IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER

Case Nos. CI/1000/2019
CI/1001/2019
CI/1002/2019

Before Deputy Upper Tribunal Judge Rowland

Decisions: The claimant's appeals are allowed. The decisions of the First-tier Tribunal dated 11 September 2019 in respect of Prescribed Diseases C2, C5A and C21 are set aside and the cases are remitted to a differently-constituted panel of the First-tier Tribunal to be re-decided. (This means that the judge and medically-qualified panel member who actually sat on 11 September 2019 are excluded from sitting on the remitted appeals but the medically-qualified panel member who was due to sit on 11 September 2019 but was unable do so is not.)

Direction: Subject to any further direction by the First-tier Tribunal, there is to be a hearing of the remitted appeals (which may be by video link or by telephone). I draw attention to my comments at paragraphs 78 to 84 below. In particular, the claimant is strongly encouraged to participate in the hearing.

REASONS FOR DECISION

1. These are appeals, brought by the claimant with permission granted by Upper Tribunal Judge Wright, against decisions given by the First-tier Tribunal on 11 September 2018, dismissing the claimant's appeals against decisions of the Secretary of State to the effect that the claimant was not entitled to disablement pension in respect of Prescribed Diseases C2 or C21 and that the assessment of his disablement arising out of Prescribed Disease C5A was 15%. The decisions were not expressed quite like that by either the Secretary of State or the First-tier Tribunal, but that was their general effect.

2. These cases were both medically complicated and, at least when viewed from the claimant's perspective, legally complicated. Although the Secretary of State accepts that the First-tier Tribunal erred in law in respect of all six of the issues to which Judge Wright drew attention when giving permission to appeal, I will set out the background in some detail so that I can address some of the other issues that the claimant has raised and untangle some of the procedural knots.

The factual background and the legislation

3. The underlying facts are not in dispute. The claimant is a retired aircraft maintenance engineer. He worked on aircraft for almost all of his working life, first in the Royal Air Force and then in civilian employment from 1968 until he was badly injured in a road traffic accident in 1990 that forced him to give up employment in 1992. In that work, he was exposed to a wide variety of chemical agents. He is now aged 78 and has many medical problems, not all of which, as he accepts, are related to his former employment. The claims giving rise to this appeal were made over four years ago. It is obviously not satisfactory that they have still not finally been determined.

4. Although only three prescribed diseases were considered by the First-tier Tribunal, the claimant had in fact claimed disablement pension in respect of no fewer than eight prescribed diseases that he claimed he suffered from as a result of his exposure to chemical agents in the course of his civilian employment working with aircraft. He apparently made his first claims in 2016 because it was only then that he became aware that he could do so as a result of advice he received from his local citizens' advice bureau. (He also made a separate claim for a service disablement pension in respect of his service in the Royal Air Force, but that matter is not before me.) It seems that he had earlier tried to bring an action against his former employers but his claim was struck out on the ground that it was out of time and his solicitors appear to have failed to advise him about the industrial injuries scheme.

5. Section 108(1) of the Social Security Contributions and Benefits Act 1992 provides that "industrial injuries benefits" shall be payable in respect of any prescribed disease or prescribed personal injury "which is a disease or injury due to the nature of that employment". By virtue of section 94, industrial injuries benefits include disablement benefit, which is now payable only in the form of disablement pension under section 103, with possible increases under sections 104 and 105 where disablement is assessed at 100%. Regulation 2(a) of the Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985 (SI 1985/967) provides that, for these purposes and subject only to immaterial exceptions, "each disease or injury set out in the first column of Part I of Schedule 1 hereto is prescribed in relation to all persons who have been employed on or after 5th July 1948 in employed earner's employment in any occupation set against such injury or disease in the second column of the said Part".

6. There is no need to draw a precise distinction between a disease and injury and so the diseases and injuries set out in the first column of the Schedule, which is headed "Prescribed disease or injury", are normally known simply as "prescribed diseases". However, despite the heading, the effect of regulation 2(a) is that, technically, they are prescribed only in relation to persons who have been employed in a relevant occupation. This terminological ambiguity is apt to confuse the unwary. (To avoid further confusion, I will continue to use the term "relevant occupation" in this decision. Sometimes, the term "prescribed occupation" is used, because the occupations are prescribed in the Regulations. However, neither term is actually used in the legislation, save in the limited context of section 109(3) of the 1992 Act.)

7. The prescribed diseases or injuries in respect of which the claimant originally made his claim for disablement pension, dated 28 May 2016 and received by the Secretary of State on 3 June 2016, were Prescribed Diseases C2, C21, C26(b), C30(a) and D5. I am told by the Secretary of State's current representative, Mr Kendall, that the Secretary of State received a separate claim in respect of Prescribed Disease C6 on the same date, but there is no copy of a separate claim form in the documents before me which may simply be because that prescribed disease is not central to these appeals. In any event, she certainly treated the claimant as having claimed in respect of that prescribed disease and considered it at the same time as the others. Prescribed Diseases C5A and C29 were considered as alternatives to, or in addition to, respectively, Prescribed Diseases C2 and C6. In the case of Prescribed Disease C5A, that appears also to have been done from the outset, whether or not a formal claim form had been completed in respect of it.

However, the Secretary of State did not begin consideration of Prescribed Disease C29 until the end of 2017, when a formal claim was apparently made, and she did not make a decision in respect of it until 2018.

8. Prescribed Disease D5 (non-infective dermatitis of external origin) seems to have fallen out of the picture at an early stage – possibly because the Secretary of State accepted that Prescribed Disease C30(a) was prescribed in respect of the claimant and was prepared to accept that the dermatitis suffered by the claimant was caused entirely by the occupation relevant to that prescribed disease – and therefore I will say no more about it.

9. The seven other diseases relevant to this case are, as set out in Schedule 1 to the 1985 Regulations:

Prescribed disease or injury	*Occupation*
	Any occupation involving:
C. Conditions due to chemical agents	
C2. Central nervous system toxicity characterised by parkinsonism.	The use or handling of, or exposure to the fumes, dust or vapour of, manganese or a compound of manganese, or a substance containing manganese.
C5A. Central nervous system toxicity characterised by tremor and neuropsychiatric disease.	Exposure to mercury or inorganic compounds of mercury for a period of, or periods which amount in aggregate to, 10 years or more.
C6. Peripheral neuropathy	The use or handling of, or exposure to, carbon disulphide (also called carbon disulfide).
C21. Primary carcinoma of the skin.	Exposure to arsenic or arsenic compounds, tar, pitch, bitumen, mineral oil (including paraffin) or soot.
C26. (a) Liver toxicity; (b) kidney toxicity.	The use or handling of, or exposure to, carbon tetrachloride (also called tetrachloromethane).
C29. Peripheral neuropathy	The use or handling of, or exposure to, n-hexane or n-butyl methyl ketone.
C30. (a) Dermatitis; (b) ulceration of the mucous membrane or the epidermis.	The use or handling of, or exposure to, chromic acid, chromates or dichromates.

