MJG/RPM

SUPPLEMENTARY BENEFITS ACT 1976

APPEAL FROM DECISION OF SUPPLEMENTARY BENEFIT APPEAL TRIBUNAL ON A QUESTION OF LAW

DECISION OF SOCIAL SECURITY COMMISSIONER

payment of Doctor's — need?'

808/1982

1. I allow the claimant's appeal against the decision of the supplementary benefit appeal tribunal dated 6 July 1982 as being erroneous in law. I set that decision aside and remit the case for re-hearing to a differently constituted tribunal: Supplementary Benefits Act 1976, section 15A and the Supplementary Benefit and Family Income Supplements (Appeals) Rules 1980 /S.I. 1980 No 605/ rules 7(2) and 10(8) (as amended by S.I. 1982 No 40).

2. The claimant is a retired man aged 68 and at the material time was receiving a supplementary pension. His wife and dependent son live with him in a council house. On 14 May 1982 he claimed a single payment to pay for the cost of a letter written by his doctor as a recommendation to the council that the claimant should be re-housed in a council bungalow on health grounds, the claimant having had open heart surgery in June 1979. The claimant has explained in his grounds of appeal to the Commissioner that the council house had no downstairs toilet and that, in spite of his protestations to the council that he foresaw difficulty in having to go up and down the steep straight stairs to use the toilet (which he has to do 12-20 times a day), the council insisted that the claimant should accept the house allocated to him and later apply for a bungalow on medical grounds. The doctor had apparently written to the claimant to say that the charge for the letter of recommendation for rehousing was £6.45. I do not know whether that sum had been paid by the claimant to the doctor by the time of the hearing before the local tribunal.

3. The supplementary benefit appeal tribunal at which the claimant was present, and presumably gave evidence, dismissed the claimant's appeal. Their record of the proceedings (Form LT 235) was defective in that under the head "Findings of Tribunal on questions of fact material to decision" the tribunal merely entered, "No new facts relevant to the decision". That was a breach of rule 7(2) of the above-cited Appeal Rules, which requires the tribunal to include in their written determination "a statement of the reasons for their determination and of their findings on material questions of fact".

Even if (as submitted by the benefit officer now concerned) the so-called findings of fact by the tribunal involved an adoption of the statement of facts put before it by the benefit officer, that would not constitute compliance with rule 7(2)(b). The tribunal must make its own independent findings of fact and express them on form LT 235. A failure to do so can lead to difficulties, as is exemplified by the fact that I do not know in this case whether or not the doctor's bill had been paid by the date of the hearing. That is relevant to the question of "need" - see below.

4. Moreover I do not know on what findings of fact the tribunal based their decision that regulation 30 of the Single Payments Regulations (see below) did not apply in that there was no "serious damage or serious risk to the health or safety of any member of the assessment unit" (regulation 30). The chairman's note of evidence simply reads,

> "In the absence of the benefit officer the clerk read the appeal to the benefit [sic] of the tribunal. The appellant explained the background to his reasons for removal, which was not relevant to the appeal".

I do not know why the benefit officer was not present at the hearing before the tribunal but I should have thought it undesirable that the clerk of the tribunal should read out the benefit officer's statement or in any way seem to present his case. Moreover the note of evidence is too brief and does not explain the nature of the statement made by the claimant in support of his appeal. The words "which was not relevant to the appeal" should not really be in a note of evidence as the words are a comment on the evidence, not a note of it. Nor would such evidence necessarily be irrelevant. In view of these matters and of the failure to make any proper findings of fact, I must hold the tribunal's decision to be erroneous in law and in accordance with the rule 10(8) of the Appeals Rules remit the case a differently constituted supplementary benefit appeal tribunal for re-hearing and decision in accordance with the directions in this decision. I do not consider that I can determine this case myself as in my view there needs to be applied to the case the provisions of regulation 30 of the Single Payments Regulations and for that purpose evidence is needed from the claimant and proper consideration of that evidence after it is given.

5. The benefit officer now concerned has made a detailed written submission to the Commissioner (dated 17 November 1982) in which he deals with the combined application of regulations 3 and 30 of the Supplementary Benefit (Single Payments) Regulations 1981 [S.I. 1981 No 1528] to the facts of this case. I will deal with those submissions shortly but first I should deal with a submission by the benefit officer that "this claim is in any event excluded from the provisions of the Act and regulations by section 1(3) of the Act" (paragraph 12).

