DMG Chapter 69: Industrial injuries disablement Benefits

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Introduction 69001 - 69008

Introduction

69001 IIDB provides payments for the long-term effects of IAs and PDs[1]. The rate of benefit is linked to the loss of faculty.

1 SS CB Act 92, s 103

69002 To obtain IIDB there must be personal injury from an accident or the contraction of a PD resulting in loss of physical or mental faculty which results in disability and disablement.

Meaning of terms

69003 Injury is the hurt to the body or mind and includes all the adverse physical and mental consequences of an accident.

69004 Loss of faculty is an impairment of the proper functioning of the part of the body or mind and is used in the statute to describe a cause of disabilities to do things which in sum constitute disablement[1].

1 Hudson and Jones v. S of S for Social Services AC 944 - Supplement to R(I) 3/69; R(I) 4/94

69005 Disability is the partial or total failure of power to perform normal bodily or mental processes.

69006 Disablement is the sum of disabilities which, by contrast with the powers of a normal person, can be expressed as a percentage.

69007 These factors govern all claims for IIDB, but some of the essential conditions differ considerably depending on whether the claim was made before or after 1.10.86. Where there is a difference this will be identified by separate headings and care should be taken to ensure that the guidance being followed is applicable.

69008 References to accidents include references to PDs unless otherwise stated.

Conditions of entitlement 69009 - 69011

Claims made before 1.10.86

69009 An employed earner was entitled to IIDB if, as a result of an IA, a loss of physical or mental faculty occurred for which the extent of disablement was assessed at not less than one 1%[1]. A person with pneumoconiosis was treated as having satisfied that condition irrespective of whether there was an actual loss of faculty[2].

1 SS Act 75, s 57(1); 2 s 78(3)

Claims made on or after 1.10.86

69010 To become entitled to IIDB an employed earner must establish that

1. as a result of an IA, a loss of physical or mental faculty occurs for which disablement is assessed at not less than 14%[1]**or**

2. as a result of more than one accident, losses of physical or mental faculty occur, for each of which disablement is assessed at less than 14% but which in total amount to 14% or more[2]**or**

3. in pneumoconiosis and byssinosis cases, disablement is assessed, or treated as assessed, at not less than 1%[3]**or**

4. in the case of claims for occupational deafness, disablement is assessed at not less than 20%[4].

1 SS CB Act 92, s 103(1); 2 s 103(2)(a)(b); 3 SS (II) (PD) Regs, reg 20; 4 reg 34(6)

Provision of NINO

69011 For IIDB there is a specific requirement[1] for a claimant to provide sufficient information or evidence to establish their NINO. See DMG 02172 et seq for full guidance.

1 SS A Act 92, s 1(1A) & (1B)

Date from which entitlement to IIDB arises 69012 - 69019

Claims before 6.4.83 69012

Claims after 6.4.83 69013 - 69015

Late claims 69016 - 69019

Claims before 6.4.83

69012 For claims based on accidents before 6.4.83, entitlement to IIDB depends on whether incapacity resulted within 156 days, excluding Sundays, from the date of accident. If not, entitlement arises from the fourth day following the date of accident or, in a PD case, from the beginning of the assessment. If there was a period of incapacity due to the accident entitlement is from the earlier of

1. the day following the last day of such incapacity **or**

2. the day following the expiry of 156 days from the date of accident[1].

1 SS (Abolition of Injury Benefit) (Consequential) Regs 1993

Claims after 6.4.83

69013 There is no entitlement to IIDB for the 90 days, disregarding Sundays, beginning with the date of the accident or date of onset in PD claims[1]. However, entitlement arises from the date of onset in claims for

1. occupational deafness[2] (PD A10) **and**

2. diffuse mesothelioma[3] (PD D3) **and**

3. primary carcinoma of the lung (PD D8 and PD D8A) from 6.4.06[4].

Note 1: In PD A10 claims the date of onset is the date of claim[5].

Note 2: The date of onset for a PD can be prior to the date the disease was added to the schedule, although no benefit can be payable prior to that date[6].

1 SS CB Act 92, s 103(6); 2 SS (II) (PD) Regs, reg 28; 3 reg 20(4)(a); 4 reg 20B(2)(a); 5 reg 6(2)(c)(ii) ; 6 R(I) 4/96

69014 This 90 day period is absolute. It applies regardless of whether or not the accident has caused

incapacity in the intervening period.

69015 In calculating the period of 90 days Sundays are excluded. The period can, therefore, never begin or end on a Sunday. IIDB can, however, be awarded from a Sunday and so, where an accident occurs on a Sunday or Monday, the 90th day will be a Saturday and IIDB may be awarded from the next day, Sunday[1].

1 SS CB Act 92, s 103(6)

Late claims

69016 Guidance on the time limits for claiming IIDB and disentitlement penalties for late claims is in DMG Chapter 02.

69017 - 69019

Questions arising on claims for IIDB 69020 - 69099

General

69020 DMs will give an outcome decision on the claim which consists of a statement to the effect that the claimant is either entitled or not entitled to benefit. In arriving at an outcome decision, the DM must consider various questions. For IIDB, these questions fall into two categories

1. non medical questions such as employed earners employment, rate of benefit[1]**and**

2. medical questions such as diagnosis, relevant loss of faculty and disablement assessment.

Note: See DMG Chapter 01 for further guidance on IIDB decisions.

1 SS CB Act 92, s 94

69021 In a claim based on injury by IA, the DM should establish whether there was an IA. This question may arise for the first time on

1. the IIDB claim **or**

2. an application for a declaration of an IA for the relevant accident[1].

1 SS Act 98, s 29

69022 If the accident question arises for the first time on an IIDB claim, the DM should consider the question as in DMG Chapter 66. If the case is of the 'accident is the injury' type the DM must be satisfied that the claimant suffered personal injury by accident before a favourable accident decision can be given[1].

1 R(I) 7/73

69023 Where the accident question affects more than one benefit all papers should be kept together to avoid conflicting decisions.

69024 The DM does not need to give separate consideration to the personal injury question if a favourable IA decision has already been given and IIDB is the only benefit claimed. Consideration of the personal injury question is part of the process of reaching an outcome decision on entitlement. This may

involve the DM in seeking medical advice which will include advice on the question of personal injury.

69025 - 69029

Medical questions

General

69030 The law provides for the DM to seek medical advice from a HCP in deciding a claim for IIDB[1]. Medical advice to the DWP is currently provided under contract. These HCPs are specially trained in disability analysis and how this relates to claims for industrial injuries benefits[2]. Therefore, although the medical advice is not binding on DMs it should be given appropriate weight (see DMG 69036). Medical examinations conducted by a HCP can be conducted in person, by telephone or by video[3]. Where there is conflicting medical evidence for example between an HCP and a consultant, DMs should record in detail the reasons for accepting one opinion and rejecting the other.

1 SS Act 98, s 19; 2 SS CS (D&A) Regs, reg 12(1); 3 SS (C&P) Regs 79, reg 26 (1)(a)

69031 Although the IIDB claim form encourages the claimant to provide any medical evidence they might have (e.g. reports from their GP, hospital or consultant,) it would be exceptional for the DM to be presented with sufficient information that would enable all the medical issues to be decided without seeking medical advice.

69032 The DM has therefore the option to refer any medical question which has to be answered in

1. deciding a claim **or**

2. reconsidering a decision

to a medical adviser for advice.

Meaning of HCP

69033 A HCP[1] is a

1. registered medical practitioner **or**

2. registered nurse **or**

3. registered occupational therapist or physiotherapist[2]**or**

4. member of such other regulated profession[3] as prescribed.

Note: Only for the purposes of the higher rate of DLA mobility component for the severely visually impaired have regulated professions of optometrist and orthoptist been prescribed as HCPs (see DMG

Chapter 61).

1 SS Act 98, s 39(1); SS (C&P) Regs 79, reg 2(1); 2 Health Act 1999, s 60;
3 NHS Reform & Health Care Professions Act 2002, s 25(3); SS Act 98, s 39(1)

Referring questions for medical advice

69034 The DM can refer the following questions for medical advice in connection with claims for IIDB

1. whether there is a relevant loss of faculty

2. the extent at which disablement caused by that loss of faculty is to be assessed

3. the period to be taken into account by the assessment

4. in PD claims, questions relating to

4.1 diagnosis

4.2 whether the PD is likely to have resulted from the claimant's employment

69035 The opinion given in response to such a request is

1. the advice of the individual medical adviser although under the terms of the contract, more than one medical adviser can be used in cases of special difficulty **and**

2. not binding upon the DM.

69036 Although the advice of a medical adviser is not binding, it should, in view of the medical adviser's expertise in disability analysis and the IIDB Scheme[1], be exceptional for the DM not to follow it.

1 SS CS (D&A) Regs, reg 12(3)

The role of the medical adviser

69037 The medical adviser has experience of disability assessment for the purposes of IIDB. It is important that the DM recognises that disability assessment differs from clinical medicine and requires a different set of skills and different training.

69038 In clinical medicine the objective is to diagnose a patient's condition as precisely as possible, in order to plan treatment.

69039 In disability assessment, the objective is to assess the functional effects of a person's condition - what does it prevent them from doing, or from doing as well or easily as someone without disability?

69040 Other medical practitioners e.g. GPs or hospital consultants, are not usually trained to assess functional effects. Medical advisers who are contracted to provide a medical advice service to the

Secretary of State are trained to assess functional effects in the context of benefit claims.