How the legislation works

10. The combined effect of section 108(1) of the 1992 Act and regulation 2(a) of the 1985 Regulations is that, in respect of any particular disease or injury, three issues arise before further consideration can be given to a claimant's possible entitlement to disablement pension. It is necessary for a claimant to show (a) that he or she was employed in an occupation set out in the second column of Schedule 1 to the 1985 Regulations ("issue (a)", the "relevant occupation" issue), (b) that he or she is actually suffering from the particular disease or injury set out in column 1 of that Schedule ("issue (b)", the "diagnosis" issue) and (c) that he or she is suffering from the disease "due to the nature of that employment" ("issue (c)", the "causation" issue). Diseases are, of course, only prescribed in respect of occupations if the Secretary of State accepts that those occupations can cause the disease (see section 108(2) of the 1992 Act). However, while regulation 4 of the 1985 Regulations creates a presumption that certain prescribed diseases suffered by claimants were caused by the claimant's employment if the claimant was employed in a relevant occupation, that regulation does not apply to any of the prescribed diseases relevant to this case. So, each of issues (a) (relevant occupation), (b) (diagnosis) and (c) (causation) had to be established separately on the balance of probabilities if the claimant in the present case was to be entitled to disablement pension in respect of any of those prescribed diseases. If successful on those issues, the extent of the claimant's disablement due to the relevant disease would then be assessed and that would determine the amount of benefit, if any, that was payable.

11. However, it is obvious that, if a claim fails on issue (a) or (b), questions of causation and assessment do not arise. Moreover, issue (a) does not involve medical judgments, whereas issues (b) and (c) do. Therefore, if a decision-maker is not satisfied that the claimant has been employed in a relevant employment (issue (a)), the case need never be referred for a medical report on either issue (b) (diagnosis) or issue (c) (causation). In consequence, the practice is, or at least was in these cases, to consider issue (a) first and then, only if the claimant is found to have been employed in a relevant occupation, to refer the case to a health care professional for a medical report (which is usually made on a standard form) in relation to issues (b) and (c) before a decision is made on those issues. If the health care professional considers that both issue (b) and issue (c) should be decided in the claimant's favour, he or she will go on to give advice as to the assessment of disablement. A decision-maker then issues a decision in the name of the Secretary of State, relying on the health care professional's advice.

12. As regards issue (b), there are some cases in which a claimant is able to provide clear evidence from his or her own doctors of a diagnosis of a condition in terms that obviously fit within the terms of a condition within Schedule 1 to the 1985 Regulations, *e.g.*, primary carcinoma of the skin or dermatitis, so that the only contentious issue is issue (c) (causation). However, in other cases, issue (b) is much more closely related to issue (c), *e.g.*, in those diseases where "toxicity" (which in this context obviously means damage due to poisoning, rather than the quality of being poisonous) is part of the prescription and a link between the damage and the relevant chemical agent may or may not have been made by the claimant's doctors. It is, of course, possible to find that a person suffers from toxicity of an organ but to find that the poisoning was not caused by the claimant's employment in the relevant occupation, even though he or she was exposed to a relevant chemical agent, but in practice the findings will often go together. In any event, where issue (a) is decided

against the claimant, the claim for disablement pension is disallowed without any medical report being obtained. If issue (a) is decided in the claimant's favour, the decision as to whether disablement pension should be awarded or disallowed is made in the light of the health care professional's advice on issues (b) and (c).

13. I explain all of this because there has been some confusion on the claimant's part as a result of him not appreciating how issue (a) is related to issues (b) and (c). This has caused him to believe that the Secretary of State has made inconsistent decisions when, as I shall explain below, she has not, although the terms of some of the decisions have been less than clear and have probably contributed to the claimant's confusion.

14. Another point raised by the claimant is that the First-tier Tribunal considered only three prescribed diseases whereas he had raised the question of entitlement to disablement pension in respect of six. This arose in part because the Secretary of State treated the claimant's claim for disablement pension as a number of separate claims – one in respect of each industrial disease that she had considered – and she gave separate decisions awarding or disallowing disablement pension in respect of each prescribed disease. I raised the question whether this was the correct approach. I observed when doing so, and the Secretary of State accepts, that it appears to be clear from R(I) 4/03 at [31] to [35] that a separate claim in respect of a prescribed disease is possible, and presumably necessary, if there has been a previous award of disablement benefit in respect of either another prescribed disease or an industrial accident, but that it does not necessarily follow that there needs to be a separate claim for disablement pension in respect of each prescribed disease before any final decision awarding (or disallowing) disablement benefit has been made.

15. Mr Kendall went on to submit that the practice of having a separate claim in respect of each prescribed disease is not only permissible but is desirable, at least from the Department's perspective. He said:

> "From the Department's perspective it enables consistency of approach to evidence gathering and claims handling both in general terms and when compared with the circumstances set out in R(I) 4/03. It would not, in my submission, be desirable to have different ways of handling claims depending on whether there had been a previous award of disablement benefit or not. There is, I submit, also the point that an advantage for claimants in the separate claim scenario is that if successful, a claimant will often benefit from the backdating provisions whereas the effective date rules are not so generous."

He accepted that requiring separate claims would limit the ability of a tribunal to consider the possibility of the claimant's entitlement to disablement pension in respect of a prescribed disease other than the one under appeal, but he submitted that that situation was relatively uncommon.

16. Understandably, the claimant has not made submissions on this technical legal issue.

17. Upon reflection, it seems to me that it may be more important to consider whether separate decisions are required or permissible, rather than whether

separate claims are required or permissible. This reflection has been prompted by Mr Kendall's submission that there may be "an advantage for claimants in the separate claim scenario", with which I agree only up to a point. Once there has been an award of disablement benefit, it is true that the decision in R(I) 4/03, requiring a new claim rather than an application for supersession, is advantageous to a claimant in relation to the date from which the decision can be effective. However, that is not the issue that I raised, or intended to raise, in this case, which was whether a claim for disablement pension made in respect of one prescribed disease may, before it is determined, be treated as having been made, additionally or alternatively, in respect of another prescribed disease without a further, formal, claim having been submitted.

18. I have come to the conclusion that it is not necessary for me to decide that precise point and I prefer not to, particularly as I have not heard full argument on it and am not entirely sure whether it is in fact the Secretary of State's invariable practice to insist on a separate formal claim in respect of each prescribed disease, rather than merely treating the claimant as having made such a claim in respect of each prescribed disease that she considers. An insistence on too much formality may be inconvenient for the Secretary of State as well as for claimants. For instance, in the present case, I am not entirely sure that the claimant actually signed claim forms in respect of Prescribed Diseases C5A and C6 or, if he did, whether the Secretary of State regarded the date of claim in respect of those particular diseases as the date on which the form was received or the date on which the, as yet undetermined, original claim for disablement pension had been made. Therefore, I leave open the question whether a further formal claim is necessarily required where there is an outstanding claim for disablement pension before the Secretary of State based on a different prescribed disease. I will, however, say that I am not persuaded by Mr Kendall's argument about evidence-gathering because, insofar as claim forms contain a questionnaire, there is absolutely no reason why the Secretary of State should not issue a questionnaire that is separate from a claim form and, in other respects, evidence-gathering does not depend on a formal separate claim having been made. It merely depends on the Secretary of State having decided to consider another prescribed disease, whether prompted by the claimant or on her own initiative. In practice, it may therefore generally be necessary for the claimant to identify any prescribed disease that he or she wishes the Secretary of State to consider, but it does not follow that he or she must do so by way of a formal claim or that the Secretary of State may not act on her own initiative to, say, consider a similar prescribed disease to one in respect of which a formal claim has been made.

