[2016] AACR 35

**(SD v Secretary of State for Work and Pensions (ESA)
[2016] UKUT 100 (AAC))**

Judge Knowles QC **CE/1402/2015**
19 February 2016

Employment and support allowance – regulation 29(2)(b) – substance or drug dependence a mental disease or disablement

Following an assessment by a health care professional the Secretary of State decided that the appellant, a homeless drug user, was not entitled to employment and support allowance (ESA). The appellant appealed against that decision and among the findings of fact made by the First-tier Tribunal (F-tT) was that he was a drug user and he had been imprisoned for possession with intent to supply drugs. Despite these findings the F-tT rejected the appellant's appeal, holding that any limitations arising from his mental health issues were insufficient to bring him within regulation 29(2)(b) of the Employment and Support Allowance Regulations 2008 ie that there would be substantial risk to the mental health of any persons if he were found not to have limited capability for work. The appellant appealed to the Upper Tribunal (UT) arguing that the F-tT had failed to have regard to his mental health problems and drug misuse when assessing, in particular, whether regulation 29(2)(b) applied in his case.

Held, allowing the appeal, that:

1. the F-tT failed to consider the effect of the appellant's drug use when considering regulation 29(2)(b). Despite finding that he used street drugs, it made no findings as to the effect that this drug use had on his functioning relevant to its consideration of regulation 29(2)(b) (paragraphs 17 and 44 to 51);

2. the factors pointing towards alcohol dependence set out in *JG v Secretary of State for Work and Pensions (ESA)* [2013] UKUT 37 (AAC); [2013] AACR 23 had application in the case of drug dependency and should have been considered by the F-tT to establish whether the appellant's drug dependency constituted a bodily or mental disablement for the purposes of regulation 29(2)(b) (paragraphs 30 to 43);

3. the tribunal had failed to consider whether regulation 29(3)(b) applied. If the risk to him or others could be reduced by the use of medication prescribed to manage the appellant's drug dependency then regulation 29(2)(b) would not apply (paragraph 53);

4. in the circumstances it was not necessary to address whether the F-tT had identified the range of work the appellant could do in accordance with the requirements of *Charlton v Secretary of State for Work and Pensions* [2009] EWCA Civ 42, reported as R(IB) 2/09, but guidance was given for those tribunals rejecting an appellant's case that regulation 29(2)(b) applied (paragraph 55).

The judge set aside the decision of the F-tT and remitted the appeal to a differently constituted tribunal to be decided in accordance with her directions.

DECISION OF THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

Decision: The appellant's appeal is allowed.

The decision of the First-tier Tribunal sitting in Llandudno on 18 February 2015 under file reference SC155/14/00126 involved an error on a point of law and is set aside.

The tribunal's decision is set aside and the case remitted to the First-tier Tribunal (Social Entitlement Chamber) for rehearing before a differently constituted tribunal in accordance with the directions set out at the conclusion of the Reasons below.

REASONS FOR DECISION

The issue in this appeal

1. The issue in this appeal concerns the appellant's entitlement to employment and support allowance (ESA) in the context of his drug use. The tribunal found that (a) he used street drugs including heroin and that he bought – and by inference – used street valium; (b) Social Services had been involved with the appellant, his ex-partner and his 14-month old baby daughter because of the appellant's drug use but there were said to be no child protection concerns; and (c) though the appellant had been in prison from 2008 to 2010 for possession with intent to supply class A drugs, he had not been in trouble with the police with respect to other drug offences in the last few years. In the light of those findings, the appellant's drug use was an important factor for a tribunal to consider when determining whether he was drug dependent and thus suffering from a bodily or mental disablement by reference to the descriptors in Schedule 2 and regulation 29(2)(b) of the Employment and Support Allowance Regulations 2008.

2. I find that the tribunal, despite having made the findings set out above, failed to take the next step which was to consider and determine whether the appellant's drug use amounted to drug dependency and thus constituted a mental disease or disablement. In that respect its reasoning was materially inadequate and I allow this appeal on that ground.

