SICKNESS BENEFIT

Absence of a claim—jurisdiction of the insurance officer.

Sickness benefit was paid from 27 November 1978 to 7 December 1978 although no medical evidence had been submitted in support and no claim had been made in respect of that period. Two girocheques were sent to the claimant respectively on 30 November 1978 and 7 December 1978 and each cheque stated on the face of it that it was in respect of sickness benefit for the period there specified. The insurance officer reviewed and revised his decisions awarding benefit and required repayment of the amount overpaid.

Held that:—

1. the insurance officer was without any authority whatsoever to make an award for the period in question (paragraph 4);

2. a decision given by an insurance officer without proper authority is nevertheless effective and binding until it is set aside (paragraph 6);

3 such a decision is capable of being reviewed and revised under section 104(1) of the Social Security Act 1975 (paragraph 6);

4. in the receipt of the benefit the claimant failed to exercise the appropriate standard of care and diligence and repayment is required (paragraph 11).

1. Our decision is as follows:

(i) each of the original decisions of the insurance officer awarding sickness benefit for the inclusive period from 27 November 1978 to 7 December 1978 should be reviewed and revised so that no such benefit is payable for that period, and

(ii) repayment of the benefit overpaid is required, the claimant not having throughout exercised due care and diligence to avoid such overpayment.

2. The claimant, a shipping manager, claimed sickness benefit for the inclusive period from 6 November 1978 to 25 November 1978. On 23 November 1978 a Form BF60B was sent to the claimant together with the relevant payment, informing him that, if he wished to continue to receive benefit, further medical evidence was required and warning that payment was being made on the understanding that throughout the period shown on the girocheque the claimant satisfied all the conditions for receiving benefit. In the event, on 30 November 1978 a final doctor's statement was received, advising the claimant to refrain from work until 27 November 1978. On 30 November 1978 benefit was paid in respect of the inclusive period from 24 November 1978 to 30 November 1978, and on 7 December 1978 further benefit was paid in respect of the inclusive period from 1 December 1978 to 7 December 1978. It is clear from this that benefit was paid for the period from 27 November 1978 to 7 December 1978, although no medical evidence had been submitted in support. More important for the purposes of this appeal, the claimant had not even made a claim in respect of that period.

3. When the insurance officer became aware of the position, he reviewed and revised each of his original decisions awarding sickness benefit for the inclusive period from 27 November 1978 to 7 December 1978 on the ground that such decisions were based on a mistake as to a material fact, and he issued a revised decision to the effect that benefit was not payable for this period because the claimant was not incapable of work by reason of some specific disease or bodily or mental disablement. Furthermore, he required repayment of the benefit overpaid, not being satisfied that the claimant had throughout used due care and diligence to avoid such overpayment. After an unsuccessful appeal to the local tribunal, the claimant lodged an appeal to the Commissioner, and in view of the legal issues involved and the conflict existing between different decisions of Commissioners, it was thought desirable that there should be an oral hearing, and that it should take place before a Tribunal of Commissioners. At that hearing the claimant did not appear and the insurance officer was represented by Mr D. James of the Solicitor's Office of the Department of Health and Social Security. We are indebted to Mr James for his submissions.

4. An insurance officer has jurisdiction to make a determination only when a claim or question is submitted to him under Section 98 of the Social Security Act 1975 ("the Act") (see Section 99 of the Act). As explained above, in the present case the claimant simply never made a claim for the period under appeal. It follows that the insurance officer was without any authority whatsoever to make an award for the period in question. Accordingly, his action could be described as a nullity, and this form of terminology has been used in past decisions of Commissioners. (See, for example, unreported decision CSS 3/76; decision on Commissioner's file CWS 10/74). However, this kind of language, if given too strict an interpretation, can be misleading because on no footing can such a decision be regarded as having no effect whatever. In other words, there can be no question of proceeding on the basis that nothing has happened. Such a

decision, albeit it has no legal support whatsoever, is still effective unless and until it is set aside on appeal or review. This conclusion was arrived at as long ago as 1963 in decision R(U) 3/63 where at paragraph 12 it was observed as follows:

> "..... the words 'void' and 'a nullity' and 'ultra vires' and similar expressions have been used of the tribunal's decision. In our judgment, whatever word is used, the true position is that, where a decision is liable to be set aside, it is in all the instances to which we shall refer a nullity only in the sense in which that word was used in *Craig v. Kanssen* [1943] 1 K.B. 256. It is not void or a nullity in the sense of being in law non-existent, even though no one takes any steps to have it set aside. The consequences of holding it void in that sense would be so startling that we are satisfied that none of these expressions can have been used in that sense (cf paragraphs 19 to 22 of Decision R(I) 9/63)".