19. However, I am prepared to accept that the Secretary of State is entitled, although perhaps not required, to issue a separate decision as regards entitlement to disablement pension in respect of each prescribed disease that she has considered. In this regard, there is considerable force in Mr Kendall's submission as regards the consistency of case-handling in the light of R(I) 4/03 or, to put it another way, consistency in the application of the legislation. As there are provisions requiring the aggregation of separate assessments that enable separate decisions where a claimant is successful and it has been held necessary to make separate decisions in circumstances such as arose in R(I) 4/03, it is difficult to see why it should be unlawful to make separate decisions in other circumstances in the absence of an express provision to that effect. Although, as these cases show, there is the possibility of a claimant misunderstanding what is being decided, the procedure is

not inherently unfair. Indeed, it seems to me that, not only does this approach make matters administratively simpler for the Secretary of State and for the First-tier Tribunal where a number of prescribed diseases are considered at the same time, but also the resulting decisions are then more likely to be understood by most claimants most of the time than would a single composite decision.

20. It is unnecessary for me to decide whether this has the result that, on an appeal, the First-tier Tribunal is unable to consider a prescribed disease that has not been considered by the Secretary of State at all – it may be sufficient that the First-tier Tribunal ensure that the Secretary of State has had an opportunity to consider it and obtain her own medical advice – but it does have the result that there will often, perhaps usually, be a decision in respect of every prescribed disease that has been considered. Where the claimant has appealed against a decision in respect of one prescribed disease, the First-tier Tribunal can only treat the claimant as also having appealed against the decision in respect of another prescribed disease if the claimant had, either when bringing the first appeal or at a later stage during the course of the proceedings, a right of appeal against that other decision. That is because, subject to supersession, revision or an appeal, a decision of the Secretary of State is final (see section 17 of the Social Security Act 1998). There may in practice not be a right of appeal against a decision either because there has not been "mandatory reconsideration" (see regulation 3ZA of the Social Security and Child Support (Decisions and Appeals) Regulation 1999 (SI 1999/991)) or because the absolute time limit for appealing has expired – *i.e.*, the appeal is late and there is no adequate to extend the time for appealing (see rule 22(8)(b) of the Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008 (SI 2008/2685)). If there was, or is, a right of appeal that has not been expressly exercised, it will be for the First-tier Tribunal to decide, as a matter of judicial discretion, whether to waive procedural requirements and to treat the claimant as having brought an appeal.

The 2016 decisions on the claims

21. I can now turn to the history of these cases. Not all of the initial decisions made on the claimant's claims are in the documents before me but it is clear from the claimant's submissions that all six of the relevant claims in respect of prescribed diseases that were considered in 2016 (not counting for this purpose Prescribed Disease D5 and also bearing in mind that Prescribed Disease C29 was not considered until later) were initially rejected on the ground that the claimant had not been employed in a relevant occupation (issue (a)) and, accordingly, disablement pension was disallowed without consideration of issues (b) and (c). However, on "mandatory reconsideration", the decision maker accepted on 2 November 2016 that the claimant had been employed in a prescribed occupation in relation to five of the six cases. Those five cases (in respect of Prescribed Diseases C2, C5A, C21, C26(b) and C30(a)) were then referred for a medical report on issues (b) and (c) and, if necessary, on the assessment of disablement.

22. I observe that, after setting out the reasoning, the decisions issued on 2 November 2016 in those five cases were expressed in what appears to be a standard form of words, for instance (doc 7 on file CI/1000/2019):

> "I accept that you have met prescription relating to Prescribed Disease C2 as you would have been exposed to manganese in the aviation industry."

It is clear, from both the accompanying reasoning and the fact that there had been no prior reference to a health care professional, that the Secretary of State was determining only what I have called "issue (a)" and that the decision was only to the effect that the prescribed disease was prescribed in relation to the claimant because he had been employed in a relevant occupation. It was therefore not a decision to the effect that the claimant was suffering from the prescribed disease or was entitled to disablement pension in respect of it and was only the first step in the reconsideration of the earlier disallowance of that benefit. This raises the question whether it was appropriate to issue "mandatory reconsideration notices" at this stage in these five cases. I have not fully explored this issue, as nothing of importance to these appeals turns on it, but I have some doubt as to whether the claimant had a right of appeal at that stage in those cases because no new "outcome" decision had yet been made (see CIB/2338/2000).

23. However, I am not at all surprised that the claimant has thought that issues (b) and (c) had also been decided in his favour, and that the only issue that remained was the assessment of disablement. The consequence of the claimant's understanding of the decisions of 2 November 2016 is that he has submitted in these appeals that subsequent decisions notified to him on 11 May 2017, to the effect that he failed either on issue (b) or on issue (c) in three of the five cases that had been referred for medical reports, were inconsistent with, and were made in ignorance of, the earlier decisions[1]. He is clearly wrong about that, but the Secretary of State may nonetheless wish to consider whether a different form of wording might in future make it clearer in cases like these that only issue (a) (relevant occupation) has been decided when that is the case. In my view, saying "you have met prescription" is liable to mislead a claimant who is unfamiliar with both the legislation and the usual procedure for determining claims. Moreover, the issuing of "mandatory reconsideration notices", when final decisions as to the claimant's entitlement to disablement pension in respect of these five prescribed diseases had not been made, can only have served to reinforce the claimant's confusion.

24. The only disease in respect of which a decision issued on 2 November 2016 was to the effect that the claimant had *not* been employed in a prescribed occupation and that the disallowance of disablement pension would therefore be maintained was Prescribed Disease C6 and that seems to have been because the claimant had been unable to produce evidence of exposure to carbon disulphide, as opposed to other disulphides or polysulphides. The Secretary of State was clearly right to issue a "mandatory reconsideration notice" in this case. However, the claimant did not appeal but instead appears to have asked for Prescribed Disease C29 to be considered as an alternative. Whether or not such a request was received by the

[1] The claimant's belief that the decisions were inconsistent appears to have been bolstered by a belief that the Department had lost or mislaid the decisions of 2 November 2016. This appears to have arisen because, when the claimant referred to earlier decisions that he said were inconsistent, the Department asked for copies of those decisions. However, as the Department must have been well aware that the decisions of 2 November 2016 had been made and that those decisions were not in fact inconsistent with the decisions of 11 April 2017, it seems likely either that the Department was merely making sure that no other decision, of which the relevant office was unaware, had been issued or that it had failed to keep a copy of the notification letter sent to the claimant (which is not the same as not keeping a record of the decision) and wished to check its wording.

Secretary of State towards the end of 2016, she took no action relating to that prescribed disease until a year later and, as I have said, did not make a decision in relation to it until 2018.

The 2017 decisions

25. Of the five cases referred for a medical report, three were decided adversely to the claimant in decisions issued to him on 11 May 2017 to the effect that either issue (b) or issue (c) had been decided against him and he was therefore not entitled to disablement pension in respect of Prescribed Diseases C2, C21 or C26(b). (It appears that, in at least in one instance, the decision had been made some time earlier, but notifying the decisions at the same time seems a desirable practice.)

26. In relation to Prescribed Disease C2, which I will consider in more detail below, it is not entirely clear whether it was accepted that the claimant was suffering from the disease or injury as set out in the first column of Schedule 1 to the 1985 Regulations (issue (b)) but, in any event, insofar as the claimant's central nervous system was impaired, it was not accepted that the impairment was due to the nature of his employment in the relevant occupation (issue (c)).

27. In relation to Prescribed Disease C21, it was at first not accepted that the claimant was suffering from the disease or injury as set out in the Schedule (issue (b)) but that decision was revised on "mandatory reconsideration" on 26 July 2017 and instead the claim was disallowed on the ground that the disease was not due to the nature of his employment in the relevant occupation (issue (c)). (This was a case where the health care professional had plainly filled in her standard report form incorrectly.)