69041 The medical adviser's advice will be given in the context of this training and their experience in disability assessment for claims to benefit[1]. If necessary the medical adviser will obtain such further medical evidence as is thought necessary in order to give comprehensive advice and will include an assessment of this evidence in the report.

1 SS CS (D&A) Regs, reg 12(3)

69042 The medical adviser's advice should meet the quality standards set out in the contract. These are that the advice should

1. be legible

2. be comprehensive and clearly explain the medical issues raised

3. address all the evidence and if any evidence is rejected the medical adviser should explain why

4. be in plain English and avoid medical jargon (other than terms covered in the DM's Medical Glossary)

5. answer all the questions.

If any of these standards are breached, the DM should return the case to medical services for rework.

69043 If a decision on a claim for IIDB was for a provisional period then the DM should arrange for further medical advice before the expiry of the provisional assessment[1].

1 SS CB Act 92, Sch 6, para 6

69044 - 69049

Information to be put before the medical adviser

69050 The DM should ensure that any medical information or medical evidence that will help them decide a medical question is in front of the medical adviser. The DM should specify to the medical adviser that they should consider this before giving their advice on the relevant medical issue(s).

69051 The medical adviser should record the fact that they have seen this medical information or medical evidence.

Format of medical advice

69052 Medical advice should be recorded on forms approved by the Secretary of State. The forms enable medical advice to be recorded so that findings of fact material to the case and any resulting loss of faculty may be specified. Medical advisers will give their advice in plain English and where necessary will explain any medical terms used. The DM should ensure that the medical advice meets the quality

standards (see DMG 69042) before giving a decision on entitlement. Once the decision has been made it is not possible to return the advice for rework. It is therefore important that the DM considers the medical advice carefully before giving a decision.

69053 The medical advice on initial and renewal claims will, in most cases, be based on an examination by the medical adviser. In initial claims for PD cases however, the medical adviser may obtain a report from another medical professional e.g. an audiometric test in claims for PD A10. Where this report indicates that the diagnosis condition is not satisfied, the medical adviser will return the case to the DM without examining the claimant. Where the report shows that the diagnosis condition is satisfied or is inconclusive, the medical adviser will arrange for an examination to consider diagnosis and, if necessary the assessment of disablement.

69054 Medical advice based on examination will consist of advice on the questions in DMG 69035. The report will also contain

1. a statement taken from the claimant, this will either be taken by the medical adviser or by a member of medical services staff before the examination (see DMG 69055) **and**

2. a medical and occupational history **and**

3. a statement of clinical findings.

69055 For the purposes of DMG 69054 **1.** whoever takes the statement will try to focus on the accident/PD and only include relevant matters. However, if the claimant insists on including matters of doubtful relevance these should have been included.

69056 When considering the advice, the DM should ensure that all evidence has been considered and that all elements of the report are consistent. The report from the medical adviser should

1. specify all the evidence considered

2. where one piece of evidence is preferred over another, explain why.

Where the report is deficient in either respect it should be returned as rework.

69057 - 69059

Assessment of disablement

69060 The classification of the disabilities found will be recorded as follows

F Fully relevant. Disability arises solely from the relevant loss of faculty.

P Partly relevant. Disability arises partly from the relevant loss of faculty and partly from other causes.

O(pre) A condition present at the time of the accident, and not itself resulting from that accident, and

which makes a relevant loss of faculty more disabling than it would otherwise have been.

O(post) A condition arising after the accident, and not itself resulting from that accident, and which makes a relevant loss of faculty more disabling than it would otherwise have been.

69061 The report from the medical adviser should also list in the 'unconnected injuries, diseases' section of the medical advice form any other abnormal conditions in the findings of fact that

1. have no effect on the disablement resulting from the loss of faculty **and**

2. have not been taken into account in giving their opinion on the disablement assessment.

69062 The principles of assessment are governed by law[1]. In addition prescribed degrees of disablement are laid down for certain injuries[2].

1 SS CB Act 92, Sch 6; 2 SS (Gen Ben) Regs, reg 11; Sch 2

69063 An assessment of disablement

1. is expressed as a percentage **and**

2. specifies the period to be taken into account **and**

3. if limited to a definite date, states whether the assessment is provisional or final[1].

Note: A life award may be superseded (see DMG Chapter 04).

1 SS CB Act 92, Sch 6, para 7

69064 Where more than one disability is sustained in an accident, the assessment of disablement must represent the total loss of faulty resulting from the relevant accident, that is, the total of the disabilities. Assessments of 2 or more disabilities should not be made for different periods[1]. If this arises the DM should refer the case back to the medical adviser asking them to clarify their advice.

1 R(1) 42/55

69065 The Medical Advisor's report may advise that the award should be made in two or more stages, for example 15% for 6 months followed by 5% for life.

Further medical evidence received before a decision made

69066 If further medical evidence is received after medical advice has been received but before the DM has made a decision, the DM may refer the claim for further advice. This is a re-referral not rework.

69067 - 69069

Reconsiderations involving medical issues

69070 A claimant can apply to the DM to reconsider the decision on a claim to IIDB. Guidance on the general principles on reconsideration is given in DMG Chapter 03. The guidance at DMG 69071 et seq applies where the issue under dispute is a medical one.

69071 Where the DM is reconsidering a claim they can, if necessary, seek further medical advice. This should only be necessary where the claimant produces some new medical evidence which

1. had not been considered by the medical adviser **and**

2. the DM considers may have affected the advice given by the medical adviser, or the DM is unable to decide its relevance.

69072 Where the new evidence is simply a further statement from the claimant it would be unlikely that the DM would need to seek further medical advice based on that statement alone. There would need to be some supporting medical evidence from the claimant's GP, hospital or consultant, and that evidence would need to raise

new factors which the medical adviser had not considered and which were, in the DM's opinion, clearly relevant to the medical issues.

69073 Where the evidence does not raise new issues, the DM should still reconsider the earlier decision to decide if that decision was correct. If the decision was correct the claimant would then have the opportunity of pursuing the matter before a FtT.

69074 If the DM is unsure whether the new evidence raises fresh issues further medical advice should be sought. Advice can be sought by using medical services advice line. However, if the evidence raises fundamental issues a formal referral for further advice will be needed. DM’s should note that the advice line should not be used to discuss cases in detail with medical services. It should only be used to resolve simple queries.

69075 If the DM decides to refer the case for further medical advice the DM should

1. refer the medical adviser to the new evidence **and**

2. set out the facts which are not in dispute

3. set out the facts which are in dispute and on which further advice is sought (e.g. the claimant may produce a medical report which suggests a longer period of assessment or a higher percentage level of disablement is appropriate).

69076 On receipt of a referral for further advice in dispute cases, the medical adviser (this need not necessarily be the same medical adviser who provided the previous advice) will consider the evidence and advise the DM accordingly setting out clearly the reasons for accepting or rejecting the evidence.

69077 Where the medical adviser considers that the evidence does affect the advice previously given, they will

1. provide further advice on the documentary evidence alone **or**

2. arrange for the claimant to be re-examined.

It is for the medical adviser to decide whether a further examination is necessary.

69078 On receipt of the medical adviser's advice, the DM should reconsider the earlier decision and if appropriate, revise or supersede it. The general guidance in DMG Chapters 03 and 04 should be followed to determine restrictions on any new award.

69079 - 69084

Appeals involving medical questions

69085 Where a claimant appeals against an outcome decision, and the dispute relates to one of the medical questions, the FtT will contain a medically qualified panel member. To assist in reaching a decision, the FtT can either examine the appellant at the hearing, or request further medical evidence prior to making a decision[1].

1 SS Act 98, s 20; SS CS (D&A) Regs, reg 36(2) & 52

69086 Where the FtT find in favour of the appellant they should go on to consider all other conditions of entitlement to enable an outcome decision to be reached.

69087 Occasionally the FtT will return the case to the DM for this action to be taken. The case should be returned to Medical Services for further advice. If Medical Services agree that the evidence does now support a diagnosis of the PD, they will advice on the level and period of the assessment in the normal way.

69088 If Medical Services are of the opinion that the history (that is the claimants account of the onset and progression of symptoms, treatment etc.) and the clinical findings do not support a diagnoses of the PD they will a "no lose of faculty" opinion with a full explanation of why and on what basis that opinion has been formed. The DM should then take that opinion into account when deciding the claim.

69089 - 69099

Disablement Pension 69100 - 69109

69100 With the exception of PDs A10, D1, D2, D3, D8 and D8A, IIDB is paid as a Dis P if the assessment is 14% or more[1]. In claims to

1. PD A10 the minimum level of disablement that attracts payment of IIDB is 20%[2]

2. PDs D1 and D2, IIDB is payable providing disablement is assessed at 1% or more[3]

3. PDs D3, D8 and D8A are assessed at 100%[4].

The weekly rate of the Dis P depends on the percentage assessment of disablement.

Note 1: Before 5.12.12 special rates were payable for claimants under age 18.

Note 2: Trainees receiving payment for an industrial injury or disease[5] before 31.10.13 will receive equivalent payments of IIDB from that date[6].

Note 3: A claim for payment for an industrial injury or disease[7] made but not determined before 31.10.13 is treated as a claim for IIDB[8].

1 SS CB Act 92, s 103(1); 2 SS (II) (PD) Regs, reg 34; 3 reg 20(1); 4 reg 20A; reg 20B; 5 E & T Act 73, s 11(3); 6 II (ETS & C) Regs, reg 4; 7 E & T Act 73, s 11(3); 8 II (ETS & C) Regs, reg 5

69101 Assessments between 14% and 19% are rounded to 20%. Assessments above 20% are rounded to the nearest multiple of 10, 5 being rounded up[1].

