The tribunal submission asserted continuing suicidal thoughts, bouts of self harm and attacks on people and property due to depression and unpredictable panic attacks which also cause self neglect and lack of motivation to attend to her personal care needs. In particular, it is alleged she is unable to change her clothes and bathe herself after her daily episodes of bowel incontinence. She has dizziness, confusion and blackouts associated with her panic attacks which lead to falls as detailed in her renewal claim pack and to EMP2. (EMP2 accepted falls but thought she could sit down if legs felt like turning to jelly).

10. The tribunal submission then points to the various statements of opinion by EMP2 that suggest a psychiatric basis for her problems. It is argued that her care needs do not require a physical causation as a specific mental health condition suffices.

11. A letter from the claimant's general practitioner (GP) dated 9 February 2000 was lodged in support of the appeal. According to the GP, the claimant has:-

> "… had significant psychiatric problems in the past with nasty bouts of depression. Because of her frequent episodes of incontinence and diarrhoea she does need fairly regular help with her bowels. The problem certainly makes going any distance difficult and obviously she needs to be near a toilet all the time."

12. The claimant attended the tribunal hearing accompanied by Mrs. Doggart. A presenting officer was also in attendance. The Chairman kept a lengthy record of proceedings.

Tribunal decision

13. The tribunal unanimously confirmed the AO decision under appeal to it.

14. In its full statement, the tribunal narrates the history of the claim. In this narration, it notes that "she does not see anyone in connection with her mental state and had refused the offer of a referral from her GP" and that "in her claim pack she indicated that she had night needs 5-6 times per night, 7 nights a week to help her due to the irritable bowel syndrome".

15. On the merits, the tribunal reasons as follows:-

> "There is no evidence before us today to suggest that the award of lower rate mobility be amended. The Benefits Agency has not disputed this and will doubtless look at it carefully when that award comes up for renewal. We therefore confirm that it should continue until it expires in the normal course of events.
>
> We went on to consider the question of care. To qualify for the highest night-time rate the claimant had to show she needed prolonged or repeated attention from another person in connection with bodily functions, or needed another person to be awake for a prolonged period or at frequent intervals to watch over them in order to avoid substantial danger to themselves – Section 72(1)(c)(i).
>
> We are satisfied bearing in mind the clinical examination of the claimant by the EMP, whose findings we adopt, that there are no night needs. The claimant indicated considerable needs in her reclaim pack, but told the EMP she could change the bed covers and get to the toilet if she felt strong enough. She told us today she could sometimes clean up. Then she told us her friend came over every night to clean up. Yet she does not use incontinence pads and the EMP made no referenced [sic] to large amounts of wet or drying bedding everywhere in the house and nor did he mention any smell, which we consider would have been inevitable if the claimant were to be believed. We have regarded much of the claimant's evidence today as self contradictory and we consider that whilst there are episodes where she does need help from time to time she does not require repeated or prolonged sessions at night. We do not believe that she lies in her own excrement 5-6 times a night, 7 nights a week. Her GP refers to having had psychiatric problems 'in the past' and nasty bouts of depression but neither he nor the claimant provide any evidence of the 'severe physical or mental disablement' which is the prerequisite of entitlement to DLA. We also consider that her mental state could be helped if she were to accept help as offered and it is unreasonable to provide funds for someone who refuses help from medical services.
>
> Her asthma and arthritis pose a slight impairment to her but as the EMP says do not impinge on her ability to care for herself if she chose to do so.
>
> To qualify for the middle rate the claimant had to show she needed frequent attention from another person in connection with bodily functions or needed continual supervision from another person to avoid substantial danger to

themselves or others. Her GP suggests she needs 'fairly regular help' and needs to be near a toilet but this does not amount to frequent attention in our view, given that she can and does help herself on occasion. Frequent has been held to mean several times, happening at short intervals an (sic) continual means uninterrupted. This claimant indicated various problems with her care in her claim pack. The EMP carried out a full examination of the claimant and noted some slight impairment of her limbs. He also noted that she was depressed and was taking Lustral.

It is clear the claimant's estimate of her difficulties vary considerably with the opinion of the EMP. They vary with what she told the EMP. He having talked and examined felt that whilst she had some problems, would be aware of common dangers, unlikely to self harm and needed care only to get someone to go out for food for her. We do not consider that these needs qualify her for the middle rate, she does not require frequent attention, as she can carry out virtually all her bodily functions without help although she may do these things slower than other people. We have no evidence that she would come to harm if left unsupervised continually. To qualify for the lowest care rate the claimant had to show that she would be unable to prepare a cooked main meal for herself only, and if the ingredients were available, or needed attention for a significant portion of the day whether during one period or more in connection with bodily functions – Section 72(1)(a)(i) and (ii).