28. In relation to Prescribed Disease C26(b), it was not accepted that the claimant was suffering from the disease as set out in the Schedule (issue (b)).

29. In each of the other two cases referred for a medical report – those relating to Prescribed Diseases C5A and C30(a) – it was accepted both that the claimant was suffering from the prescribed disease (issue (b)) and that that was due to the nature of his employment in the relevant occupation (issue (c)). The extent of the claimant's disablement was assessed at 15% in respect of Prescribed Disease C5A and at 2% in respect of Prescribed Disease C30(a). Decisions to that effect were issued to the claimant on 18 May 2017 and disablement pension was awarded accordingly.

30. Unfortunately, although the decision notices dated 18 May 2017 issued in respect of each prescribed disease correctly stated the assessment in respect of that disease, they then contradicted themselves when explaining that the assessments would be aggregated and said that the assessment was 2% in respect of Prescribed Disease C5A and 15% in respect of Prescribed Disease C30(a). Unsurprisingly, the claimant asked for clarification, although he correctly considered it to be probable that the 2% was in respect of dermatitis.

31. The claimant also expressed dissatisfaction with all five decisions – those issued on 11 May 2017 and those issued on 18 May 2017 – although perhaps not as clearly as he might have done in relation to Prescribed Diseases C26(b) and C30.

The decisions in respect of Prescribed Diseases C2, C5A and C21 were maintained on "mandatory reconsideration" on 2 October 2017 – this was apparently the second "mandatory reconsideration" since 11 May 2017 in the case of Prescribed Disease C21 – but there was no reconsideration of the decisions in respect of Prescribed Diseases C26(b) and C30(a).

The appeals to the First-tier Tribunal

32. Following the "mandatory reconsideration" decisions issued on 2 October 2017, the claimant promptly appealed to the First-tier Tribunal. He did so initially in a letter dated 4 October 2017, which appears at doc 9-10 on file CI/1000/2019 (although doc 9 is missing in my copy), doc 14-15 on file CI/1001/2019 and doc 3-4 on file CI/1002/2019 and was sent to the First-tier Tribunal's Direct Lodgement Centre in Bradford, where it was received on 10 October 2017. This letter was plainly an appeal only in respect of the decisions in respect of Prescribed Diseases C2, C5A and C21. The claimant submitted with it the relevant "mandatory reconsideration notices" dated 2 October 2017 and he also submitted the "mandatory reconsideration notices" dated 2 November 2016 relating to those prescribed diseases and he argued that the later ones were inconsistent with the earlier ones (which, for reasons that I have already given, they were not).

33. The receipt of six "mandatory reconsideration notices" caused the Direct Lodgement Centre to register six appeals in response to the letter of 4 October 2017 to which I have referred above, when in fact there had only been three as the claimant had indicated in that letter a wish only to challenge the decisions that had not been revised on 2 October 2017, rather than the earlier decisions insofar as they had been partially revised on 2 November 2016, since the partial revision had been entirely in his favour. The Direct Lodgement Centre apparently told the claimant that the appeals against the decisions that had been partially revised on 2 November 2016 were out of time (doc 1233-1234 on file CI/1000/2019), which they would have been if the claimant had any right of appeal at all as a result of the partial revision and wished to exercise it, although not irredeemably so. A week later, the Department accurately informed the First-tier Tribunal that the "mandatory reconsideration notices" from 2016 had been sent by the claimant as evidence in his appeals against the 2017 decisions and that the appeals against the 2016 decisions appeared to have been registered in error, but it then asked the First-tier Tribunal to "lapse" those appeals. This resulted in the First-tier Tribunal closing the unnecessary files but telling the claimant that that was because the decisions against which he had appealed had lapsed because they had been revised, which was not accurate. He probably should just have been told that they had been closed administratively because they were duplicates, but nothing turns on this.

34. However, the claimant appears to have believed that the Direct Lodgement Centre had been correct to register six appeals in the light of another letter that he had submitted. This was also dated 4 October but seems to have been posted after the earlier letter of that date because, having been forwarded by the Direct Lodgement Centre to the Administrative Support Centre in Birmingham, it was stamped by the latter office as having been received on 25 October 2017 (doc 100-107 on file CI/1000/2019), after which it was treated as "further evidence". This second letter arguably disclosed an intention to appeal against decisions in respect

of Prescribed Diseases C26(b) and C30(a) and concerning the lack of a decision in respect of Prescribed Disease C29 "in place of C6". It was followed by a letter dated 13 October 2017 (doc 108-109 on file CI/1000/2019), addressed to the Administrative Support Centre but stamped as received by it only on 14 November 2017, with evidence in relation to all six prescribed diseases. (I have the impression that the date stamps refer to when the post was opened rather than when it was received.) The First-tier Tribunal does not seem to have considered at any stage whether there were, or whether the claimant wished there to be, appeals before it concerning any of Prescribed Diseases C26(b), C29 or C30(a), even though some of the submissions made by the claimant referred to the decisions relating to those diseases and some of the evidence submitted by him was relevant to them. This may have been simply because appropriate "mandatory reconsideration notices" had not been submitted. The claimant did not explicitly pursue this issue further at the time, but I will return to it below (see paragraphs 70 to 76).

35. In the claimant's original letter of appeal, he had said that he would not be able to attend a hearing because he had only just been released from hospital, where he had been receiving treatment for a back problem, and was having difficulty walking. However, he then arranged representation by the local Citizens' Advice Bureau and notified the First-tier Tribunal. As a result, when, on 26 January 2018, a district tribunal judge issued directions (doc 211-212 on file CI/1000/2019), they included a direction that there be an oral hearing.

36. The judge also directed that two medical members sit on the panel and that they be a neurologist and a dermatologist, that a Presenting Officer attend the hearing, that the claimant's medical records be obtained and that the claimant supply copies of any relevant documents, including medical reports, that had been obtained in relation to any personal injuries claim brought against his former employers or in relation to his claim for a service disablement pension.

37. The Department replied (doc 213 on file CI/1000/2019) saying –

> "Industrial Injuries Disablement Benefit (IIDB) will only provide a Presenting Officer if specifically directed.
>
> Given that the benefit has for many years been processed centrally and in particular the response Submissions to IIDB Appeals are written in just one office covering the whole of Great Britain, there is no resource available to fund travelling Presenting Officers for the many sites where Tribunals are held.
>
> Where Presenting Officers are specifically directed to attend, an officer from a local office will be assigned to attend, but as there is limited knowledge of Industrial Injuries Disablement Benefit remaining in other areas of the DWP, such a Presenting Officer may not be able to assist the Tribunal to any great extent."

That letter appears to have been treated by the First-tier Tribunal as "further evidence" and no further action on the issue appears to have been taken either by the First-tier Tribunal or the Department.

38. When the claimant responded to the directions on 8 February 2018 (doc 214 et seq on file CI/1000/2019), he said that the Citizens' Advice Bureau would not be

able to represent him due to cutbacks by the local authority and he asked that there be a "paper hearing" as he did not think he would be well enough to attend a hearing by himself.