6. Section 1(3) of the Supplementary Benefits Act 1976 provides as follows,

> "1(3) The requirements of any person to be taken into account for the purposes of this Act do not include any medical,

surgical, optical, aural or dental requirements; and regulations may provide that the requirements which by virtue of this subsection are not included in a person's requirements include or exclude prescribed requirements".

The benefit officer then argues that a doctor's letter, though of iteself not needed to cure or heal a sick person, could come within the phrase "medical requirements". However I do not consider that there is any need for me to consider the meaning of "medical requirements" because in my view section 1(3) of the 1976 Act has no application to single payments. Section 1(3) refers to "the requirements of any person to be taken into account for the purpose of this Act ...", i.e. the extent to which a person's resources are insufficient to meet his requirements (see section 1(1)) and therefore to entitle him to a supplementary pension or supplementary allowance. Section 1(3) does not apply to single payments, which are the subject of section 3 of the Act, the preliminary qualification for them being that a claimant should already be entitled to supplementary pension or allowance. There is a list in regulation 6 of the Single Payments Regulations of matters for which a single payment cannot be made but medical requirements are not in that list.

7. It remains to consider the combined application of regulations 3 and 30 of the Single Payments Regulations to this case. Regulation 3 (so far as it is material) provides as follows:-

"3(1) In these regulations 'single payment' means supplementary benefit payable by way of a single payment to meet an exceptional need in circumstances to which Parts II to VIII of these regulations apply.

(2) A single payment shall be made only where -

(a) there is a need for the item in question ..."

Regulation 30, so far as is material, provides,

"30(1) Where a claimant is entitled to a pension or allowance and he -

(a) claims a single payment for an exceptional need under any of the regulations in Parts II to VIII but fails to satisfy the conditions for that payment; or

(b) claims to have an exceptional need for which no provision for a single payment is made in any regulation in those parts,

a single payment to meet that exceptional need shall be made in his case if, in the opinion of a benefit officer, such a payment is the only means by which serious damage or serious risk to the health or safety of any member of the assessment unit may be prevented".

8. As to the question of "need" under regulation 3, the benefit officer submits (paragraph 9(ii)), "It has been established in this case that a need for the item in question - the fee charged by the claimant's doctor for supplying a letter recommending re-housing on medical grounds - existed and that the claimant satisfied regulation 3(2)(a)". However later in the submission (paragraph 13) the benefit officer submits, "... the doctor's letter had in this case already been provided when a claim for a single payment was made. Therefore, at that stage, the only need that could in any event arise was for payment of the debt to the doctor and not for the certificate itself".

9. It does seem that those two submissions are in some sense contradictory. In my judgment the item for which there was alleged to be a need was the letter from the claimant's doctor recommending re-housing on medical grounds. It is true that at the date of the tribunal hearing the claimant had obtained that letter but it would seem that he had not paid for it though that is not certain (see above). If in truth he had not paid for it out of some other funds then it would appear to me that it is arguable that the "need" for the doctor's letter still existed even though the claimant had obtained it on credit. The case is not necessarily the same as one where a claimant has already purchased an item e.g. by borrowing the money (compare reported Commissioner's Decision R(SB) 8/81). Moreover I understand that the definition of "need" is to be the subject of a decision of a Tribunal of Commissioners in the near future and the new supplementary benefit appeal tribunal that hears this case ought to enquire as to whether that decision has been promulgated, before arriving at a decision in this case.

10. On the question of whether there was shown to be "serious risk to the health or safety of any member of the assessment unit" the benefit officer submits,

> "In the claimant's submission it is his present home that gives rise to any serious risk to his health or safety. However, in my submission this is irrelevant to the need for which his claim is made and the tribunal was provided with no evidence to support a submission that the need to pay the doctor's fee would give rise to serious damage or serious risk to the claimant's health or safety. The claimant has the appropriately worded letter from his doctor and there has been no suggestion that the doctor might take such steps to obtain payment for his services as would adversely affect the health of one of his patients".

That submission of course depends on the view that the need was for payment of the fee for the doctor's letter and not for the letter itself but I have indicated above my doubts on that proposition.

If the truth is that the only need was to pay a debt to the doctor (cf. R/SB 8/81, paragraph 7) then the benefit officer's submission might well be correct but that matter must await the determination by the new tribunal of what the true need was.

(Signed) M J Goodman
Commissioner

Date: 17 January 1983

Commissioner's File: C.S.B. 808/1982
C SBO File: 791/81