We confirm the award of lowest rate care for the duration. However bearing in mind the EMP report and the fact that attention required must be reasonably required, we have no doubt that this will be carefully looked at on renewal.

We have concluded that we can only rely on such parts of the claim pack and the evidence today which has been corroborated by medical evidence and applying this tot he [sic] components at issue we do not consider that the claimant fulfils the criteria to DLA as far as care is concerned."

Appeal to the Commissioner

16. The claimant appeals to the Commissioner, leave having been granted by a full-time Chairman. Several errors of law are contended. The functions of the AO have now been taken over by the Secretary of State. The Secretary of State supports the appeal. There have been 3 written submissions from the Secretary of State, a Commissioner's direction and finally an oral hearing. Standing the number of matters raised on the appellant's behalf and that the nature of the support by the Secretary of State has changed over the course of the proceedings, I concentrate on the arguments and issues raised at the hearing.

Oral Hearing

17. The case came before me for an oral hearing on 24 August 2001. As noted above, the claimant was represented by Mrs. Doggart. The Secretary of State was

represented by Mr. Bartos, Advocate, instructed by Miss Cairns, Solicitor, of the Office of the Solicitor to the Advocate General. I am grateful to both for their helpful submissions.

The Issues

The tribunal's powers

18. Mr. Bartos raised a preliminary point. The decision under appeal to the tribunal is an "any ground" review under Section 30(1) of the Social Security Administration Act 1992. Review has been abolished by the Social Security Act 1998 to be replaced by revision and supersession. These changes take effect for DLA purposes from 18 October 1999 under the Social Security Act 1998 (Commencement No. 11, and Savings and Consequential and Transitional Provisions) Order 1999. Paragraph 4(1) of Schedule 16 to the Order provides that decisions of AOs made before 18 October 1999 are treated on or after that date as decisions of the Secretary of State under Section 8(1)(a) or (c) of the Social Security Act 1998.

19. The appeal to the tribunal was lodged 14 October 1999 and heard by the tribunal early the next year. Mr. Bartos queried precisely what powers the tribunal would exercise given these major changes in the procedure for DLA decision making.

20. I follow the approach of other Commissioners in CI/1327/1998 and CIB/213/1999 (starred 59/99). In the former, the Commissioner points out that the transitional provisions provide a procedural mechanism to keep existing adjudication going by "re-basing" decisions in the new law, through treating them as decisions of the Secretary of State after the old law ceased to have effect. In the latter, the Commissioner put it this way with respect to the comparable paragraph 4 in the Commencement Order applying the new scheme to incapacity benefit (see paragraph 40):-

> "Paragraph 4(1) of Schedule 14 to the No. 9 Commencement Order provides that decisions of adjudication officers made before 6 September 1999 are treated on or after that date as decisions of the Secretary of State under section 8(1)(a) or (c) of the Social Security Act 1998. This brings those decisions into the new adjudication scheme. It allows them to be revised or superseded by the Secretary of State and it allows appeals to be made against those decisions to the new Appeal Tribunal. It may create the impression that the tribunal at the rehearing must apply the revision and supersession rules rather than the review rules. However that it is not its effect. As Mr Cooper argued, that provision does not rewrite history."

21. Review powers have gone and no first exercise of such powers could be undertaken from 18 October 1999. But the tribunal stands in the shoes of the decision maker and exercises the powers available to that officer at that time. Therefore, the tribunal's jurisdiction was to consider the merits of the AO's "any ground" review and, if necessary, correct its exercise. The same jurisdiction falls to the new tribunal on rehearing.

Adequacy of facts and reasons

22. Mr. Bartos concedes the claimant's argument that the tribunal was wrong to rely on the lack of any mention by EMP2 of the smell or large amounts of bedding in the house. It is said that this is sheer speculation and an inadequate reason for disbelieving the claimant about the extent of her nocturnal incontinence. I disagree. It seems common sense that these conditions might be expected if the claimant has the incontinence described. It seems equally common sense that a doctor could be expected to comment on such conditions, if they were there. An error of law lay, however, in the tribunal's failure to put its inferences to the claimant so that she had the opportunity to comment.

23. The claimant argues there was no evidence to support a finding that she said she lay in her own excrement 5-6 times a night, 7 nights a week. The tribunal relied on the inconsistency of this with other statements made. But I accept the Secretary of State's point that such a statement was made in the renewal claim pack. Similarly, with respect to the complaint that the tribunal wrongly found the claimant had refused psychiatric help, the record of proceedings is to the contrary. Mrs. Doggart says that more was said at the hearing than is disclosed on the record of proceedings. However, Mrs. Doggart accepts that referral was discussed by the GP and the claimant said she could not accept a referral if made. I am unable to see any real difference between refusing referral and refusing an offer to refer. I find no error of law here.