39. The case was nonetheless listed for an oral hearing on 11 September 2018. The claimant did not appear and was not represented, having reiterated in a letter dated 12 August 2018 (doc 1165-1166 on file CI/1000/2019) that he would not attend because he was afraid that his nerves would fall apart and that he was not very good at explaining things under stress. Nor did any representative of the Secretary of State attend. More significantly for the purposes of these appeals, one of the medically-qualified members panel members, the neurologist, also did not appear, having been taken ill over the preceding week-end and it not having been practical to replace him.

40. The tribunal considered whether it should proceed in these circumstances with just the other medically-qualified panel member, the dermatologist, and in the absence of both parties. It decided that it should. It dismissed the claimant's appeals in respect of each of Prescribed Diseases C2, C5A and C21, although in relation to Prescribed Disease C5A it did so on rather different grounds from those of the Secretary of State. I will consider the reasoning below.

The appeals to the Upper Tribunal

41. Having obtained a statement of reasons from, and been refused permission to appeal by, the First-tier Tribunal, the claimant applied to the Upper Tribunal for permission to appeal which was granted by Upper Tribunal Judge Wright on six grounds, None of those grounds had been advanced by the claimant (although some of the claimant's grounds overlapped with some of Judge Wright's) and, as Judge Wright did not limit his grant of permission to the grounds he gave, I will first briefly explain why I do not consider that any of the claimant's additional grounds demonstrates an error of law.

42. The claimant's grounds were broadly that the First-tier Tribunal did not have enough evidence to support its decision, that it did not give adequate reasons for its decision and that it did not treat him fairly. The last of those grounds does not appear to add anything to the other two given the way the claimant put it.

43. As to evidence, the First-tier Tribunal had all the evidence that the claimant had submitted and which he had argued was sufficient for the case to be determined in his favour without his attendance at a hearing. It may be correct that in fact that evidence did not address all of the issues that were really before the First-tier Tribunal, but that is covered by Judge Wright's points.

44. As to reasons, this also is partly covered by Judge Wright's points but the claimant has additionally argued that the First-tier Tribunal made wrong findings of fact, particularly as to the extent of his disablement, and had failed to have regard to the decisions of 2 November 2016 and to certain other documents. However, wrong findings of fact are not usually errors of law in themselves, although they may be the result of errors of law, and, if the First-tier Tribunal misunderstood the extent of the claimant's disablement, that seems to me to be largely because that disablement

was not fully described in the medical evidence and the claimant had not attended in order to provide oral evidence or be examined. I have already explained why the decisions of 2 November 2016 did not in fact contradict any of the decisions made by the Secretary of State in 2017. It has also transpired that the other documents that the claimant said that the First-tier Tribunal had overlooked had in fact not been sent to the Social Entitlement Chamber of the First-tier Tribunal, but had been sent to the War Pensions and Armed Forces Compensation Chamber which had been considering an appeal in relation to the claimant's claim for a service disablement pension. Moreover, perhaps the most important of those documents – a letter from a consultant geriatrician dated 20 November 2018 saying that the claimant had been "Told no definite link between heavy metal exposure and developing PD [*i.e.*, Parkinson's Disease] but is suspected as a possible causal relationship so should include in his industrial injuries claim" (doc 1212-1213 on file CI/1000/2019) – had not even be written at the time of the First-tier Tribunal's decision. A tribunal cannot generally be criticised for not having regard to documents that were not before it.

45. I therefore turn to the grounds on which Judge Wright gave permission to appeal.

Ground 1 – the composition of the tribunal

46. The first ground on which Judge Wright gave permission to appeal was that it is arguable that the First-tier Tribunal was not validly constituted.

47. By virtue of article 2 of the First-tier Tribunal and Upper Tribunal (Composition of Tribunal) Order 2008 (SI 2008/2835), made under paragraph 15 of Schedule 4 to the Tribunals, Courts and Enforcement Act 2007, the composition of the First-tier Tribunal when deciding any matter is to be determined by the Senior President of Tribunals, who is entitled effectively to delegate that function. By virtue of article 5 of the First-tier Tribunal and Upper Tribunal (Composition of Tribunal) Amendment Regulations 2018 (SI 2018/606), there remains in force the *Practice Statement on the composition of tribunals in social security and child support cases in the Social Entitlement Chamber on or after August 1, 2013*, paragraphs 5(e), 7(b) and 8 of which have the effect that the Chamber President of the Social Entitlement Chamber may decide that a case raising issues relating to industrial injuries benefit should be decided by a judge, a judge and a registered medical practitioner or a judge and two registered medical practitioners, as appears appropriate. That function is delegated by the Chamber President to district tribunal judges under paragraph 4 of Schedule 4 to the 2007 Act. Therefore, when the district tribunal judge directed in this case that there be two registered medical members on the panel to hear the claimant's appeals, he was exercising the function of the Chamber President under the Practice Statement.

48. When giving permission to appeal, Judge Wright drew attention to paragraph 15(6) of Schedule 4 to the 2007 Act, which provides –

> "(6) Where under sub-paragraphs (1) to (4) a matter is to be decided by two or more members of a tribunal, the matter may, if the parties to the case agree, be decided in the absence of one or more (but not all) of the members chosen to decide the matter."

It so happens that the presiding judge at the hearing was the same district tribunal judge who had given the original direction and so, as Judge Wright pointed out, he could have issued another direction varying the original direction. However, there is no indication that he did that and the First-tier Tribunal's statement of reasons indicates fairly clearly that the decision to proceed in the absence of one of the registered medical practitioners was made by the tribunal acting as such. As neither party's agreement was obtained, the Secretary of State concedes that the First-tier Tribunal erred in law by deciding the case in the absence of one of the members chosen to decide it.

49. I prefer not to decide these appeals on that basis because I consider it arguable that, even though the district tribunal judge did not in fact issue another direction under the Practice Statement, he could be treated as having done so if there was no unfairness to the claimant and the reasoning process he would have gone through was precisely the same as the reasoning process he did go through. It would be wrong to issue such a direction merely to circumvent paragraph 15(6), but if, as appears to have been the case here, the district tribunal judge was satisfied, having consulted the registered medical practitioner who was present, that the expertise of a consultant neurologist was not in fact necessary for the proper determination of the appeals, it is difficult to see why there should have been unfairness to the claimant when a claimant has no right in the first place to insist on a second registered medical practitioner or a registered medical practitioner having particular expertise. More particularly, I do not consider that there could have been any objection if the district tribunal judge had postponed the cases concerned with Prescribed Diseases C2 and C5A and directed that the case concerned with Prescribed Disease C21 be decided by a judge and one registered medical practitioner who was a dermatologist. I therefore merely consider the absence of the registered medical practitioner who was a neurologist as part of the background against which there were other errors in determining the appeals concerned with Prescribed Diseases C2 and C5A.

Ground 2 – Prescribed Disease C2

50. As regards Prescribed Disease C2, the First-tier Tribunal said –

> "25. As noted above and apparently now accepted by the Appellant, if the Appellant has been diagnosed with Prescribed Disease C2, the loss of faculty arising in respect of this was reflected in the loss of faculty arising in respect of Prescribed Disease C5A. Nevertheless, for the sake of completeness, although the Appellant may have been exposed to many chemicals over the years, his Parkinson's Disease has been repeatedly described as idiopathic. The Tribunal was, therefore, unable to find, upon the balance of probabilities, that it arose from exposure to manganese. Accordingly, the Tribunal found that it did not meet the criteria for an award of Prescribed Disease C2."

I will consider the significance of the first sentence in more detail in the context of Prescribed Disease C5A, but the First-tier Tribunal clearly regarded the question whether the claimant was suffering from central nervous system toxicity characterised by parkinsonism due to exposure to manganese as academic.