Examples

An assessment of 23% is rounded down to 20%.

An assessment of 25% is rounded up to 30%.

An assessment of 24% is rounded down to 20%.

1 SS CB Act 92, s 103(3)(a)(b)

69102 Payment of IIDB is made on a weekly basis, for the week from Wednesday to Tuesday[1]. Therefore, when the first day of entitlement is not a Wednesday, payment will not start until the following Wednesday.

1 SS (C&P) Regs, reg 16(3), 22 & Sch 6, para 3

69103 Since payment will be up to a Tuesday IIDB will be paid until the Tuesday following the last day of entitlement, unless entitlement ends on a Tuesday.

69104 Where a successful claim is made for a past period, the weekly rate of IIDB is the rate in force during the period of assessment, taking account of any general uprating of benefits[1].

1 R(I) 1/86

69105 - 69109

Disablement Gratuities 69110 - 69179

General

69110 Until 1.10.86 IIDB was paid in the form of a Dis G if the assessment of disablement was less than 20%, with the exception that

1. IIDB for pneumoconiosis, byssinosis and diffuse mesothelioma was always in the form of a Dis P[1]

2. IIDB was not payable for occupational deafness if the assessment of the resulting loss of faculty was less than 20%[2]

3. during the period of entitlement to SHA, where the claimant elected to have the Dis G paid as a pension in lieu of a gratuity (see DMG 69135 - 69140)

4. where a claimant already entitled to a Dis P for an accident or disease chose to receive a pension instead of a gratuity for a subsequent accident or disease (see DMG 69145 - 69148).

1 SS (II) (PD) Regs, reg 20(1A); 2 reg 34(6)

69111 In certain circumstances a Dis G could be paid by instalments (see DMG 69130 -69131)[1].

1 SS CB Act 92, Sch 7, Part III, para 10(3)

69112 The amount of a Dis G depended on the length of the period of the assessment and the degree of disablement[1]. Where the period of assessment was

1. for seven years or more, or for life, the amount payable was the full amount of the Dis G appropriate to the degree of disablement[2]

2. less than seven years, the amount payable bore the same ratio to the full amount as the period of assessment bore to seven years[3].

1 SS CB Act 92, Sch 7, Part III, para 10(3); 2 SS (Gen Ben) Regs, reg 14(1)(a); 3 reg 14(1)(b)

69113 If the adjudicating medical authority had given a composite assessment the Dis G was calculated in relation to the total assessment not the total of the amounts which would correspond to each of the smaller percentages[1].

1 CSI 74/50(KL)

69114 Where

1. a claim resulted in the payment of a Dis G **and**

2. the period of the assessment was for a past period

the amount of the Dis G was calculated by reference to the rates in force on the day on which the assessment began[1]. Subsequent up-ratings were ignored.

1 R(I) 5/82

69115 Where the claimant had chosen to receive, with SHA, a pension in lieu of a gratuity, the decision awarding the pension could not be revised if at a later stage the beneficiary wanted to receive the balance of the Dis G as a lump sum[1]. See DMG 69135 et seq for guidance on pension in lieu of gratuity.

1 R(I) 77/53; R(I) 38/57

69116 From 1.10.86 IIDB was paid in the form of a Dis G only where

1. transitional protection could assist the claimant **or**

2. entitlement to a pension in lieu ceased.

Transitional provisions

69117 Where

1. there is an application for an unforeseen aggravation review or supersession on the grounds of changes of circumstances **and**

2. the original claim was made before 1.10.86 **and**

3. there is an assessment which

3.1 is provisional **or**

3.2 was final but the period of any new assessment begins before 1.10.86 **or**

3.3 was final but any new assessment begins on or after 1.10.86 and the claimant is entitled to a pension in lieu of gratuity

the pre 1.10.86 provisions will apply[1]. However, a payment under any new assessment between 1% and 19% can only be paid as a Dis G[2].

1 SS (II&D) Misc Prov Regs, reg 12; 2 reg 12(2)

69118 Where DMG 69117 **3.3** applies, any new assessment of less than 14% will be paid as a Dis G. However, there will be no entitlement to a pension in lieu of gratuity. The provisions from 1.10.86 will apply to any new assessment of 14% or more[1].

1 SS (II&D) Misc Prov Regs, reg 12(3)

69119

Death of claimant

69120 If a claimant died during the period covered by an assessment, the death would not affect either entitlement to, or the amount of, a Dis G even if at the date of death an award or payment of the Dis G had still to be made. However, if the claimant died before the start date of the period of assessment, there was no entitlement to a Dis G for that assessment.

69121 Payment of benefit was not normally made before the start of the period of assessment. Exceptionally, where payment was made before the start of the assessment and the beneficiary then died before the period began, the award could be reviewed[1].

1 R(I) 23/52

69122 If the adjudicating medical authority

1. considered a claim after the death of the claimant **and**

2. made a life assessment to start on the day the claimant died

the full amount of the Dis G was payable. The length of the claimant's life after the start of the assessment was irrelevant[1].

1 R(I) 59/54

69123 - 69129

Gratuity by instalments

69130 A Dis G could be paid by instalments

1. if the beneficiary was under age 18 at the date of award **or**

2. in any other case where the amount of the Dis G exceeded £52 and the beneficiary requested payment to be made by instalments[1].

Except where the beneficiary was under age 18, a Dis G payable to the widow of a deceased person could not be paid by instalments on her remarriage.

1 SS (C&P) Regs, reg 31(3)

69131 The amount and frequency of the instalments were at the discretion of the adjudicating authority awarding the Dis G, based on what was reasonable in the circumstances of the case[1].

Note: The question of the method of payment is generally for the Secretary of State but questions about the payment of a Dis G by instalments were for the adjudicating authorities.

1 SS (C&P) Regs, reg 31(3)

69132 - 69134

Pensions in lieu

Pensions in lieu when SHA was payable

69135 Before 1.10.86[1], a claimant who was entitled to a IIDB and SHA could choose to have a pension in lieu of the gratuity providing the choice was made before the Dis G was paid. The pension in lieu offered the claimant certain advantages over payment by Dis G because

1. the rate of the pension was uprated with the general uprating of benefits **and**

2. it continued to be paid throughout the period of the assessment which meant that assessments for more than seven years, or for life, would remain payable beyond seven years whilst the assessment was current and the conditions for payment of a pension in lieu remained satisfied.

The option was removed from 1.10.86 with the amendments which introduced REA.

1 SS Act 75, s 60(7); SS (Gen Ben) Regs, reg 18

69136 Claimants who were entitled to a pension in lieu immediately before 1.10.86 remained entitled to such pensions until the first date on which[1]

1. the assessment expired, was reassessed or reviewed **or**

2. payment of REA ceased (including RA from 1.11.89, see DMG 69140).

Whilst existing pensions in lieu are protected, no new pension in lieu elections may be made. A claimant who was in receipt of a pension in lieu and whose disablement is reassessed between 1% and 19%, must be paid in the form of a Dis G. Where REA is no longer payable and a pension in lieu has been in payment, consideration of a balancing Dis G arises[1].

1 SS (II&D) Misc Prov Regs, reg 7(5) & (6); 2 SS (Gen Ben) Regs, reg 18(4)

69137 From 10.4.89 entitlement to REA was replaced by entitlement to RA for a claimant who

1. attained pensionable age **and**

2. retired from regular employment **and**

3. was entitled to REA immediately before the date of retirement[1]**and**

4. the rate of REA payable immediately before retirement was at least £2 a week[2].

Note: See DMG Chapter 75 for the meaning of pensionable age for RP purposes and DMG Chapter 74 for the meaning of pensionable age for SP purposes.

1 SS CB Act 92, Sch 7, para 13(1); 2 Sch 7, para 13(2)

69138 Payment of pensions in lieu for those beneficiaries over pensionable age whose REA entitlement ceased on conversion to RA continued, but the payments were made on an extra-statutory basis.

69139 From 1.10.89 the earnings rule for RP was abolished[1]. The transition from REA to RA entitlement could no longer be tied to the date of retirement. Instead entitlement to RA arose as soon as a person over pensionable age gave up regular employment[2].

1 SS Act 89, s 7; 2 SS CB Act 92, Sch 7, Part V, para 13(1)(a)(b) & (c)

69140 From 1.11.89[1] entitlement to the pension in lieu has been restored while

1. REA is payable **or**

2. RA is payable **or**

3. RA would be payable had the weekly rate of REA not been less than £2 on the day immediately before

3.1 the date of retirement (if before 1.10.89) **or**

3.2 the date of giving up regular employment (if on or after 1.10.89).

Where a pension in lieu was paid on an extra-statutory basis from 10.4.89 to 31.10.89, the Secretary of State asked the adjudication officer to consider a further award of pension in lieu from 1.11.89.

1 SS (II&D) Misc Prov Regs, reg 7(5)

69141 - 69144

Pensions in lieu when pension already in payment

69145 Before 1.10.86, a claimant who was entitled to a Dis P for a life assessment could choose to receive as a pension in lieu any gratuity that was payable as a result of any subsequent accident[1]. This was on condition that the total of the two assessments would enable that person to receive a rate of pension higher than the existing pension rate.

1 SS (Gen Ben) Regs, reg 38

69146 The amending legislation which came into force on 1.10.86 made no amendment to the provisions allowing for these pensions in lieu. But after that date their application will only be to cases where a pension in lieu is already in payment or where the claim, although made on or after 1.10.86, is decided under earlier legislation.