5. This approach has in effect recently been confirmed by the House of Lords in *London & Clydeside Estates Ltd v. Aberdeen District Council and Another* [1980] 1 W.L.R. 182 where with reference to a certificate issued by the local authority which did not contain a recital of the recipient's right of Appeal Lord Hailsham L.C. observed at p. 187 (A – B) as follows:

> "If the requirement that the subject should be informed of his legal rights was mandatory, what follows? The respondents attempted, as I thought, at one time to argue that it thereupon became a nullity, and that therefore a decree of reduction was inappropriate because there was nothing upon which it could operate. But I do not accept this argument. The certificate was effective until it was struck down by a competent authority (cf *Brayhead (Ascot) Ltd v. Berkshire County Council* [1962] 1 Q.B. 229; *James v. Minister of Housing and Local Government* [1968] A.C. 409)".

The Lord Chancellor went on to warn against the misleading effect of terms such as "void" and "voidable" commenting at p. 190 (A – B):

> "..... though language like ..... 'void', 'voidable', 'nullity' and so forth may be helpful in argument, it may be misleading in effect if relied on to show that the courts, in deciding the consequences of a defect in the exercise of power, are necessarily bound to fit the facts of a particular case and a developing chain of events into rigid legal categories or to stretch or cramp them on a bed of Procrustes invented by lawyers for the purposes of convenient exposition".

Previously (at p. 189 E) the Lord Chancellor had said:

> "..... I wish to say that I am not at all clear that the language itself may not be misleading in so far as it may be supposed to present a court with the necessity of fitting a particular case into one or other of mutually exclusive and starkly contrasted compartments, compartments which in some cases (e.g. 'void' and 'voidable') are borrowed from the language of contract or status, and are not easily fitted to the requirement of administrative law".

6. Accordingly in our judgment, a decision given by an insurance officer without proper authority is (at any rate where, as in this case, the want of jurisdiction is not apparent on the face of the decision) nevertheless effective and binding until it is set aside. *A fortiori* it is susceptible of an appeal. The appealability of a vitiated decision was considered by Lord Wilberforce in the Privy Council case of *Calvin v. Carr* [1979] 2 W.L.R. 755. The learned Law Lord says at p. 763 of a contention that a decision of

the stewards of the Australian Jockey Club was void for breach of natural justice:

> "This argument led necessarily into the difficult area of what is void and what is voidable, as to which some confusion exists in the authorities. Their Lordships' opinion would be, if it became necessary to fix upon one or other of these expressions, that a decision made contrary to natural justice is void, but that, until it is so declared by a competent body or court, it may have some effect, or existence, in law. This condition might be better expressed by saying that a decision is invalid or vitiated. In the present context, where the question is whether an appeal lies, the impugned decision cannot be considered as totally void, in the sense of being legally non-existent. So to hold would be wholly unreal."

Accordingly, the fact that a decision is one which ought never to have been made does not preclude its being appealed against. Any other view could cause manifest injustice. Furthermore, we are satisfied that such a decision is capable of being reviewed and revised under section 104(1) of the Social Security Act 1975.

7. In our judgment, notwithstanding that the insurance officer's original decision was made in the absence of an actual claim and therefore totally without authority, it still was effective until it was set aside, and it was open to the insurance officer to do this by means of a review, provided, of course, that the conditions for such review obtained. The relevant conditions are set out in section 104(1) of the Social Security Act 1975. Paragraph (a) of section 104(1) provides that a review may be undertaken if "the officer ... is satisfied ..... that the decision was given in ignorance of, or was based on a mistake as to, some material fact".