3. I consider whether the factors pointing towards alcohol dependence set out in *JG v Secretary of State for Work and Pensions (ESA)* [2013] UKUT 37 (AAC); [2013] AACR 23 have application in the case of drug dependency and conclude that they do.

Factual background

4. At the time of the relevant decision on 25 September 2013, the appellant was a young man aged 33 years. He was homeless and was "couch-surfing" at the homes of his cousin, a friend and an ex-partner respectively. He had a baby daughter who he saw every couple of days on an unsupervised basis. He was no longer in a relationship with the mother of his child.

5. The appellant had been in the army from 1998 to 2001. He was medically discharged after being shot whilst on leave in Manchester. Subsequently it is fair to say that he struggled to find stability in his life: he had been in prison and it was thought he may be suffering from post-traumatic stress disorder.

6. Following an assessment by a health care professional in July 2013, the Secretary of State decided that the appellant was not entitled to ESA as he scored no points for any of the descriptors listed in Schedule 2 to the Employment and Support Allowance Regulations 2008 (SI 2008/794) (the Regulations). The appellant appealed against that decision with the assistance of the Royal British Legion.

7. Unfortunately the tribunal hearing had to be adjourned on two occasions for reasons which are not relevant to this appeal. At the third hearing on 18 February 2015 the appellant gave oral evidence and submissions were made on his behalf by the Royal British Legion. The tribunal found that, whilst the appellant had mental health issues, the nature and extent of the resulting limitations were insufficient to score the required number of points to qualify for ESA. It also found that regulation 29(2)(b) did not apply. In reaching its decision, the tribunal recorded that it placed particular reliance on the medical evidence.

8. The appellant sought permission to appeal against the tribunal's decision and on 26 October 2015 I held an oral hearing of the application for permission to appeal in Prestatyn

which was attended by the appellant and his representative. I gave permission to appeal by a ruling dated 29 October 2015.

9. I have received written submissions from the respondent for which I express my thanks. The appellant through his representative has made no further submissions. Neither party requested an oral hearing and I am satisfied that I can determine this appeal properly and fairly without one.

10. In coming to my decision I have read all the evidence and the submissions in the bundle very carefully.

The tribunal's decision

11. The tribunal found that the appellant had no physical limitations which were relevant. His representative invited the tribunal to consider descriptors 14(b), 16(b) and 17(c) as well as regulation 29(2)(b) if necessary.

12. With respect to descriptor 14(b), the tribunal found there was no persuasive evidence that the appellant could not cope with change and thus did not satisfy that descriptor. Likewise the tribunal found that the appellant was able to cope with social engagement (activity 16). It acknowledged that the appellant had trouble maintaining involvement with some of the agencies/specialists he had been referred to for help but stated that it "felt this was due to his drug abuse and not due to mental health reasons".

13. Having reviewed the evidence in some detail, the tribunal concluded that the appellant's behaviour was not uncontrolled so as to satisfy descriptor 17(c). It found that the appellant could control his behaviour when he wished to do so, for example, when involved with his baby daughter. Though the medical records made reference to the appellant's loss of temper and aggression, the tribunal found this occurred when the appellant did not get what he wanted. His behaviour at the hearing demonstrated that he was able to answer questions calmly unless it was a question he did not want to answer. He had not been in trouble with the police over the last few years and the tribunal concluded that, were his aggression and violence as great as he said they were, the appellant would have had recent contact with the police.

14. The tribunal went on to consider the appellant's mental health issues as a whole. It considered a report from Dr K, a specialist doctor in acute psychiatry, dated April 2014 and quoted this passage from that report:

> "… I did not notice any signs of depression or psychosis. He was well kempt and established good eye contact. His speech was coherent and normal in rate, tone and volume. No psycho-motor retardation was seen … the impression was that he does not have a mental illness of the degree that he needs an admission or acute care."

In conclusion the tribunal stated that, whilst it accepted that the appellant had some mental health issues, "these were not to the extent that are relevant to this appeal".