69147 In cases

1. that fall to be decided under the pre 1.10.86 legislation **and**

2. for which the conditions of a pension in lieu are satisfied

the claimant can still choose to have the Dis G paid as a pension[1]. Any pension in lieu which remains payable under the provisions[2], whereby a Dis G was payable as a pension in lieu when the claimant was also entitled to receive SHA, constitutes an existing pension[3].

1 SS (Gen Ben) Regs, reg 38; 2 reg 18; 3 R(I) 2/84

69148 Though the pension in lieu option in successive accident cases still remains in force, DMs should note that it can only apply where a Dis G for the succeeding accident would be payable. Where as a result of a successive accident

1. a claim made on or after 1.10.86 is decided under the legislation in force from 1.10.86 **and**

2. the resulting assessment is less than 14%

a pension in lieu is not available since IIDB is not payable for such assessments.

69149 - 69154

Limitations on pensions in lieu for successive accidents

69155 Limitations on pensions in lieu for successive accidents[1] apply only to claims which were, or may be treated as having been, made before 1.10.86. Their application is likely to be very limited.

1 SS (Gen Ben) Regs, reg 38

69156 A choice to have a Dis G paid as a pension in lieu must be made before the claim to IIDB for the second accident is determined[1]. Once a choice has been made the claimant will be deemed to be entitled to the relevant benefits from the date of the beginning of the respective periods of assessment of disablement[2]. The pension based on the aggregation of assessments is payable

1. for the period of the Dis G assessment only **and**

2. at a rate equal to the difference between the rate of the existing pension and the higher rate appropriate to the aggregate of the 2 assessments.

1 SS (Gen Ben) Regs, reg 38(1)(b); 2 reg 38(3)(c)

69157 Where the assessment for the existing pension has been rounded to the nearest multiple of 10 (the figures 1-4 being rounded down and 5-9 being rounded up), the rounded figure should be used for aggregating[1]. The resulting figure should then be rounded as appropriate.

1 SS CB Act 92, Sch 6, para 7

69158 But in the event of further aggregation because of another successive accident which falls within the scope of the pre 1.10.86 legislation, the final rounded figure should not be used. The actual assessments of the gratuities should be added to the assessment for the existing pension (which is a multiple of ten) and the total rounded up if appropriate.

69159 If a person is already entitled to two or more Dis Ps based on life assessments when they are given a Dis G assessment, the Dis P assessments and the rates of pension are aggregated and regarded as forming one life assessment and one existing pension[1]. But see DMG 69220 - 69242 on the limits to be applied to the total amount of weekly IIDB payable for successive accidents.

1 SS (Gen Ben) Regs, reg 38(3)(a)

69160 It is only the basic Dis P or Dis G assessment, that is, excluding increases, which is taken into account for the purposes of deciding the rate of Dis P and pension in lieu. If an assessment had been treated as being 100% for hospital treatment allowance[1] this was also disregarded[2]. Payment of such an increased assessment would be taken into account when applying the weekly limits for successive accidents, so also would the payment of SHA.

1 SS CB Act 92, Sch 7, Part III, para 10(2); 2 SS (Gen Ben) Regs, reg 38(3)(b)

Extinguishment or reduction of gratuity

69170 If a person is entitled to Dis P of 100% and then becomes entitled to a Dis G or another accident, they are not entitled to receive the Dis G for any period covered by the assessment of 100%[1].

1 SS (Gen Ben) Regs, reg 38(2)(b)

69171 If the assessment of 100% is then reduced during the currency of the Dis G assessment, see DMG 69120. If a person entitled to a Dis P for an assessment of less than 100% becomes entitled to a Dis G for another accident the amount of the Dis G which they are able to receive cannot exceed the difference between 100% and the existing Dis P assessment[1].

1 SS (Gen Ben) Regs, reg 38(2)(b)

69172 If a person is already entitled to two or more Dis Ps when they become entitled to a Dis G, the Dis P assessments are aggregated and treated as one assessment[1]. An increase of an assessment for hospital treatment allowance is disregarded[2].

1 SS (Gen Ben) Regs, reg 38(3)(a); 2 reg 38(3)(b)

69173 The provisions preventing or reducing payment of a Dis G can only apply if the claimant is already entitled to Dis P at the date on which they become entitled to the Dis G. They do not apply if entitlement to the Dis G arises

1. before entitlement to Dis P begins **or**

2. after entitlement to Dis P ends.

For this purpose the date of entitlement to the Dis G is the date on which the Dis G assessment begins.

69174 The extinguishment and reduction provisions should only be applied to the actual period of overlap of assessments[1]. Adjustments may be required at a later stage if an existing Dis P assessment is followed on renewal, by a lower assessment during the currency of the affected Dis G assessment. The principles at DMG 69175 - 69177 should be applied.

1 SS (Gen Ben) Regs, reg 38(2)(a) & (b)

69175 If payment of a Dis G for a life assessment is prevented[1] by an existing 100% Dis P and this is later replaced by a lower assessment, the life gratuity then becomes payable subject to any reduction[2] for example if

1. the 100% Dis P is followed by an assessment of 80% or less, an overlapping life gratuity becomes payable in full

2. the further Dis P assessment is 90% and the life gratuity is 11% or more, only a 10% life gratuity can be paid

3. following reduction from 100% to 90% the existing Dis P is further reduced to 80%, the balance of the life Dis G can be paid.

1 SS (Gen Ben) Regs, reg 38(2)(a); 2 reg 38(2)(b)

69176 If payment of a Dis G for a life assessment is reduced by an existing Dis P which is replaced by a lower assessment, a further payment may be made for the unpaid balance of the life Dis G assessment[1].

1 SS (Gen Ben) Regs, reg 38(2)(b)

69177 If the Dis G assessment affected by the provisions is for a limited period, not for life, it does not become payable in full when a reduction in the existing Dis P assessment renders those provisions inoperative or operative only to a lesser extent[1]. In this case the amount of the Dis G is reduced by an amount related to the period during which the assessments overlapped.

1 SS (Gen Ben) Regs, reg 38(2)(a) & (b)

69178 If an existing Dis P assessment is followed on renewal by a higher assessment during the currency of a Dis G assessment to which the reduction or extinguishment provisions have not applied or have applied in part, the change has no effect on the Dis G payment.

69179

Pneumoconiosis and Byssinosis 69180 - 69199

Effect of changes from 1.10.86 69185 - 69199

69180 Compensation for these PDs is always paid as a Dis P, providing the relevant loss of faculty resulting from the disease is assessed at 1% or more[1].

1 SS (II) (PD) Regs, reg 20(1)

69181 Under the legislation in force before 1.10.86 the rate of Dis P payable, where the assessment was less than 20%, was determined by reference to the rates specified for a pension in lieu of a gratuity where SHA was in payment[1]. Assessments of 1% but less than 11% received a Dis P at the rate specified for assessments of less than 11% but not less than 6%. Where the assessment was between 11% and 19% the rate was that specified for a degree of disablement of less than 20% but not less than 16%. In cases where the assessment was 20% or more the appropriate Dis P rate was payable.

1 SS (II) (PD) Regs, reg 20(1); SS (Gen Ben) Regs, Sch 4

69182 - 69184

Effect of changes from 1.10.86

69185 The required minimum assessment for benefit to be payable for these diseases remains at 1%[1]. Where the degree of disablement is in the range of 1% to 10% the Dis P rate is one tenth of weekly rate payable for 100% degree of disablement. Where the assessment is more than 10% but less than 20% the Dis P payable is at the 20% rate[2].

1 SS (II) (PD) Regs, reg 20(1); 2 reg 20(1A)

69186 Guidance on the aggregation of assessments for these PDs with assessments for other PDs or accidents is at DMG 69251. In addition DMG 69217 contains guidance on the savings provisions which may apply to assessments for these diseases.

69187 - 69199

Transitional protection for claims made before 1.10.86 69200 - 69219

General

69200 Claims for accidents made before 1.10.86 should be decided under the provisions in force before 1.10.86[1]. DMs should have regard to the guidance in DMG Chapter 02 when determining the date of a claim. Therefore where disablement is assessed at 1% to 13% compensation will continue to be made in the form of a Dis G to those beneficiaries. Where disablement is 14% to 19% compensation will continue to be in the form of a Dis G and not as a 20% Dis P. It is not possible to put a fresh pension in lieu into payment, where REA is also payable, in these circumstances (see DMG 69136).

1 SS (II&D) Misc Prov Regs, reg 14

69201 Where DMG 69200 applies provisional assessments for are referred for medical reassessment but will be decided by the DM in accordance with the old rules. These assessments may, however, be available for aggregation with assessments on claims made under the scheme operating from 1.10.86 providing it will result in payment of a Dis P or increased rate of Dis P under the new provisions (see DMG 69240).

Delayed claim

69202 Special delayed claim provisions enabled claims made on or after 1.10.86 to be treated as having been made on 30.9.86[1]. These provisions were revoked from 12.2.90 but should still be considered by the DM when determining certain applications for reconsideration (see DMG 69215).

1 SS (II&D) Misc Prov Regs, reg 13

69203 The provisions set out what amounted to good cause for delay. To qualify it must be established that

1. the claim for IIDB was delayed until on or after 1.10.86 **and**

2. the degree of disablement is assessed at less than 14% **and**

3. throughout a period commencing on a date before 1.10.86 and ending with the date of claim the claimant

3.1 was incapable of making an earlier claim **or**

3.2 delayed making the claim because of advice provided by the Department.