51. However, I accept the Secretary of State's concession that the First-tier Tribunal erred in basing its finding that exposure to manganese had not caused central nervous system toxicity characterised by parkinsonism in the claimant solely on the fact that his Parkinson's disease had always been described as idiopathic, given that there is no indication that any of the doctors who used that term, most of whom seem simply to have been referring to an earlier diagnosis, addressed his or her mind to the question whether the claimant's condition has been caused by exposure to manganese or was even aware that the claimant had been exposed to that substance.

52. I would point out, however, that the First-tier Tribunal was merely following the approach of the health care professional whose advice had been accepted by the Secretary of State, although it is not altogether clear whether or not she even accepted that the claimant was suffering from central nervous system toxicity characterised by parkinsonism. She was a registered medical practitioner, whose report was altered on "audit" (for the significance of which see *MP v Department for Communities (PIP)* [2019] NICom 55). Very properly, the alterations made to her report can clearly be seen. The fact that a report has been altered is, by itself, neutral – a health care professional is entitled to change his or her mind after discussion with a colleague – but it may be useful to know what went before even if the later opinion is generally to be taken as the more considered one. Here, (docs 46 to 50 on file CI/1000/2019), the health care professional first decided that the claimant was suffering from central nervous system toxicity characterised by parkinsonism and that it had been caused by exposure to manganese but then changed her mind and not only decided against the claimant on causation but also crossed out both the answer "yes" to the question whether any of the conditions she had diagnosed fulfilled the medical criteria to be considered as the disease being claimed as a prescribed disease and the answer "C2 – central nervous system toxicity characterised by Parkinsonism" to the question asking which disease. Subsequently, she reinstated the answer "yes" to the former question but did not reinstate the answer to the latter, leaving the picture somewhat confused although I suspect that she accepted that the claimant was indeed suffering from central nervous system toxicity characterised by parkinsonism. In any event, the key sentence of her reasoning was originally –

> "With correspondence provided there is a link to previous exposure to manganese, compounds of manganese or substances containing manganese."

That sentence was then amended to read –

> "With correspondence provided there is no reference to any link to previous exposure to manganese, compounds of manganese or substances containing manganese documented (letter 11/11/2016)."

I am fairly sure that the words "documented (letter 11/11/2016)", or at least the word and date in brackets, at the end of that sentence were not in the original version because, although they are not initialled as an amendment, the letter dated 11 November 2016, which was from a consultant geriatrician, did not make the link mentioned earlier in the sentence.

53. Neither version was really sufficient. I am not sure to what "correspondence" the original sentence referred but it may have been the "mandatory reconsideration notice" in which the Secretary of State had accepted that there had been exposure to manganese in one form or another but there was no documentary evidence specifically linking that exposure to the claimant's condition and, as there is no presumption of a causal link in the legislation, some more reasoning was required. On the other hand, the lack of evidence in the documentation did not entitle the health care professional simply to say that the claimant had not proved his case, given that the Secretary of State had accepted that the claimant had been exposed to chemical agents known to cause the prescribed disease. It was, as I understand her role, her function to use her expertise to give her own opinion and, unless there was an adverse inference to be drawn from the lack of evidence, the lack of documentary evidence on that particular issue required her to obtain evidence either by taking a history from the claimant or examining him or obtaining (or suggesting that someone else obtain) the results of tests or the opinion of a specialist or whatever else might be required. This is because the Secretary of State's role, and therefore that of a health care professional upon whose advice the Secretary of State will rely and who in practice has the role formerly exercised by adjudicating medical authorities, is inquisitorial or at least investigatory (see *Kerr v Department for Social Development* [2004] UKHL 23; [2004] 1 W.L.R. 1372 (also reported as an appendix to R1/04(SF)) even if it is described as merely advisory.

54. The same applies to the First-tier Tribunal. Had the First-tier Tribunal said that the natural inference to be drawn from a description of Parkinson's Disease as idiopathic was that the diagnostician would have considered the possibility of manganese poisoning and decided that that was improbable, that might have been an adequate reason for proceeding on the available evidence. But, if that could not be asserted with a reasonable degree of confidence, then the First-tier Tribunal was obliged to make its own decision on causation, given that the Secretary of State had accepted that the claimant had been exposed to manganese in his work and that that is a known cause of the prescribed disease. It was obviously handicapped by the absence of the claimant. An explanation to the effect that the symptoms described in the medical reports and other evidence were not consistent with manganese poisoning would have been adequate but, if the reports did not contain sufficient detail, the First-tier Tribunal needed to look for evidence from another source. It was not very impressed by the claimant's reason for not attending but, if it needed to take a history from him or examine him, I am not satisfied that it adequately considered whether it was fair to proceed in his absence.

55. Quite apart from the fact that his conditions may have impaired his mental health, it seems fairly clear that the claimant did not realise the importance of attending. His view was that the documentary evidence was sufficient to prove the causal link, which was not so. In its lengthy explanation for proceeding in the claimant's absence, the First-tier Tribunal said –

> "20. … The Tribunal was mindful that this was an appeal where the Tribunal has specifically directed that it should proceed by way of an oral hearing where the claimant might attend for the purposes of being examined and in order that the Tribunal might obtain a detailed medical and work history. …"

However, I can see no indication that the claimant was told that that was why the hearing had been directed. Such an indication certainly did not appear in the directions themselves. Moreover, I can see no evidence in the First-tier Tribunal's file that either of the claimant's letters of 8 February 2018 or 12 August 2018 saying that he did not wish to attend a hearing was referred to the judge at the time it was received, which would have provided an opportunity to explain to the claimant how important it was for him to attend. In the statement of reasons, the First-tier Tribunal said that it did not consider that the claimant's offer in his letter of 12 August 2018 to answer written questions was an adequate substitute for appearing in person at an oral hearing. It would obviously have been helpful if the claimant had been told that before the hearing. But what is most important in this case is that the First-tier Tribunal needed to elicit relevant evidence from the claimant because the health care professional had failed to do so on behalf of the Secretary of State.

56. The lack of legitimate pressure on the claimant to attend in his own interests is in stark contrast to the direction to the Secretary of State to send a representative, which appears to have turned out to be both ineffective and unnecessary. (I have some doubt as to the propriety of directing – rather than requesting – that the Secretary of State be represented but, if such a direction is issued, the Secretary of State should comply with it unless she successfully applies for it to be set aside and it is difficult to regard deliberately sending a representative who, through a lack of relevant expertise, "may not be able to assist the Tribunal to any great extent" as amounting to proper compliance. I suggest that there needs to be a better understanding between the First-tier Tribunal and the Secretary of State as to the role of, and the practicality of providing, presenting officers.)

57. In any event, I allow the appeal against the dismissal of the appeal in respect of Prescribed Disease C2 on the ground that the First-tier Tribunal's reasoning was flawed, but the underlying problem may be that, not having engaged effectively with the claimant before the hearing (which is understandable given the pressure under which the First-tier Tribunal works), it failed to adjourn to persuade him to attend and give evidence upon which a better decision could have been made.