15. Finally the tribunal considered regulation 29 and concluded that it did not apply. The tribunal found that there was no reason why the appellant could not travel to a job centre and could travel to and from work. It found that the appellant "did not have any physical or mental health limitations that would prevent him from working". It made reference to the fact that the

appellant had been in army and concluded that there would be an adequate range of work he could undertake without creating a substantial risk to the mental or physical or physical health of any person, including his own, if he were found capable of work.

Permission to appeal

16. I gave permission on the following grounds, which I reproduce here at [17]–[20] with some minor amendment.

17. First, the tribunal arguably neglected to consider the effect of the appellant's drug use when considering regulation 29(2)(b). This was a matter in issue by virtue of the letter from the Royal British Legion dated 30 September 2014 (see specifically page 51). The tribunal found that the appellant used street drugs including heroin and that he bought – and by inference used – street valium. The tribunal made no findings as to the effect that this drug use had on the appellant's functioning relevant to its consideration of regulation 29(2)(b) and thus arguably erred in law. I note that a letter from a consultant psychiatrist, Dr R, diagnosed the respondent as having "relapsed to street heroin dependency" over the previous 12 months (page 71). Whilst the date of that letter was 26 February 2014 and thus post-dated the relevant decision by some six months, it arguably shed light on circumstances relevant to the appellant's health at that time.

18. A three-judge panel considered alcohol dependence and its relevance to a person's capability for work within the meaning of the Employment and Support Allowance Regulations *(JG v Secretary of State for Work and Pensions (ESA)* [2013] UKUT 37 (AAC); [2013] AACR 23). It found that alcohol misuse must rank as "alcohol dependency" by reference to a constellation of markers set out in [45] in order for such dependency to constitute a "disablement". Should the tribunal have considered whether the factors set out in that judgment were relevant to the issue of drug dependency and made findings on this issue? Arguably it should have done given that the appellant had to demonstrate that his drug dependency constituted a bodily or mental disablement in order to satisfy part of the test in regulation 29(2)(b).

19. The written evidence before the tribunal about the effect of drug use/drug dependency was unclear and arguably required clarification by the tribunal at the hearing. This did not happen. The tribunal had an inquisitorial function and arguably should have explored this issue with the appellant even if his representative failed to do so. If it wished to avoid distress to the appellant by such questioning, should it not have considered an adjournment and directed the production of a statement by the appellant addressing this issue?

20. Finally, the tribunal concluded that there would be an "adequate range of work" which the appellant could undertake without risk to himself or another. It is arguable that such a finding did not follow the procedure set out in *Charlton v Secretary of State for Work and Pensions* [2009] EWCA Civ 42, reported as R(IB) 2/09, which requires a tribunal – with sufficient particularity – to identify the range of work a claimant could do. Here all the tribunal did was to state that the appellant had been in the army.

The relevant law

21. I have only made reference to the law which is relevant to the issues raised by this appeal.

22. This relevant law is helpfully analysed in *JG v Secretary of State for Work and Pensions (ESA)* [2013] UKUT 37 (AAC), a decision by a three-judge panel. [12]–[21] of *JG* consider the Welfare Reform Act 2007 which underpins the regulations pertaining to ESA. *JG* held that sections 15A and 18 of the Act supported the proposition that alcohol or drug dependence was capable of falling within the definition of a "specific disease or bodily or mental disablement" in order to found a claim for ESA (see [18]–[21]).

23. Regulation 19 of the Employment and Support Allowance Regulations 2008 sets out how limited capability for work is to be determined via the limited capability work assessment. I reproduce those parts of regulation 19 relevant to this appeal below:

> "(1) For the purposes of Part 1 of the Act, whether a claimant's capability for work is limited by the claimant's physical or mental condition and, if it is, whether the limitation is such that it is not reasonable to require the claimant to work is to be determined on the basis of a limited capability for work assessment of the claimant in accordance with this Part.
>
> (2) The limited capability for work assessment is an assessment of the extent to which a claimant who has some specific disease or bodily or mental disablement is capable of performing the activities prescribed in Schedule 2 or is incapable by reason of such disease or bodily or mental disablement of performing those activities.
>
> …
> (5) In assessing the extent of a claimant's capability to perform any activity listed in Schedule 2, it is a condition that the claimant's incapability to perform the activity arises –
>
> > (a) in respect of any descriptor listed in Part 1 of Schedule 2, from a specific bodily disease or disablement;
> >
> > (b) in respect of any descriptor listed in Part 2 of Schedule 2, from a specific mental disease or disablement; or
> >
> > (c) in respect of any descriptor or descriptors listed in –
> >
> > > (i) Part 1 of Schedule 2, as a direct result of treatment provided by a registered medical practitioner for a specific physical disease or disablement; or
> > >
> > > (ii) Part 2 of Schedule 2, as a direct result of treatment provided by a registered medical practitioner for a specific mental illness or disablement.
> >
> > …"

24. Regulation 19 establishes a causative link between the disease or disablement and the incapability to perform the activities in Schedule 2. The same link between disease/disablement and incapability is seen in regulation 29(2)(b) which comes into play where the claimant has been found not to have limited capability for work. The paragraphs of regulation 29 relevant to this appeal are as follows:

"(1) A claimant who does not have limited capability for work as determined in accordance with the limited capability for work assessment is to be treated as having limited capability for work if paragraph (2) applies to the claimant.

(2) Subject to paragraph 3 this paragraph applies if –

…
(b) the claimant suffers from some specific disease or bodily or mental disablement and, by reason of such disease or disablement, there would be substantial risk to the mental or physical health of any person if the claimant were found not to have limited capability for work.

(3) Paragraph (2)(b) does not apply where the risk could be reduced by a significant amount by –

(a) reasonable adjustments being made in the claimant's workplace; or

(b) the claimant taking medication to manage the claimant's condition where such medication has been prescribed for the claimant by a registered medical practitioner treating the claimant.

…"

25. In most cases there will be little difficulty, given the medical evidence, as to whether a claimant's condition amounts to a disease or disablement. [44] of *JG* suggested that the most practical approach was for a tribunal to work backwards by starting with the Schedule 2 activities and descriptors in issue; assessing the evidence in respect of each of them; and awarding points (or not) accordingly. The wording of the descriptor in some cases requires the tribunal to decide whether the claimant's incapability to perform the activity arises from a physical or mental disablement or disease.

26. *JG* is also authority for the proposition that alcohol dependency falls within the phrase "specific disease or bodily or mental disablement". The summary of the expert evidence on alcohol dependence in R(DLA) 6/06 could and should be adopted by decision-makers and tribunals in ESA cases as representing the currently accepted and mainstream medical view in respect of alcohol dependence ([47]). The evidence referred to is set out in [45] of *JG*.

The parties' respective cases on appeal: summary

27. In essence, the appellant argued that the tribunal had failed to have regard to his mental health problems and drug misuse when assessing, in particular, whether regulation 29(2)(b) applied in his case. Additionally the tribunal was said to have overlooked evidence pointing to the appellant's aggressive and threatening behaviour in general rather than just when he did not get what he wanted. That latter ground of appeal was very much secondary to the submission centred around regulation 29(2)(b) and the appellant's drug use.

28. The respondent argued that the tribunal did not err in law in its approach to this case. He accepted that, applying the principles set out in *JG*, drug dependency might constitute a bodily or mental disablement by reference to the descriptors in Schedule 2 and regulation 29(2)(b).

However his case was that the claimant was not dependent on drugs at the date of the decision under appeal.

Drug dependency: specific disease or bodily or mental disablement

29. Turning to the third of the permission grounds, I am indebted to the submission from the respondent.

30. The criteria for diagnosing alcohol dependence set out in [45] of *JG* relied on the factors listed in the category of Substance Dependence contained in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM IV). The diagnostic criteria are as follows:

> "A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same twelve month period:
>
> i) tolerance as defined by either of the following: (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect or (b) markedly diminished effect with continued use of the same amount of the substance;
>
> ii) withdrawal as manifested by either of the following: (a) the characteristic withdrawal syndrome for the substance or (b) the same (or a closely related substance) is taken to relieve or avoid withdrawal symptoms;
>
> iii) the substance is often taken in larger amounts over a longer period than was intended;
>
> iv) there is a persistent desire or unsuccessful efforts to cut down or control substance use;
>
> v) a great deal of time is spent in activities necessary to obtain the substance (eg visiting multiple doctors or driving long distances), use the substance (eg chain-smoking), or recover from its effects;
>
> vi) important social, occupational or recreational activities are given up or reduced because of substance use;
>
> vii) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problems that is likely to have been caused or exacerbated by the substance (eg current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)."