69204 - 69209

Incapable of making an earlier claim

69210 A claimant should be regarded as incapable of making an earlier claim if in the circumstances of the case there are facts which indicate a justifiable lack of appropriate knowledge for making a claim. It is not enough for a claimant to plead ignorance, facts have to be proved from which it can be inferred that there was justifiable ignorance for the claim not being made earlier[1]. A lack of knowledge of the right to claim and of the procedures for claiming does not of itself make a person incapable of making a claim.

1 R(I) 1/90

69211 - 69214

Application for supersession

69215 Where an application for review is made either before or after 12.2.90, or an application for supersession is made on or after 5.7.99 and the

1. date of claim was between 1.10.86 and 11.2.90 **and**

2. IIDB assessment is less than 14% **and**

3. date of accident or date of onset of the disease is prior to 1.10.86

the special delayed claim provisions should still be considered by the DM when determining that application[1].

1 SS (II & D) Misc Prov Regs, reg 13

Pneumoconiosis, Byssinosis and Diffuse Mesothelioma

69216 Before 1.10.86 it was the practice of the special medical board to give assessment in respect of pneumoconiosis, byssinosis and diffuse mesothelioma in multiples of 10. If the claimant also suffered from some other respiratory disease, for example emphysema, which does not arise from the PD, but which makes it more disabling than it would otherwise be, the special medical board would also make an

assessment to take account of the extent to which the PD is made more disabling. Assessments for the other condition would also be in multiples of 10. Consequently the overall assessment was increased as a result of double rounding.

69217 From 1.10.86 assessments have been given to the nearest percentage point. There is therefore, the possibility of a claimant whose last assessment was before 1.10.86 finding on reassessment that the overall assessment is reduced despite the fact the claimant's condition has remained unchanged. So that the claimant's rate of benefit is not adversely affected the rate of IIDB payable will be determined by reference to the degree of disablement established on the last assessment made before 1.10.86[1]. The mark-time provision applies until on supersession

1. disablement is assessed at less than 1% **or**

2. the assessment of disablement equals or is greater than that determined on the last assessment before 1.10.86 **or**

3. the other disability ceases to exist.

1 SS (II) (PD) Regs, reg 20(1B)

69218 - 69219

Aggregation of Assessments 69220 - 69259

Statutory limitations on rate of benefit

69220 If a claimant is entitled to IIDB for an IA or a PD and qualifies during the same period for more than one assessment of IIDB, the maximum payment a claimant receives may be limited[1]. The limit is 100% of the Dis P rate specified[2].

1 SS CB Act 92, s 107; 2 Sch 4, Part V, para 1 & 4

Note: Before 5.12.12, special rates applied to claimants under age 18.

69221 Where a claimant is receiving a pension in lieu of a gratuity, the weekly sum payable must be included in the total amount when applying the limit. Increases such as US or those for children or dependants are payable in addition to the statutory limit. SHA was taken into account when applying the limit[1] but REA from 6.4.87 is payable in addition, subject to the limit of 140% of the maximum rate of Dis P[2].

1 SS CB Act 92, s 107(1)(a); 2 Sch 7, para 11(10) & (11)

69222 - 69224

Role of DM

General

69225 Aggregation was introduced on 1.10.86. It is the process whereby two or more concurrent assessments are added together to produce one award of benefit. The DM should aggregate assessments[1] unless it is advantageous to the claimant not to do so[2]. Where aggregation is not appropriate there will be separate awards. This applies to assessments arising from both accidents and PDs[3]. However, see DMG 69251 for guidance where at least one of the assessments is for PD D1 or D2.

Note: See DMG 69231 et seq for guidance on whether separate awards are advantageous.

1 SS (II) (PD) Regs, reg 15A; 2 R(I) 4/03; 3 SS CB Act 92, s 103(1): SS (II) (PD) Regs, reg 15A

69226 Aggregation is the responsibility of the DM. Where aggregation is appropriate, it should be applied in all cases where

1. assessments of disablement cover a common period

2. a claim to benefit resulting in an assessment of disablement is made on or after 1.10.86 (a claim in this instance includes an application for an unforeseen aggravation review or supersession on the grounds of changes of circumstances where the assessment is increased by at least 1%).

Example 1

A claimant has an assessment of 10% for life in respect of an IA on 5.1.69 for which a Dis G was paid. Following a claim for a further IA on 10.2.71 he is assessed at 7% for life and awarded a further Dis G.

On 19.8.99 he notifies that his condition for the second IA has worsened. Medical opinion is that there has been no change. The DM supersedes but does not change the previous assessment. As there is no requirement for a claim the assessments cannot be aggregated.

Example 2

A claimant has an assessment of 10% for an IA on 1.5.62 and 10% for an IA on 10.1.75. He is examined by an Adjudicating Medical Authority on a claim for unforeseen aggravation on 15.8.94 and the assessment for the first IA is increased to 11%. No award is paid.

On 7.3.01 the claimant applies for a supersession in light of a Commissioner's decision[1] which held that assessments for which life gratuities had been paid could be aggregated. As the claim on 15.8.94 was after 1.10.86, and the assessment was increased, the assessments can be aggregated. The DM supersedes the decision made on the claim for error of law and awards benefit from 24.7.95, the date of the relevant determination, at 20%.

1 R(I) 3/00

69227 Aggregation can only be applied during the period of the claim made on or after 1.10.86. If that claim ceases then aggregation must also cease.

Example

IA on 6.1.04. Disablement is assessed at 8% from 21.5.04 to 20.11.04 final.

IA on 15.4.73. Disablement assessed at 14% for life, Dis G paid.

IA on 7.8.84. Disablement assessed at 5% for life, Dis G paid.

Aggregation is appropriate and an award of IIDB at 30% is made from 21.5.04 to 20.11.04 only.

69228 Where the aggregated assessments are 14% or more, a Dis P is payable. If this level is not

reached the claim should be disallowed in the normal way.

Example 1

1st IA assessed at 10%

2nd IA assessed at 7%

Aggregation produces an assessment of 20% and a Dis P at this rate is payable.

Example 2

1st IA assessed at 5%

2nd IA assessed at 5%

Aggregation produces an assessment of 10%, therefore the claim would be disallowed.

69229 Assessments under pre 1.10.86 legislation can also (subject to certain conditions) be aggregated with assessments on or after that date.

Rounding

69230 Individual assessments of disablement should be aggregated first and then the total assessment rounded to the nearest multiple of 10% (5% being rounded up). However, an aggregated assessment of 14% is always payable at the 20% rate[1].

1 SS CB Act 92, s 103(3) & (4)

Example 1

1st IA assessed at 15%

2nd IA assessed at 10%

The aggregated assessment totals 25% and a Dis P at the 30% rate is payable.

Example 2

1st IA assessed at 18%

2nd IA assessed at 6%

The aggregated assessment totals 24% and a Dis P at the 20% rate is payable.

Determining whether separate awards are advantageous

69231 In order to determine whether separate awards are more advantageous to the claimant than aggregation, the DM needs to consider which option

1. produces the most weekly benefit **or**

2. allows any increase in benefit to be paid from the earliest date, taking into account the supersession effective date rules.

Note: IIDB **cannot** be paid for any day prior to the introduction of a new PD[1]. Therefore, when considering aggregation of a new PD the effective date of supersession **cannot** be before the introduction of that PD.

1 R(I) 4/96

Example 1

Jason has an assessment of 6% for life in respect of an IA that happened in 2001. On 13.12.06 he makes a claim for a second IA that happened in March 2006. Following medical advice, the DM gives a separate assessment of disablement of 8% from 20.6.06 in respect of the second accident. The new assessment runs concurrently with the existing one and cannot produce an award on its own, so aggregation is advantageous to the claimant. There is no award of benefit to supersede, so the DM makes a new rounded award of 20% from 13.9.06, three months before the date of claim.

Example 2

John has an assessment of 15% for life from 7.9.04 in respect of a PD and benefit is in payment at the rounded rate of 20%. He claims on 10.4.06 in respect of an IA that happened in October 2005. Following medical advice, the DM gives a separate assessment of disablement of 10% from 23.1.06. The new assessment runs concurrently with the existing one and cannot result in a separate award, so aggregation is advantageous to the claimant. The DM treats the new claim as an application for supersession of the existing award of benefit on the grounds of a relevant change of circumstances and supersedes so as to give a new award at the rounded rate of 30%. If the DM accepts that special circumstances prevented the claimant from applying earlier, supersession of the benefit award is effective from 23.1.06. If not, supersession is only effective from 10.4.06, the date of application.

Example 3

Karen has an assessment of 15% for life in respect of an IA that happened in 2003 and an award of benefit is in payment at the rounded rate of 20%. She makes a claim for a PD on 7.10.06 and following medical advice, the DM gives an assessment that she is 20% disabled from 5.4.06 due to the disease. The new assessment runs concurrently with the existing one so the DM considers aggregation. Aggregation would produce one award of 40%, but supersession of the existing award of benefit could only be effective from 7.10.06 as there were no special circumstances that prevented the claimant from

applying for supersession earlier. It is therefore more advantageous for the DM to make a separate award of 20% from 7.7.06, three months before the date of claim.