8. In the present case the insurance officer gave his original decisions notwithstanding that no claim had been made and that the claimant had in fact returned to work. At the time he made such decisions he was aware, or ought to have been aware, of all the relevant facts. Certainly, the question of whether or not claims had been made was known to him, and their absence must have carried the implication that the claimant had recovered his health. In those circumstances we are of the view that there can be no question of the insurance officer's being "in ignorance of ..... some material fact" within section 104(1)(a).

9. However, it was equally open to the insurance officer to review his decision if it was "based on a mistake as to some material fact" the material fact in this case being the claimant's capacity for work, and it was on this ground that the insurance officer actually based his review. We have no reason to doubt that the insurance officer did genuinely make a mistake. We have considered the question whether or not any restriction should be imposed on the insurance officer's power to review if the mistake relied upon was wholly unjustified. In other words, has the mistake to be a reasonable one in the circumstances for the insurance officer to have jurisdiction to review his original erroneous decision? We are concerned that there may be no finality, if it is open to an insurance officer to review and revise a decision given with full knowledge of the facts, simply because a mistake (not being a mistake of law) has been made. But the statutory provision is so wide that we are unable to define (let alone justify) any limitation such as that the mistake should be reasonable. The mistake has to be a *bona fide* mistake of fact, but beyond this there would appear, in our judgment, to be no limitation whatsoever.

10. Accordingly, we are satisfied on the facts that the insurance officer was fully entitled to review and revise his original decision, so as to disallow payment of sickness benefit for the inclusive period from 27 November 1978 to 7 December 1978. It remains for us to consider the further question whether the insurance officer was right to require repayment of the benefit overpaid. Two girocheques were sent to the claimant respectively on 30 November 1978 and 7 December 1978, and each cheque stated on the face of it that it was in respect of sickness benefit for the period there specified. Moreover form BF 60B recorded as sent with an earlier girocheque contained a specific instruction not to cash the cheque but to return it if the claimant had worked on any of the days in the period shown in the girocheque. If the claimant had looked at the cheque, he should have been in no doubt that it related to a period when he was not incapacitated and that he ought to have returned it.

11. Under section 119(1) and (2) of the Social Security Act 1975 repayment *must* be required unless the claimant is able to take advantage of the one escape route permitted by that section, that is to say, unless he can show that in the obtaining and receipt of the benefit he exercised throughout due care and diligence to avoid overpayment. In the present circumstances we have no doubt that in the receipt of the benefit the claimant failed to exercise the appropriate standard of care and diligence. It follows that repayment is required.

12. In reaching this conclusion we must emphasise that there is no question of the claimant's integrity being called into question. In the words of paragraph 11 of Decision R(G) 1/79:

> "The statutory language does not necessarily import considerations of honesty or good faith but a standard of care and diligence which it is expected will be exercised."

13. The claimant has contended that the party, which has really failed to exercise due care and diligence, is not so much himself, but rather the Department itself. They had no reason for sending the girocheques in the first place, and it was not up to him to check their errors. However, this argument, superficially attractive though it may be, proceeds upon a totally erroneous basis. The issue is not whether it was the Department or the claimant who was *more* at fault; it is whether or not the claimant can himself satisfy the adjudicating authority that at least *he* was without blame. It must never be forgotten that, if the claimant has received money to which he is not entitled, moral considerations dictate that he should return it. This is normally the view of the law as well, but a concession is made in section 119 relieving a claimant from the obligation to do what is morally right and proper, if it can be said that he has in no way been responsible for the overpayment. Of course, the negligence of the Department may be a factor in determining whether or not any fault attaches to the claimant, but, subject to this, it is a totally irrelevant consideration. In the present case, had, for example, the girocheques not contained any indication on their face of the period to which they related, we consider that the claimant would have been justified in assuming that in some way they constituted payments for the period when he was genuinely incapacitated albeit payments which were somewhat late. In this event no fault would have been attached to him, and the entire responsibility would have lain at the door of the Department. However, this was not in fact the case in the present instance.

14. It follows from what has been said above that repayment must be required, and accordingly we have no option but to dismiss this appeal.

(Signed) I O Griffiths
Chief Commissioner

(Signed) J G Monroe
Commissioner

(Signed) D G Rice
Commissioner