31. I note that the factors listed in the category of Substance Dependence in DSM-IV are not alcohol specific (see (vii) above for example) and thus, as a matter of logic, they must apply to other substances such as heroin and cocaine. I find that the constellation of markers set out in [45] is therefore equally applicable to drug dependence (such as that probably seen in this particular case).

32. The respondent states that he "has no argument with *JG* about how drug dependency may be determined and how it might constitute a bodily or mental disablement by way of reference to the descriptors of Schedule 2 of the ESA Regs 2008 and regulation 29(2)(b)." I interpret this submission as support for my conclusion that the factors listed in [45] of *JG* by reference to DSM-IV are applicable to drug as well as alcohol dependence.

33. If I am wrong about the above, the respondent has made submissions about the changes wrought by DSM-5 to the clinical criteria for substance dependence. However he has not said how these changes might impact upon the finding in *JG* that a diagnosis of alcohol dependence – and I suggest, drug dependence – brought that condition within regulation 19(5), and by extension, regulation 29(2)(b), of the Regulations.

34. DSM-IV has now been superseded by DSM-5 with effect from 18 May 2013. In DSM-5, substance related/addictive disorders are divided into two groups: substance use disorders and substance induced disorders.

35. Substance use disorder in DSM-5 combines the DSM-IV categories of substance abuse and substance dependence into a single disorder measured on a spectrum from mild to severe. Each specific substance is addressed as a separate use disorder such as alcohol use disorder, opioid use disorder or stimulant use disorder. Whereas a diagnosis of substance abuse previously required only one symptom to be present in the previous twelve months, mild substance use disorder in DSM-5 requires two to three symptoms from a list of 11. In DSM-IV the distinction between abuse and dependence was based on the concept of abuse as a mild or early phase and dependence as the more severe manifestation. The revised criterion of substance use disorder is said to better match the symptoms that patients experience.

36. Substance induced disorders include intoxication, withdrawal, substance induced psychosis and substance induced neuro-cognitive disorders.

37. The diagnostic criteria for opioid use disorder (heroin being an opioid) are as follows:

> "a problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following occurring within a 12-month period:
>
> (i) opioids are often taken in larger amounts or over a longer period than was intended;
>
> (ii) there is a persistent desire or unsuccessful attempts to cut down or control opiate use;
>
> (iii) a great deal of time is spent in activities necessary to obtain the opioid, use the opioid or recover from its effects;
>
> (iv) craving or a strong desire to use opioids;
>
> (v) recurrent opioid use resulting in a failure to fulfil major role obligations at work, school or home;
>
> (vi) continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the use of opioids;
>
> (vii) important social, occupational or recreational activities are given up or their engagement is reduced because of opioid use;

(viii) recurrent opioid use in situations in which it is physically hazardous;

(ix) continued opioid use despite knowledge of having a persistent or recurrent physical of psychological problem that is likely to have been caused or exacerbated by the substance;

(x) tolerance as defined by either a need for markedly increased amounts of opioids to achieve intoxication/desired effect or a markedly diminished effect with continued use of the same amount of opioid;

(xi) and withdrawal as manifested by either the characteristic opioid withdrawal syndrome or opioids (or a closely related substance) being taken to relieve or avoid withdrawal symptoms."

38. Severity is specified as follows: mild substance use disorder is the presence of two to three of the above symptoms; moderate is the presence of four to five symptoms; and severe is the presence of six or more symptoms.

39. The category of opioid induced disorders includes opioid intoxication, opioid withdrawal; opioid induced anxiety disorder and opioid induced depressive disorder.