24. Mr. Bartos submits, and I accept, that the tribunal did make some findings on the claimant's mental state. Error of law lay, however, in their failure to address the comments of EMP2 about her mental health, particularly the suggestion that she could cope physically but there were psychiatric problems. This possible EMP support for the claimant's case was raised in the tribunal submission.

25. I do not, however, agree with either party that the tribunal distorted the evidence of EMP2 by maintaining that the EMP said she could care for herself if she chose to. What the tribunal actually said was that her **asthma and arthritis** do not impinge on her self-care ability. Having regard to the whole tenor of EMP2's report, this was a reasonable conclusion and not a distortion so far as the effects of asthma and arthritis are concerned.

26. But contrary to Mr. Bartos' submission today, I hold the tribunal was in further error of law by failing properly to address the issue of self harm or injury to others or to property. If little was said about this by the claimant at the hearing (which is suggested by the record of proceedings although Mrs. Doggart disputes its accuracy), not only were problems detailed in the tribunal submission but the previous award of highest rate care was based on supervision to prevent substantial danger. There is no presumption on renewal that an award will continue. However, the necessity for adequate facts and reasons means that a tribunal must carefully explain why it is not satisfied that from the relevant date the claimant qualifies under formerly accepted criteria. It was incorrect that the tribunal had no evidence that she would come to harm if left unsupervised. It was entitled to weigh such evidence and, if appropriate, find it insufficient to discharge the onus of proof which lies upon the

claimant (and not, as seems to be suggested in her appeal, on the AO) to make out her case. But it had a duty to explain why it rejected her evidence.

27. Finally, under this heading, Mr. Bartos concedes an error of law which I accept, that the tribunal erred in, on the one hand finding that the claimant failed DLA care criteria and, on the other, confirming the award of lowest rate care component already made. This seeming contradiction is not explained.

The correct application of the statutory criteria: DLA care component

28. So far as relevant, these are set out as follows in section 72 of the Social Security Contributions and Benefits Act 1992:-

> "72.-(1) Subject to the provisions of this Act, a person shall be entitled to the care component of a disability living allowance for any period throughout which-
>
> (a) he is so severely disabled physically or mentally that-
>
> (i) he requires in connection with his bodily functions attention from another person for a significant portion of the day (whether during a single period or a number of periods); or
>
> (ii) he cannot prepare a cooked main meal for himself if he has the ingredients; or
>
> (b) he is so severely disabled physically or mentally that, by day, he requires from another person-
>
> (i) frequent attention throughout the day in connection with his bodily functions; or
>
> (ii) continual supervision throughout the day in order to avoid substantial danger to himself or others; or
>
> (c) he is so severely disabled physically or mentally that, at night,-
>
> (i) he requires from another person prolonged or repeated attention in connection with his bodily functions; or
>
> (ii) in order to avoid substantial danger to himself or others he requires another person to be awake for a prolonged period or at frequent intervals for the purpose of watching over him."

<u>So severely disabled physically or mentally that</u>

29. I accept Mr. Bartos' submission that the tribunal erred in stating that a prerequisite of entitlement to DLA is a "severe physical or mental disablement". There is no **free-standing** need for a severe disablement. There has to be a physical or mental disablement resulting in care requirements fitting the statutory criteria. But if such needs exist, and are so caused, this is sufficient. From the wording of the phrase, the severity of the disablement is determined by reference to the care needs which arise and is not to be considered by reference to the general nature of that disablement divorced from its actual consequences with respect to the claimant's need for attendance.

30. The parties accept, as do I, that findings must be made about whether or not a physical or mental disability exists. Moreover, in order to so find, the tribunal must be satisfied that the claimant has some condition that is capable of being medically accepted as such, even if there is no exact diagnosis. The suggestion by the Commissioner in CDLA/1659/97 (starred 17/99) that a medical acceptance of disablement is not essential and reliance may solely be based on the actual behaviour and functioning of the claimant, has been disapproved in several Commissioners' decisions.