Grounds 3, 4 and 5 – Prescribed Disease C5A

58. The Secretary of State had accepted advice from the health care professional who had assessed the claimant's disablement in respect of Prescribed Disease C5A at 15% after "offsetting" 15% in respect of pre-existing Parkinson's disease and had recommended a final assessment for life. She assessed upper limb impairment due to tremor at 20% (comparing it to the non-statutory standard assessment of 40% for an ankylosed shoulder) and impairment of mental health due to stress and depression at 10% and effectively attributed half of that total disablement to Prescribed Disease C5A and half of it to Parkinson's disease. Skin cancer, bowel cancer, back pain and sciatica symptoms and bronchiectasis and dermatitis were listed as unconnected injuries and diseases and so their effects were not included in the 30%.

59. The claimant appealed. However, in his letter of 12 August 2018, he wrote as regards this particular appeal –

> "I have been advised to cancel this Tribunal Hearing …. As I have already been awarded benefit for C5 [*sic*, presumably C5A was intended] and C30 and I am afraid this will be taken away from me. I wanted to have the Industrial Injury Benefit people to merely look at this award again as I believe it to be very low. This they have refused to increase."

The First-tier Tribunal noted this, but said –

> "11. … He had not, however, confirmed his wish to withdraw this appeal. …"

The First-tier Tribunal then dismissed the appeal but for wholly different reasons from those of the Secretary of State. It effectively halved the gross assessment but then attributed all of the relevant disablement to Prescribed Disease C5A and so did not offset anything in respect of Parkinson's disease.

60. Against that background, Judge Wright gave permission to appeal on three grounds in addition to the ground that I have already considered relating to the composition of the tribunal. The first ground was that the First-tier Tribunal failed adequately to consider whether the claimant had withdrawn his appeal. A withdrawal would have taken effect automatically. The second ground was really three different grounds: that there had arguably a breach of the rules of natural justice in halving the gross assessment without raising the issue with the claimant; that the First-tier Tribunal had arguably failed adequately to explain why it felt able to reach a different gross assessment from the health care professional who had seen, heard and examined the claimant; and that it had arguably failed to given any adequate reason for reducing the gross percentage in respect of impairment of mental health function. The third ground was that the First-tier Tribunal had arguably failed adequately to explain why it had not made an offset in respect of Parkinson's disease. The Secretary of State supports the appeal on all of these grounds.

61. I am not persuaded that the First-tier Tribunal erred on the first of those grounds. The claimant had clearly not said positively in his letter of 12 August 2018 that he wished to withdraw his appeal. As Judge Wright observed, the use of the words "confirmed his wish" in the First-tier Tribunal's decision is odd. It may be the case that the judge was aware that, some months earlier, the First-tier Tribunal had been told by the Department of Work and Pensions that the claimant wished to withdraw his appeal but it had decided to take no action because the claimant had not himself notified the First-tier Tribunal as he should have done. Alternatively, the First-tier Tribunal may merely have expressed itself badly and only meant that any wish to withdraw had not been made sufficiently clear. It might have been neater if the First-tier Tribunal had obtained clarification from the claimant as to whether he did wish to withdraw his appeal but it seems to me that the decision made by the First-tier Tribunal avoided the need to do that because, although the reasoning was different from that of the Secretary of State and the First-tier Tribunal found that the impairment of the claimant's upper limb function due to tremor and the impairment of his mental health were less disabling than the Secretary of State had done, its overall decision in fact left the claimant in exactly the same position as he would have been in had he withdrawn his appeal. In any event, the question whether the First-tier Tribunal erred in not considering whether the appeal had been withdrawn has become entirely academic because, in answer to direct questions from me, the claimant has said that, despite the advice that he had received, he had not intended

to withdraw his appeal in respect of Prescribed Disease C5A and, moreover, he does not wish to do so now.

62. However, it is possible that the desire to avoid any procedural injustice to the claimant, while at the same time considering the Secretary of State's gross assessment to be too high, distorted the First-tier Tribunal's reasoning. The most striking aspect of the reasoning is that the First-tier Tribunal did not apply an offset in respect of the idiopathic Parkinson's disease from which it had found the claimant was suffering. As the Secretary of State points out, applying an offset is the way in which effect is given to regulation 11(3) of the Social Security (General Benefits) Regulations 1982 (SI 1982/1408) which applies where a loss of faculty is caused partly by a prescribed disease and partly by a pre-existing or congenital condition that is the result of neither an industrial injury nor a prescribed disease. It has the effect that the disablement to be attributed to the prescribed disease is all the disablement that the claimant would not have suffered had the prescribed disease not been contracted. What is offset, therefore, is the disablement that the claimant would have suffered had the prescribed disease not been contracted.

63. The First-tier Tribunal did not apply an offset because "it considered that the symptoms arising [from Parkinson's disease] were inseparable in effect from the symptoms of C5A and did not contribute to or worsen the overall degree of disability". This appears consistent with its view that the question whether Prescribed Disease C2 was prescribed in relation to the claimant was academic because "the loss of faculty arising in respect of this was reflected in the loss of faculty arising in respect of Prescribed Disease C5A" (see paragraph 50 above), although its reasoning makes it clear that it did not regard the claimant as suffering from a single condition, with the diagnosis of Prescribed Disease C5A replacing the diagnosis of idiopathic Parkinson's disease. It may be that for practical purposes the First-tier Tribunal was right to say that the significantly disabling symptoms of the three conditions were indistinguishable, but it does not necessarily follow that they would have been as severe had the claimant not been suffering from either idiopathic Parkinson's Disease or Prescribed Disease C2 (or both) as well as Prescribed Disease C5A. Had the neurologist been able to sit, he might have had a view on this issue.[2] As it was, the First-tier Tribunal may have decided that it was really impossible to decide to what extent Prescribed Disease C5A had contributed to the overall extent of the relevant disabling symptoms and that it would be fair and reasonable to attribute the whole of that disablement to that prescribed disease. That seems a more probable explanation for its decision than that the experienced members of the tribunal overlooked regulation 11(3) or failed properly to interpret it in the light of R(I) 3/91. Moreover, while I accept that the reasoning is not entirely clear, failing to consider an offset was an error in the claimant's favour and would not, by itself cause me to allow the claimant's appeal.

[2] It is to be noted that the diseases listed as C2 and C5A in column 1 of Schedule 1 to the 1985 Regulations, although similar, exhibit themselves in slightly different ways even though there are common symptoms such as tremor. This is apparent from the report of the Industrial Injuries Advisory Council on Conditions due to Chemical Agents (Cm 5395), 2002, available on the National Archives website. (Effect was given to the recommendations of that report by the Social Security (Industrial Injuries) (Prescribed Diseases) Amendment Regulations 2003 (SI 2003/270), which introduced into Schedule 1 to the 1985 Regulations both the current formulation of Prescribed Disease C2 and the, then, new Prescribed Disease C5A (which, with Prescribed Disease C5B, replaced the former Prescribed Disease C5).)

64. However, not applying an offset made the gross assessment of the claimant's disablement more important than it otherwise would have been. On this issue, the First-tier Tribunal said –

> "26. … the Appellant's medical records indicate that he is still very active. They disclose that in 2017 the Appellant was undertaking DIY tasks about the house and that he was lifting and carrying heavy buckets of water. As noted upon assessment, he had upper limb tremor and was experiencing difficulties with coordination. He was also showing increased signs of stress and depression with mood changes and loss of temper. He also demonstrated some cognitive impairment, only being able to complete one round of serial sevens. He was a little unbalanced on standing and demonstrated a loss of grip. Overall, the Tribunal considered the Appellant's loss of faculty in respect of prescribed disease C5A was 15%, made up of 10% impaired upper limb function and 5% impaired mental functioning. …"

The first two sentences seem to have been derived from a discharge letter among the claimant's medical records (doc 877 on file CI/1000/2019), which says –

> "[The claimant] is a 75 yo gentleman who was admitted to hospital on 23/09/17 after complaining of back pain. He had been lifting heavy buckets of water when cleaning his fish tank. He has had back pain since which is exacerbated by movement."