40. *JG* concluded that a diagnosis of alcohol dependence or alcohol dependency syndrome plainly brought that condition within regulation 19(5) of the Regulations ([48]). The position now is rather more complex given the adjustments made by DSM-5 to the category of substance-related disorders.

41. I have come to the conclusion that a diagnosis of mild substance abuse disorder in accordance with DSM-5 would not bring that condition within regulations 19(5) or 29(2)(b) of the Regulations. I consider that, in order to fall within the ambit of the relevant regulations, the substance abuse disorder must fall within either the moderate or severe categories. My reasons for so concluding are as follows.

42. A DSM-IV diagnosis of alcohol dependency required three or more symptoms from the list occurring at any time in the same 12-month period. It is clear that all of the factors listed in DSM-IV are incorporated into the factors for substance abuse disorder listed in [37]. The presence of three or more factors in a twelve-month period from the DSM-5 list would establish a diagnosis of mild substance use disorder. However a DSM-5 diagnosis of substance use disorder equivalent to DSM-IV substance dependency requires, in my view, the presence of, at least four to five symptoms from the eleven listed, thus bringing it within the moderately severe category of substance use disorder. This is because the distinction between abuse and dependence in DSM-IV was based on the concept of substance abuse as a mild or early phase and substance dependence as the more severe manifestation.

43. In conclusion, my comments about the changes occasioned by DSM-5 to the reasoning in *JG* with respect to substance dependence support the reasoning in *JG* by which I am bound.

The appellant's drug use

44. In the light of *JG*, was the tribunal in error of law in its approach to the appellant's drug use having regard to Schedule 2 and regulation 29(2)(b)? I have concluded that it was, with

respect to its consideration of regulation 29(2)(b). On reflection, I can see little scope for criticism of the tribunal's findings or reasoning with respect to the Schedule 2 descriptors in issue.

45. The Secretary of State submitted that the question was whether the tribunal was right to say that regulation 29 did not apply in the appellant's case when it made no reference in that context to drug abuse. He says the tribunal was correct because, although the appellant is said to have been taking drugs later, as at the date of the decision he denied taking Class A drugs.

46. The second of those submissions is difficult to accept given the tribunal's finding of fact that the appellant was using street drugs including heroin and was buying valium off the street. The tribunal had made it explicitly clear in paragraph 22 of the Statement of Reasons that it was considering the position at the date of the decision under appeal and thus its findings of fact must be read in that context. What the appellant may or may not have said at the date of the decision was irrelevant in the light of the tribunal's unequivocal finding.

47. Having made that finding of fact, the tribunal failed in the remainder of its reasons to make any reference to it whatsoever. I find that very surprising given that the tribunal had before it a letter from Dr R, a consultant psychiatrist from the Substance Misuse Service, dated 26 February 2014, which contained a diagnosis of "relapse back to street heroin dependency with intermittent use of crack cocaine" (page 71). That diagnosis was based, in part, on an account given by the appellant that he had relapsed back to smoking heroin for about the last twelve months. Dr R noted that he had not disclosed this until recently and had not discussed it when seen by the primary care mental health team in the autumn of 2013. The tribunal had relied on some of what was said in that letter when considering whether the appellant satisfied descriptor 17(c) (see paragraph 29 of the Statement of Reasons). Its failure to consider whether Dr R's diagnosis, alongside its own finding about the appellant's drug use, had any bearing on regulation 29(2)(b) rendered its reasoning on that issue materially inadequate and in error of law.

48. The respondent submitted that the evidence with respect to the appellant's drug use was inconsistent and that there was sufficient evidence to show that the appellant was not drug dependent at the time of the decision under appeal. Those submissions do not carry weight in the absence of any analysis whatsoever in the Statement of Reasons either of the evidence relating to drug use/dependence or its significance.

49. In my grant of permission, I observed that the tribunal arguably should have explored the effects of the appellant's drug use/dependency with him at the hearing or adjourned for him to address this in statement form if it wished to avoid distress to him (given his somewhat volatile conduct in two of the three tribunal hearings). Quite properly the respondent has referred me to the record of proceedings which makes frequent reference to the appellant's use of drugs and to incidents which may have had some drug-related aspect.