31. On behalf of the Secretary of State, Mr. Bartos doubts whether the report of EMP2 provides evidence of any mental disability. This is on the basis that anxiety, the diagnosis listed by EMP2, must reach certain clinical criteria if it is to constitute mental health disablement. In my opinion, it is a matter of fact and degree whether the evidence before the tribunal demonstrates a medically accepted mental disability. The tribunal is not bound to accept a diagnosis given by an EMP or GP as necessarily amounting to a mental disability in the claimant's case if, in their view, the totality of evidence shows the contrary. However, for a condition to be included in a list of diagnosed conditions, as "anxiety" is in the report of EMP2, provides evidence from which a tribunal could reasonably infer that such a disability exists. Moreover, in this case, the EMP has referred to psychiatric features and also to the existence of "severe anxiety depression with phobic anxiety features".

Attention in connection with bodily functions

32. As Mr. Bartos also points out, the tribunal failed to identify the bodily function or functions in issue. They are presumably defecation and movement of the limbs.

33. A further error of law argued by Mr. Bartos, which I accept, is that the tribunal mis-stated the middle rate care test with respect to "frequent attention" in omitting the important requirement of "throughout the day". (This also applies to their statement on supervision needs, which has the same qualification). "Throughout" means across the whole span of the day. Individual episodes may only be brief but it is the frequency and pattern of the attention which is important. Only if the claimant reasonably requires attention with her bodily functions, very often across the whole span of the day albeit each episode may be short, will she qualify for middle rate care through the attention route.

Continual supervision and watching over

34. Mr. Bartos submits that the tribunal failed to address the issue of supervision. I do not accept this. The tribunal refers to the relevant test both by day and by night. However, I accept that its approach is inadequate and thereby erroneous in law.

35. I find error in the tribunal's equation of "continual" with "uninterrupted". In R(A) 1/73, the Chief Commissioner pointed out that "continual" is wider than "continuous", so that the condition may be satisfied even though the claimant may safely be left alone for short periods. In the ordinary meaning of the word, it is "continuous" which means uninterrupted, whereas "continual" means "frequently recurring" which is subtly different.

36. It has been suggested in this case that unless the claimant is motivated by others she is liable to neglect herself. Mrs. Doggart drew to my attention CSA/68/89 in which Commissioner Walker said:-

> " … I see no reason why encouragement, support, comfort and reassurance can never be supervision; they may not, if properly assessed, be so in a particular case. Much will depend upon the detail of what is involved and its effect, ie does it go to prevent or minimise the onset of depression or the likelihood of neglect and self-injury? If so then whether what is involved may be supervision is a matter of English usage, depending, as I have said, on the facts and the degree involved".

37. Mr. Bartos emphasised that the starting point must always be "substantial danger". Only if there is a real risk of substantial danger to the claimant if such support to prevent self neglect and injury is not provided on a continual basis, could the claimant succeed. This qualification is, I think, necessarily involved in Commissioner Walker's approach, which I follow. Encouragement, support, comfort and reassurance to prevent neglect or self-injury is **capable** of constituting supervision but there is the additional requirement that it must be reasonably required on a continual basis throughout the day in order to avoid substantial danger. Such danger is unlikely to arise with respect to self neglect because it is probable that encouragement to wash, dress and eat would be enough if provided for part of the day only. It may however be different with a claimant who makes suicide attempts or where there is evidence that without the support, mental health may deteriorate to that state.

The relevance of medical treatment

38. I directed argument to the tribunal's comment that:-

> "Her mental state could be helped if she were to accept help as offered and it is unreasonable to provide funds to someone who refuses help from medical services".

39. Mrs. Doggart submitted that treatment could only disqualify if it is definitely and immediately available to the claimant and is guaranteed to have such an immediate effect that the claimant's attention and/or supervision needs will be immediately reduced to no more than a negligible level. She suggested that the proper approach to the mere possibility of successful treatment is to make a suitable award, recognising current care needs, for a period that will give any treatment offered time to show its efficacy or otherwise.

40. She cited CSDLA/171/98 (starred 71/98). In that case, Commissioner Walker considered the question whether, if the claimant's alcoholism was treatable, that should be allowed for in the assessment. In paragraph 12 of his decision, Commissioner Walker said:-

> "I do not think that it is relevant for a tribunal to consider whether treatment properly undertaken might ameliorate a condition or wipe out any of the need

> for supervision, attention or ease any difficulty with walking. I think that it is for the tribunal to assess the matter free from any contentions about the possible effects of such medical treatment – R(M)1/95. If treatment is undertaken and has an effect then, so far as may be relevant, an award can be reviewed and, if necessary, revised".

41. In the Secretary of State's written response to the direction, it was submitted:-

> "That the claimant's apparent refusal to accept help from medical services has no bearing on her entitlement to DLA. The medical services are there, in the main, to provide treatment and not provide the sort of care considered in any award of DLA. I also submit there is no evidence that her mental health would improve if she were to accept help from medical services. It may be a manifestation of her mental illness that she refuses any help."