Example 4

Kevin has an assessment of 15% for life in respect of an IA and an award of benefit is in payment at the rounded rate of 20%. He makes a claim for a PD on 7.10.06 and following medical advice, the DM gives an assessment that he is 20% disabled from 5.4.06 due to the disease. The new assessment runs concurrently with the previous one so the DM considers aggregation. The DM could either make a separate award of 20% from 7.7.06, or aggregate so as to produce a single award at the rounded rate of 40%. The DM accepts that special circumstances prevented the claimant from applying earlier than 7.10.06. Aggregation is therefore more advantageous to the claimant and the DM treats the claim as an application for supersession of the benefit award on the grounds that there has been a relevant change of circumstances and gives an award at the rounded rate of 40% with effect from 5.4.06.

69232 However, where there are three or more assessments, they must either all be aggregated or none aggregated at all. It is not possible to aggregate some assessments and leave others separate.

Note: This does not apply where there is an assessment for PD D1 or D2 (see DMG 69251).

69233 If there is a doubt as to whether or not separate awards are advantageous, the case should be referred to DMA Leeds for advice.

69234 In certain cases an offset decision will also be required (see DMG 69260). See also DMG Chapters 03 and 04 for advice on the limitation of arrears following revision or supersession.

69235 - 69239

Assessments under pre 1.10.86 provisions

69240 Certain assessments under the pre 1.10.86 provisions can be aggregated with those arising on or after that date. Assessments which should be aggregated are

1. provisional assessments

2. final assessments for which a Dis G has been awarded[1]

3. any assessment for which a Dis P (including a pension in lieu) has been awarded.

1 R(1) 3/00

Adjustment

69241 If a provisional assessment for which a Dis G has been paid is included in an aggregated assessment, an adjustment must be made to take account of that part of the award for which the claimant has already been compensated. This is done by reducing the rounded aggregated assessment

by the degree of the assessment already paid as a Dis G for the common period[1]. A Dis P is then payable on the remaining assessment. Special Dis P rates between 1-19% are provided for use in these circumstances[2].

1 SS (II & D) Misc Prov Regs, reg 8(1); 2 reg 8(3) & (4)

Example 1

	2.6.86 - 1.6.88	2.6.88 - 4.4.93
Pre 1.10.86 claim	5% provisional gratuity paid	9% provisional gratuity paid
	1.10.89 for life	
Post 1.10.86 claim	5% for life	

1. Aggregated assessment = 20% (9% + 5% rounded to 20%)

2. 9% already paid as a Dis G is deducted leaving balance of 11%

3. 11% paid at the special Dis P rates from 1.10.89 - 4.4.93

Example 2

	25.5.93 - 24.5.95
Pre 1.10.86 claim	9% provisional gratuity paid
	6.6.94 for life
Post 1.10.86 claim	23% for life

1. Aggregated assessment = 30% (9% +23% rounded to 30%)

2. 9% already paid as a Dis G is deducted leaving a balance of 21%

3. 21% is paid as 20% at normal rate+1% at special Dis P rate for the period 6.6.94 - 24.5.95 followed by a Dis P at the 20% rate.

Note: It is not necessary to supersede the original Dis G award.

69242 Where a provisional assessment given under the pre 1.10.86 provisions has been included in an aggregated award, and then is subsequently reassessed, the DM should note that

1. whether the reassessment is provisional or final, the pre 1.10.86 provisions will continue to apply because of transitional protection[1]. Where the assessment is therefore 1-19% a Dis G should be awarded

2. the award of a Dis G as above does not prevent an aggregated award subsequently being given but an adjustment will need to be made (see DMG 69241).

1 SS (II & D) Misc Prov Regs, reg 14

Assessments where claim is treated as made under pre 1.10.86 provisions only

69243 Assessments should **not** be aggregated where a claim is

1. made on or after 1.10.86 **and**

2. treated as a claim made under the pre 1.10.86 provisions[1].

1 R(I) 4/03

69244 - 69249

Change of circumstances

69250 Where the level of assessment is increased. The amount available for aggregation depends on whether there is an overlap with the previous assessment. Where

1. the previous assessment has expired, the whole of the revised assessment is available for aggregation

2. there is an overlap with the previous assessment, only the difference between the old and new assessments is available for aggregation.

For these purposes, a life award is treated as expiring after seven years[1].

1 R(I) 11/67

Example

First IA 1971. 5% for life awarded and Dis G paid from 1973.

An unforeseen aggravation review results in an assessment of 9% for life from 14.3.92.

Second IA 1973. 3% for life awarded and Dis G paid from 1973.

Following an application for supersession on the grounds of a change of circumstances the DM assess the level of disablement at 11% from 19.8.99 for life.

As the original assessments on the first two claims can be treated as expired the amounts available for aggregation are 9% + 11% = 20%. Dis P at the 20% rate is payable from the start of the common period

i.e. 19.8.99.

Assessments for PDs D1 or D2

69251 The general rule is that where there are three or more assessments, they must either all be aggregated or none aggregated at all (see DMG 69232). However, that does not apply in cases where there is an assessment for D1 or D2. In those cases, it is still possible to make an award for D1 and D2 and to make another award based on aggregated assessments for other diseases or accidents

69252 However, DMs should aggregate assessments only if it is to the claimant's advantage.

Example 1

PD D1 assessed at 2%, special provisions allow payment to be made at 10%.

IA 1996, 12% for life.

Aggregation is appropriate. Claimant is entitled to a Dis P of 14% - (2% D1 and 12% accident) rounded to 20%. If aggregation was not applied the claimant would only be entitled to a 10% Dis P for D1.

Example 2

PD D1 assessed at 2%, special provisions allow payment to be made at 10%.

1st IA 1996, 12% for life.

2nd IA 1998, 17% for life.

Aggregation of D1 with the other assessments is not now appropriate. Claimant is entitled to a 10% Dis P for D1 and a 30% Dis P for the two accidents, giving 40% in total. Aggregating the three assessments would only give the claimant a 30% Dis P (2+12+17=31 rounded to 30).

Example 3

PD D1 assessed at 2%, special provisions allow payment to be made at 10%.

1st IA 1996, 14% for life.

Aggregation is not appropriate. Claimant is entitled to a 10% Dis P for D1 **and** a 20% Dis P for the IA, giving 30% in total. Aggregating the two assessments would only give the claimant a 20% Dis P (2 + 14 = 16 rounded to 20).

Example 4

PD D1 assessed at 2%, special provisions allow payment to be made at 10%.

1st IA 1996, 14% for life.

2nd IA 1998, 16% for life.

Aggregation is not appropriate. Claimant is entitled to a 10% Dis P for D1 **and** a 30% Dis P for the two IAs, giving 40% in total. Aggregating the three assessments would only give the claimant a 30% Dis P (2 + 14 +16 = 32 rounded to 30).

69253 - 69259

Offsets 69260 - 69309

General

69260 Where an award of IIDB is

1. revised **or**

2. superseded **or**

3. varied on appeal

payments made under the original award may be treated as paid on account of benefit which is then found to be payable under the new award[1].

1 SS A Act 92, s 71(6); SS (POR) Regs, reg 5

69261 DMG 69262 et seq gives guidance on offsetting a Dis P against another Dis P. The likelihood of an offset where a Dis G is involved is rare because a Dis G is deemed to be for a maximum period of seven years[1]. Where the DM has to consider an offset where a Dis G is involved before the expiry of the period of seven years, the case should be sent to DMA Leeds for advice.

1 R(I) 11/67

69262 The DM's action on cases where entitlement to a Dis P is based on aggregated assessments will vary according to the circumstances (see DMG 69300).

69263 The amount of offset is the amount of the Dis P previously paid in the common period and not already offset[1].

1 SS (POR) Regs, reg 5

69264 - 69269

Limitation of offset

69270 The amount offset must never exceed the lesser of the amount

1. paid under the original award for the common period **or**

2. subsequently awarded following supersession for that period.

69271 - 69274

Odd days

69275 For offset purposes where a Dis P is involved, only weekly payments are taken into account. No offset should be made for any odd days of the original assessment period falling before the first Wednesday and after the last Tuesday of the common period.

69276 - 69279

Difference between offset amount and that originally paid

69280 Where the sum to be offset is less than that paid under the previous award, it will not be necessary to account for the balance. But should the amount arrived at for offset exceed the value of the previous award, it is not possible to offset more than was originally paid.

69281 - 69284

Hospital treatment allowance

69285 It will be rare to consider an offset where hospital treatment allowance is involved. If this situation arises seek advice from DMA Leeds.

Calculation and wording of a decision including an offset

69286 An offset determination must accurately reflect the law and can therefore be complex. DMs should note the guidance on the basic principles at DMG 69287 - 69291.

69287 **Supersession** - if the previous decision is superseded, the offset determination should state this and the grounds. This action is not required when the decision awarding the benefit to be offset has already been superseded at an earlier date[1].

1 R(I) 15/66

69288 **Re-awarding benefit previously paid** - if the new award follows supersession, the decision must re-award any part of the original award which is not affected by the new award. This is because the original decision no longer exists.

69289 **New award of benefit** - the decision should include a statement of the benefit now awarded, the weekly rate of Dis P and the period to which it relates.

69290 **Amount to be paid** - the decision should include a statement of the net amount payable following offset and the period for which that payment is due.

69291 **Offset** - the decision should include a statement of the total benefit treated as paid on account of

benefit now awarded. Where the current award is for benefit at a weekly rate, the statement should also say how much is being recovered weekly and also state the period for which recovery at that rate will be made. Where an offset from benefit originally awarded has already been made on one or more previous occasions the decision should also include a statement of the amount previously offset.