50. Given the frequent references to drug use in the record of proceedings, I observe it is even more surprising that the tribunal failed to have adequate regard to this issue in its Statement of Reasons.

51. Regrettably the tribunal's questioning was not focussed on the effect of drug use on the appellant's daily functioning which might be relevant for its consideration as to whether there was a substantial risk to the mental or physical health of any person if the appellant were found not to have limited capability for work. Bluntly, if the appellant were intoxicated on drugs during

work hours, there might be implications for not only his own health but also the health of fellow employees or members of the public (should any job bring him into contact with the public). In the statement prepared for this appeal on my direction, the appellant's representative explained that the appellant became drowsy for several hours once the initial effect of heroin had worn off (page 132). It is not hard to see how that factor might impact upon the assessment of risk required by regulation 29(2)(b) and why, in appropriate cases, an exploration by the tribunal of the effect of substance use on an individual's functioning is required.

52. In this context, the other matter which required some attention – and exploration by means of evidence – from the tribunal was whether regulation 29(3)(b) applied in this case, given that Dr R had prescribed Suboxone in an attempt to manage the appellant's dependency on heroin. If risk could be reduced by the appellant taking medication prescribed by a registered medical practitioner treating him, regulation 29(2)(b) would not apply.

53. The tribunal stated that it had considered the appellant's mental health issues as a whole and made reference to the letter from Dr K (see [14] above). However, and in possible ignorance of *JG*'s application to substance misuse, the tribunal did not analyse whether drug dependency as diagnosed by Dr R amounted to a mental health disease or disablement. It thus overlooked important evidence about a major issue in this case and thereby undermined the sufficiency of its reasoning.

54. In the light of the above analysis, I conclude that the tribunal materially erred in law by giving inadequate reasons for its decision that regulation 29(2)(b) did not apply in this case. I allow the appeal on this ground.

55. Given my conclusions, I consider it unnecessary to address in detail whether all the requirements of *Charlton v Secretary of State for Work and Pensions* [2009] EWCA Civ 42 were met in this case, specifically whether the tribunal adequately addressed the range of work the appellant could do. I note that, in circumstances where a tribunal rejects an appellant's case that regulation 29(2)(b) applies, it will be helpful if the tribunal briefly states what range of work the appellant might be expected to do.

Conclusions

56. I am satisfied that the tribunal materially erred in law and thus this appeal must be allowed for the reasons set out above.

57. I am further satisfied that the appropriate order is the setting aside of the tribunal's decision and the remittal of the appellant's case for fresh consideration by a differently constituted tribunal. In my judgment, it would not be in the interests of justice to restrict the scope of the remitted hearing, and so the appellant is entitled to advance any and all points he wishes on their merits at the fresh hearing.

58. Though the appellant has succeeded in this appeal, this should not be taken as an indication that he will be successful at any rehearing.

CASE MANAGEMENT DIRECTIONS

59. The appeal should be considered at an oral hearing.

60. The new First-tier Tribunal should not involve the tribunal judge who was previously involved in determining the appeal on 18 February 2015.

61. If the appellant has any further written evidence to put before the tribunal, this should be sent to the tribunal office within one month of the issue of this decision. Any such further evidence will have to relate to the circumstances as they were at the date of the original decision under appeal (namely 25 September 2013).

62. The differently constituted tribunal must conduct a complete rehearing of the issues that are raised by this appeal and, subject to the tribunal's discretion under section 12(8)(a) of the Social Security Act 1998, any other issues that merit consideration.

63. The tribunal must deal with any procedural questions, as may arise, on their merits.

64. The tribunal must consider all aspects of the case, both fact and law, entirely afresh.

65. The tribunal must not take into account any circumstances that were not obtaining at the date of the decision appealed against – see section 12(8)(b) of the 1998 Act – but may take into account evidence that came into existence after the decision was made and evidence of events after the decision was made, insofar as it is relevant to the circumstances obtaining at the date of the decision.