42. Mr. Bartos today adheres to the written submission from the Secretary of State with the addition that care needs must be **reasonably** required and, in certain circumstances, an unreasonable refusal of help from medical services which would eliminate or reduce the care needs, could result in such needs not being "reasonably required". Therefore, her refusal to accept help from medical services is not **as a matter of law** irrelevant in every case.

43. I accept Mr. Bartos' submission as correct. It is not what help is actually provided or what help the claimant would like to have which is determinative, but rather what help is reasonably required. Relevant factors in this evaluation include the nature and effects of the prospective medical treatment and the claimant's attitude to it. All the circumstances mentioned by Mrs. Doggart are clearly relevant to the former. Moreover it cannot be unreasonable, for example, for a claimant to refuse treatment with potentially serious consequences or invasive surgery.

44. With great respect to Commissioner Walker in CSDLA/171/98, R(M) 1/95 on which he relies is not directly in point. That case concerned mobility allowance and whether the claimant's refusal to have a colostomy was analogous to a refusal to use a prosthesis such as a walking stick. Commissioner Rice held that a claimant's capacity for walking had to be determined in the light of his existing condition and not in the light of a condition which might be improved if an operation is undertaken. There is thus no issue of "reasonable requirements". It also turned on whether "prosthesis or an artificial aid" could be construed as including surgery. It cast no light on whether the possible effects of medical treatment can ever be pertinent to the issue of what is reasonably required.

45. An analogy might be drawn with Regulation 18 of the Social Security (Incapacity for Work) (General) Regulations 1995. The claimant can be disqualified from incapacity benefit for up to 6 weeks if, *inter alia*, he fails without good cause to submit

> "… to medical or other treatment (excluding vaccination, inoculation or major surgery) recommended by a doctor with whom, or a hospital or similar institution with which, he is undergoing medical treatment and, which would be likely to render him capable of work".

46. No reasonable tribunal could adopt a radically different approach in deciding what needs are reasonably required for the purposes of DLA. So, for example, the claimant cannot be reasonably required to undergo vaccination or treatment which has been recommended by a doctor not involved in her patient care or treatment which would be unlikely to reduce her care needs to a sufficient extent. But other less extreme situations will arise. The claimant may consider proposed treatment has unpleasant side effects or (as suggested here) cause difficulties in her relationship with her children. It will all depend upon the circumstances whether the claimant's refusal of immediately available and helpful medical treatment has the result that her actual needs are not reasonably required.

47. Similarly, if the claimant's psychiatric condition is such that it causes her to shun helpful medical treatment, such refusal will not negate her actual requirements. This approach was endorsed by a Tribunal of Commissioners in R(A) 4/90 in which the claimant's bowel problem was arguably caused by her anxiety and agoraphobia leading to her over-dosing on laxatives despite medical warning not to do so. It was held that any resultant attention or supervision needs qualified, if the psychiatric condition was such that she no longer had any effective control over that aspect of her life.

Directions

48. My directions to the new tribunal are these:-

(a) Given the date of appeal to the tribunal in this case, matters are to be taken by the new tribunal only down to the date of the AO decision of 25 August 1999. Their powers remain those of an AO exercising an "any grounds" review of a renewal decision.

(b) Findings and reasons will be required on the following points:

- Whether there is a medically recognised physical or mental disablement giving rise to care needs

- If yes, what care needs are reasonably required as a result

- Is attention in connection with a bodily function required and if so, which bodily function or functions and does the pattern of reasonable requirements for attention in connection with the bodily function(s) fit the statutory criteria by day or night

- Does any medically recognised physical or mental disability cause a risk of substantial danger and, if yes, what

- Is supervision or watching over from another person reasonably required in order to reduce or avoid the risk of substantial danger and, if so, what is the pattern of any reasonably required supervision or watching over needs

- Whether by day (but not by night) any attention or supervision is "throughout the day"

- Continual supervision does not mean uninterrupted supervision – the question is "whether without substantial danger the disabled person could be by himself in a house at any rate for periods long enough to make any supervision that there was not continual" (R(A) 1/73)

- Has the claimant refused medical treatment in circumstances which mean that her needs are thereafter not reasonably required.

Summary

49. The AO decision under appeal is therefore returned to the new tribunal for a fresh decision on the merits. It is emphasised that there will be a complete rehearing on the basis of the evidence and arguments available to the new tribunal. My jurisdiction is limited to issues of law so my decision is no indication of the likely outcome of the rehearing.

Date: 6 September 2001

(Signed) L. T. PARKER
Commissioner