69292 The DM should note that

1. the offset should be made at the time the new benefit is awarded

2. a decision including an offset may be superseded on the ground that a mistake was made in arithmetic or deciding the common period (see DMG 69293)

3. any amount remaining for recovery in the future should be notified to the claimant as a footnote to the decision (see DMG 69294).

69293 Where DMG 69292 **2.** applies, if not superseded, and an incorrect sum has been offset, the error will stand. The balance available for future offset is the remaining amount, not the amount that would be remaining had the decision been correct.

69294 Where DMG 69292 **3.** applies the footnote does not form part of the decision. The sum quoted will be the maximum amount that can still be offset. Providing there is a common period, this amount can be offset on any number of subsequent occasions at any time in the future against any further awards for the same accident or disease, until it has been fully recovered.

Period of original award runs beyond the end of the common period

69295 When considering these cases the DM should note that the

1. period beyond the end of the common period is not yet available for offset, it can only be taken into account if further decisions are made to award benefit for this period

2. original award no longer exists after supersession, so cannot be the object of further supersession

3. superseded decision not only covers the common period of the altered assessment but also re-awards at the original rate the remainder of the original award so the whole period the original award is made available for offsets

4. decision in explaining the offset should not consider the period outside the common period.

69296 - 69299

Cases involving aggregated awards

69300 The aggregated award may sometimes form part of the offset decision. But in other cases a separate aggregated award will be needed. In most cases supersession of the original assessment will still be necessary.

69301 - 69309

Constant Attendance Allowance 69310 - 69321

Considering a grant of CAA 69310 - 69321

Considering a grant of CAA

69310 Entitlement to CAA may arise where

1. Dis P is paid in respect of 100% disablement[1]

2. there is entitlement to weekly payments under the relevant legislation[2] or any certified contracting-out scheme and the disablement would be assessed at 100%[3]

3. certain former constables and fire-fighters are entitled to injury pension and the disablement would be assessed at 100%[4].

1 SS CB Act 92, 104(1); 2 Workmen's Compensation Acts; 3 SS (Gen Ben) Regs, reg 43; 4 reg 44

69311 The medical adviser will advise on the need for constant attendance when they are considering an IIDB referral and their recommended level of disablement is 95% or greater. In addition to the usual medical reports on the claim for IIDB, the medical adviser will give specific medical advice about CAA on form BI118D.

69312 While decisions on CAA can be reconsidered by the DM, there is no right of appeal against a decision on CAA[1] so it is important to consider all the relevant facts fully before making a decision.

1 SS CS (D&A) Regs, Sch 2, para 14(a)

69313 - 69319

Primary conditions

69320 The primary conditions for a grant of CAA[1] are

1. the claimant's disablement resulting from the relevant accident or disease must total at least 95% as that percentage

1.1 is rounded to 100% **and**

1.2 is paid at the 100% rate **and**

1.3 may be made up by

1.3.a one or more assessments under the IIDB provisions **or**

1.3.b assessments for expired gratuities that have been aggregated **or**

1.3.c a combination of one or more assessments of disablement under the IIDB provisions and one or more assessments covered by payments made under other schemes **and**

2. the claimant is dependent on attendance for the necessities of life **and**

3. the attendance is needed as a result of the relevant loss of faculty **and**

4. attendance will be needed for a prolonged period.

1 SS CB Act 92, s 104

69321 The claimant may receive payments under other schemes after an assessment of disablement. Payments that may be added to any Dis P assessment(s) to satisfy the 95% disablement condition are

1. weekly payments under the relevant legislation or any contracting out scheme certified under relevant legislation where a person is, or has been at any time after 4.7.48 entitled to such payments[1]

2. payments of injury pension to ex-policemen or to ex-firemen relevant legislation where a person is, or has been at any time after 4.7.48 entitled to such payments[2]

3. payments by way of benefit under relevant legislation[3]

4. payments of personal benefit by way of Dis P or Dis G under any

4.1 Personal Injuries Scheme **or**

4.2 Services Pensions Instrument[4].

1 SS (Gen Ben) Regs, reg 20(2)(b); Workmen's Compensation Acts; 2 SS (Gen Ben) Regs, reg 20(2)(c): Police Pension Acts; Fire Brigade Acts; 3 SS (Gen Ben) Regs, reg 20(2)(d); II & D Old Cases Act 75; 4 SS (Gen Ben) Regs, reg 20(2)(e)

Interpretation of conditions for granting CAA 69322 - 69339

Dependent on attendance

69322 In interpreting this condition the DM should establish

1. the claimant's needs **and**

2. which needs cannot be met without assistance.

69323 The grant and rate of CAA depends on the number, frequency and importance of these needs.

69324 In deciding the degree of dependence, the DM should consider how far the claimant can attend to their ordinary human needs themselves. If the claimant needs any help, the DM should consider

1. what the claimant needs help with

2. how much help the claimant needs **and**

3. whether the needs are frequent or predictable.

69325 The DM should note that CAA is granted for the amount of attendance needed. This may not necessarily be the amount of attendance received.

69326 CAA is payable if it is necessary, not merely desirable, for someone to be on call even though the application may not need attention.

The necessities of life

69327 The DM should interpret the phrase "necessities of life" freely. Obvious examples would include

1. eating

2. drinking

3. sleeping

4. natural functions.

69328 A claimant can also expect a reasonable degree of physical and mental comfort and the disablement may create special “necessities of life”. For example some applicants may need to eat or drink more frequently than others, or needs may be increased by incontinence, insomnia, bed sores or vomiting.

A prolonged period

69329 The DM can interpret a prolonged period as six months or more. If the need for attendance is established for a past period, the DM should take this period into account when deciding if the need has lasted for six months or more.

69330 Once this condition is satisfied, it will continue as long as attendance is needed.

69331 This condition is discounted if the need for attendance arose within six months of death and continued up to the claimant’s death.

69332 - 69339

Determining the rate of CAA 69340 - 69370

69340 The rate of CAA depends on the amount of attendance needed. There are four rates of CAA[1]. The four rates are referred to as

1. P/T

2. normal maximum

3. intermediate

4. exceptional.

1 SS (Gen Ben) Regs, reg 19

Artificial limbs

69341 Unless otherwise stated, the examples given in the guidance for each rate assume (when appropriate) that an artificial limb is fitted. In any case in which an artificial limb is awaited, a higher rate of CAA may be applicable if it means that extra attendance is needed, for example if the applicant is confined to bed.

69342 The fact that an artificial limb is not yet in use may not, in itself, make much difference to the amount of attendance needed. The DM must consider each case on its own merits.

69343 - 69344

Part time rate

69345 To qualify for the P/T rate the claimant must satisfy the primary conditions and also

1. need the help of an attendant at certain predictable times of the day for routine attendance. Attendance should be needed for half a day or less **and**

2. be capable of being left for other periods.

69346 Some examples of when the P/T may apply are

1. guiding vision, when vision is not good enough to read ordinary print or get about in unfamiliar places without the help of a sighted person

2. amputation of one arm below the elbow, and one leg below the knee

3. double leg amputations, one through the knee and one higher, or both below the knee.

However, CAA is not payable when one or both lower limb amputations is a Symes or similar amputation through the ankle joint as in these cases, resulting in an end bearing stump, the applicant can stand on their leg without putting on their prosthesis.

69347 It is not usual to grant CAA if help is only needed in dressing and undressing.

69348 - 69349

Normal maximum rate

69350 To qualify for the normal maximum rate the claimant must satisfy the primary conditions and also need attendance for more than half the day.

69351 If occasional attendance at night is also needed but not every night, do not increase entitlement above the normal maximum rate.

69352 If minimal attendance is needed during the day, but regularly during part of the night (i.e. at least twice every night) normal maximum rate may be appropriate.

69353 Some examples of when the normal maximum rate may apply are

1. total blindness without added complications

2. guiding vision with any single limb amputation

3. loss of both arms with stumps from 11.5 cm below the elbow

4. double leg amputations through or above the knee

5. amputation of one leg and one arm where at least one amputation is above the knee or above the elbow

6. paraplegia with incontinence largely controlled by the aid of appliances and considerable independence both in and outside the house (i.e. not practically housebound)

7. other cases where the applicant is confined to bed or wheelchair but has good use to the upper limbs and is not incontinent

8. severe mental disability, including epilepsy, when there is a large measure of physical control of actions

9. severe respiratory disablement necessitating occasional night attendance.

69354 - 69359

Intermediate rate

69360 To qualify for the intermediate rate the applicant, in addition to satisfying the primary conditions, must need a considerable amount of attendance either

1. during most of the day and regularly during part of the night (i.e. at least twice every night) **or**

2. frequently throughout the night and part of the day.

69361 The DM should consider a grant at the intermediate rate if the applicant

1. is not regarded as completely helpless, for example because they have some use in their limbs, particularly the upper limbs **but**

2. needs a considerable degree of attendance both day and night.

69362 Occasional attendance at night does not normally qualify for the intermediate rate.

69363 Some examples of when the intermediate rate may apply are

1. total blindness with any single limb amputation or deafness to the extent of at least 60%

2. both arms amputated with stumps from 20.5cm below the shoulder to less than 11.5 cm below the elbow

3. paraplegia with material incontinence when, although not bed ridden, a considerable amount of attendance is needed both day and night (for example needs help from bed to chair, and from chair to motorised vehicle) - almost housebound without help

4. incomplete quadriplegia when there is a little use in the upper limbs so that the applicant can do some things for themselves (such as feeding) but the upper limbs are still severely disabled

5. severe respiratory disablement necessitating regular night attendance but not all night

6. severe mental disability but able to do a few useful things such as feeding.

Note: Bedsores, repeated urinary infections and considerable preventative skin care nursing also comes under **3.**.

69364 - 69368

Exceptional rate

69369 To qualify for the exceptional rate the applicant, in addition to satisfying the primary conditions, must

1. be completely or almost completely helpless **and**

2. need constant attendance day and night.

69370 Some examples of when the exceptional rate may apply are

1. amputations of both arms above the elbow with stumps less than 20.5cm

2. quadriplegia with little or no use in the hands

3. paraplegia, almost completely bedridden, with little use in the upper limbs and severe incontinence leading to regular and considerable attendance both

during the day and at night (for example tidal drainage, excessive laundry or persistent bedsores)

4. severe respiratory impairment with very severe breathlessness even at rest so that people are bed or chair-bound and unable to transfer necessitating attention day and night

5. severe mental disability resulting in complete helplessness

6. both arms amputated at any level and amputation of leg or serious injury to leg when crutches cannot be used.

Distinguishing between CAA rates 69371 - 69377

69371 The conditions for ESDA make the distinction between the intermediate rate and the normal maximum rate very important.

69372 The DM should examine each case with great care before making an initial grant at the exceptional or intermediate rate.

69373 The DM should also consider each case on its own merits, but the essential factor in determining the need for attendance at the exceptional or intermediate rate is that attendance is either

1. required regularly during most of the day and part of the night **or**

2. frequently throughout the night and part of the day.

69374 One of the higher rates normally is appropriate if more than occasional attendance at night is needed.

69375 To distinguish between the normal maximum and intermediate rates cases, the DM should consider the extent, nature and frequency of night attendance in addition to the severity of the disablement.

69376 The intermediate rate is appropriate, irrespective of the extent and nature of the attendance needed at night, when attendance is needed

1. all day **and**

2. at least twice every night.

Special factors

69377 When special factors arise which largely create the need for attendance day or night, the DM must give them due weight when deciding whether CAA is appropriate at an exceptional rate (for example special factors from domestic circumstances or mental conditions).

Period of grant 69378 - 69389

Renewal 69384

Overpayment 69385 - 69389

69378 If the claimant satisfies the conditions for CAA, the DM must decide the period of any grant.

69379 In deciding the period of a grant of CAA, the DM should take account of the period of assessment of

1. IIDB **and**

2. in aggregation cases, the period for which any other relevant benefit is awarded.

69380 The period of a grant

1. cannot be longer than the period for which an assessment of 95% or more is made **and**

2. should not exceed the period for which constant attendance is likely to last.

69381 The DM should normally make initial grants for at least six months. Grants can be made for less than six months, for example if the claimant has died within this period.

69382 When the claimant's assessment for IIDB is for life, the DM should make a grant of CAA

1. for up to two years **or**

2. for longer if

2.1 it is obvious that there will be no change in the degree of attendance needed **and**

2.2 there is no evidence that the claimant is having difficulty coming to terms with their disability.

69383 The DM should not grant CAA for life if

1. the evidence shows that the claimant is having difficulty coming to terms with their disability

2. attendance needs are likely to reduce or increase, bearing in mind the age of the claimant

3. it is known that the claimant's house is about to be adapted

4. it is known that the claimant is about to move house

5. an up to date form BI118D has not been completed in the claimant's house.

Renewal

69384 A grant will be renewed if the claimant continues to satisfy the conditions[1]. When considering renewal, the DM should consider all available evidence. The DM should refer the case to DMA Leeds for advice if a reduction in the rate of CAA would affect the grant of ESDA. Cases of difficulty should also be referred to DMA Leeds for advice.

1 SS CB Act 92, s 104(2)

Overpayment

69385 If an overpayment occurs because CAA has been paid at the same time as AA or the care component DLA, the overpaid benefit is the AA or DLA as that benefit should have been reduced to take account of the CAA[1]. CAA is the benefit which remains in payment.

1 SS (OB) Regs, Sch 1

69386 - 69389

Claimant in hospital 69390 - 69499

Conditional grant for hospital in-patient 69393 - 69499

69390 CAA is not payable while the claimant is receiving free in-patient treatment in a hospital or similar institution[1] unless DMG 69391 applies.

1 SS (Gen Ben) Regs, reg 21(1)

69391 CAA is payable for the first 28 days of free in-patient treatment following admission to a hospital or similar institution if

1. the claimant is already receiving CAA at the date of admission **or**

2. CAA is subsequently granted for a period which includes the date of admission[1].

1 SS (Gen Ben) Regs, reg 21(2)

69392 Two or more distinct periods spent as an in-patient are added together and treated as a continuous period unless they are separated by a period of at least 28 days[1].

1 SS (Gen Ben) Regs, reg 21(3)

Conditional grant for hospital in-patient

69393 A claimant who is disqualified from receiving CAA because they are receiving free in-patient treatment in a hospital or similar institution can be given a “conditional” grant of CAA.

69394 If the claimant has a conditional grant, CAA becomes payable when they leave hospital, even if only for short periods, without the need to change the decision. In these cases CAA is payable at a daily rate equivalent to one seventh of the weekly rate for days which the claimant spends out of hospital.

69395 If the claimant was in hospital when their attendance needs first were assessed, the answers to the questions on form BI118D outline the need for attendance if the claimant was not an in-patient. In such cases consider the need for CAA as normal, and in the light of any information obtained from the hospital.

69396 ESDA can be paid while the claimant is in hospital. If the conditions for ESDA are satisfied but CAA is not payable, make a conditional grant of CAA so that ESDA can be granted and paid.

69397 - 69499

Exceptionally Severe Disablement Allowance 69500 - 69999

Considering a grant of ESDA

69500 A claimant may be entitled to ESDA if the

1. conditions for CAA are satisfied **and**

2. need for constant attendance is likely to be permanent[1].

1 SS CB Act 92, s 105(1)(a) & (b); SS (Gen Ben) Regs, regs 43 & 44

69501 There is no specific form for medical advice on ESDA. The medical adviser normally will give advice on ESDA when considering CAA.

69502 While decisions on ESDA can be reconsidered by the DM, there is no right of appeal against a decision on ESDA[1] so it is important to consider all the relevant facts fully before making a decision.

1 SS CS (D&A) Regs, Sch 2, para 14(b)

69503 DMs should only grant ESDA if they are reasonably certain that the claimant's attendance needs, above the normal maximum rate of CAA, are likely to be permanent.

69504 DMs should not grant ESDA if they expect the

1. claimant's condition to improve **and**

2. rate of CAA to be reduced in the future.

69505 - 69509

"Permanent"

69510 When granting ESDA the term "permanent" means "for life".

69511 Medical advice may sometimes appear to relate to the permanent nature of the relevant loss of faculty rather than the attendance needs. DMs should use their own judgement before granting ESDA.

69512 The DM should be cautious about granting ESDA if the claimant's attendance needs are likely to decrease even if their overall physical condition does not improve.

Example

A young person is severely disabled following an accident. CAA at the intermediate rate is appropriate.

In time the person could become self sufficient and lead a fairly full life by using their upper limbs even though their basic loss of faculty will not change. If such an improvement seems possible, the need for attendance at the intermediate level on a permanent basis is not established, so ESDA should not be granted.

A grant of ESDA should not be discounted if a claimant's attendance needs were only considered to be permanent shortly before their death.

Deciding entitlement

69513 The DM should note the advice on form BI118D, but should not automatically accept that advice as conclusive.

69514 The DM should consider all the available evidence. If CAA is not granted for life, the DM should pay particular attention to the reasons why the grant of CAA is provisional or restricted to a short period.

69515 If DMs have any doubts about whether ESDA is appropriate, refer the case to medical services for advice.

69516 - 69519

Claimant is in hospital

69520 The DM should consider granting ESDA if the claimant

1. is receiving free medical treatment as an in-patient at a hospital or similar institution **and**

2. has been granted CAA at a rate higher than the normal maximum rate, or would be granted CAA at such a rate if they were not an in-patient.

69521 If the claimant has not been granted CAA because they are an in-patient, but the other conditions for a grant of ESDA are satisfied, the DM should make a conditional grant of CAA.

Conditions for ESDA are satisfied

69522 If the conditions for ESDA are satisfied, the DM should grant ESDA for the period for which entitlement to CAA has been established.

Conditions for ESDA are not satisfied

69523 If the conditions for ESDA are not satisfied, the DM should note the reasons in the claimant's B18 in case the claimant asks for an explanation of the decision.

69524 - 69529

Renewals

69530 When ESDA is due for renewal, the DM should first consider the claimant's continuing entitlement to CAA.

69531 If CAA is not payable because the claimant is in hospital or a similar institution, the DM should consider making a conditional grant of CAA.

69532 If CAA is still granted at a rate higher than the normal maximum rate, DMs should accept that the need for permanent constant attendance is still satisfied unless they have clear evidence suggesting otherwise.

Clear evidence

69533 In this context "clear evidence" must be specific and unambiguous evidence that puts doubt on the need for permanent constant attendance. The DM should not accept a change in opinion as clear evidence.

69534 If clear evidence appears to exist, the DM should refer the case to DMA Leeds for advice before making a decision not to renew a grant of ESDA.

ESDA grant is not renewed

69535 If DMs decide not to renew a grant of ESDA, they should note the reasons in detail in the

claimant's B18 in case the claimant asks for an explanation of the decision.

69536 - 69999

The content of the examples in this document (including use of imagery) is for illustrative purposes only