The claimant says that it was only one bucket (although the First-tier Tribunal could not have known that) and points out that the effect of lifting it was that he ended up in hospital for four days. There are references to him doing DIY in 2012 and decorating in 2014, but time had elapsed since then and, as the First-tier Tribunal otherwise relied on the health care professional's findings, the discharge letter seems a rather slender basis for disagreeing with her assessment of the extent of the claimant's disablement when she had had the advantage of seeing the claimant.

65. Again, an underlying issue is that the First-tier Tribunal made no effort to persuade the claimant to attend a hearing. This was not strictly a breach of the rules of natural justice because, whatever ambiguity there may have been in the claimant's letter of 12 August 2018, it is abundantly clear that he was well aware that, if he did not withdraw his appeal, the First-tier Tribunal might make a less favourable decision than the Secretary of State had done and it seems to me that he must be taken to have anticipated the possibility that the gross assessment of his disablement might be reduced even if the assessment in respect of the prescribed disease was not. However, making any assessment of disablement in the absence of a claimant can seldom be satisfactory and it is arguable that claimants should not generally be allowed to think that it might be. They may be unlikely to secure an increased assessment if they do not attend a hearing but, by the same token, some care has to be taken before an assessment that has been based on an examination of the claimant is reduced in the absence of the claimant and the reasoning in such a case needs to be particularly sound.

66. On balance, I am prepared to accept the Secretary of State's concession that the First-tier Tribunal's reasoning was inadequate. However, I also set the decision in respect of Prescribed Disease C5A aside because it seems to me that the appeal in relation to it is inextricably linked (factually rather than legally) to the appeal in

relation to Prescribed Disease C2 and that an error in respect of one affects the other. The cases should be kept together so that their reasoning is consistent.

Ground 6 – Prescribed Disease C21

67. The First-tier Tribunal's reasons for dismissing the claimant's appeal in respect of Prescribed Disease 21 were short –

> "24. … In relation to Prescribed Disease C21, whilst the Tribunal notes that the Appellant may have been exposed to a number of chemicals over the years, he also spent a lot of time in the sun. There was no cogent evidence before the tribunal to link the onset of skin cancer to exposure to any single chemical or to arsenic or arsenic compounds, tar, pitch, bitumen, mineral oils or soot. On the balance of probabilities, and noting that the Appellant spent time working in sunny and warm climates, the Tribunal found upon the balance of probabilities that any skin cancer that he had developed had been caused by exposure to the sun and did not fit the criteria for an award of prescribed disease C21."

68. Judge Wright gave permission to appeal on the ground that the First-tier Tribunal failed to address the specific contentions raised by the claimant. The Secretary of State supports that appeal and Mrs Dean, her original representative, helpfully refers to the claimant's arguments in some detail in her submission on this appeal (docs 132 to 333 on file CI/1002/2019). In short, the claimant has always accepted that some of his skin cancers may have been due to the sun but his case was, and is, that some of them were probably due to his occupation (docs 3 and 38 on file CI/1002/2019). In particular, he argued that "the pattern of lesions around the hands, head and scalp, cheeks, temples and ears are areas where the contamination is from the removal of my protective gloves and handling my protective glasses with contaminated gloves and contaminated bare hands" (docs 100-102 on file CI/1000/2019), whereas the health care professional regarded that pattern to be of "sun-exposed sites" (doc 48 on file CI/1002/2019). Moreover, it appears that some confusion may have crept in from the health care professional's note that, while in the Royal Air Force, the claimant "mostly worked abroad in Cyprus" (doc 40 on file CI/1002/2019), which may have been what the claimant said to her but, if so, may have been misleading because the words are ambiguous. It appears that most, if not all, of the claimant's work abroad while in the Royal Air Force was in Cyprus, but that is not the same thing as having worked abroad during most of his period of service. It appears (from doc 371 on file CI/1000/2019) that he was in fact in Cyprus only for some two years (as would have been usual in my experience). Of course, even in England, the sun sometimes shines on airfields, but it does not do so as often, or (usually) as fiercely, as in Cyprus and so clearly the duration of the claimant's time in Cyprus might be relevant. On the other hand, so might any significant exposure to the sun while working in Great Britain as a civilian. (By section 115(3) of the Social Security Contributions and Benefits Act 1992, service in the armed forces is not treated as employed earner's employment for the purposes of entitlement to benefit in respect of industrial injuries or diseases, but equivalent entitlement to a service disablement pension might arise under Part II of the Naval, Military and Air Forces Etc. (Disablement and Death) Service Pensions Order 2006 (SI 2006/606) – hence, presumably, the claimant's claim under that scheme.)

69. In any event, I accept the Secretary of State's concession in this case. The very least the First-tier Tribunal should have done was show that it had noticed the claimant's arguments but, if it did consider them, it ought to have been possible for it to give a brief reason for considering sun a more likely cause of skin cancer in the claimant's case than exposure to any of the relevant chemical agents. Yet again, though, the underlying problem may be that, on neither occasion when the claimant informed the First-tier Tribunal that he would not attend the hearing, did the First-tier Tribunal try to persuade him to do so, so that it could take a detailed history from him.

The prescribed diseases that were not considered by the First-tier Tribunal

70. The claimant has raised again in these appeals the question of his entitlement to disablement pension in respect of Prescribed Diseases C26(b), C29 or C30(a). Although Judge Wright suggested that it would be a matter for the First-tier Tribunal to decide what additional issues were before it if the Upper Tribunal remitted to it the appeals in respect of Prescribed Diseases C2, C5A and C21, I have taken the view that it would be desirable for the Upper Tribunal to consider the question. This is partly because the point is not entirely straightforward and the Secretary of State is represented by more experienced representatives at this level, partly because, having had to consider the history of the case in some detail, it is easier for me to deal with the point than it would be for a judge of the First-tier Tribunal coming to the case afresh and dealing with it as an interlocutory issue and partly because it was likely to be quicker in the long run. It is also arguable that the claimant's contentions should be taken as submissions that the First-tier Tribunal sitting on 11 September 2018 erred in law in not considering Prescribed Diseases C26(b), C29 and C30(a). Accordingly, I sought clarification from the claimant as to what exactly he wanted and from both parties as to the facts and I have given both parties an opportunity to make submissions on the law.

71. The broad issues of law and my conclusions on them are set out at paragraphs 14 to 20 above. I have concluded that, where the Secretary of State has made a decision awarding or disallowing disablement pension in respect of a particular prescribed disease, the First-tier Tribunal can only consider that prescribed disease if the claimant has appealed against that decision or it can treat the claimant as having done so, which requires that the claimant had a right of appeal against that decision. In this case, by the time the First-tier Tribunal made its decision on 11 September 2018, the Secretary of State had made decisions in respect of each of Prescribed Diseases C26(b), C29 and C30(a).

72. The claimant had no right of appeal to the First-tier Tribunal against the 2017 decisions in respect of Prescribed Diseases C26(b) and C30(a) because, with each decision, the Secretary of State had issued a notice under regulation 3ZA(1) of the Social Security and Child Support (Decisions and Appeals) Regulations 1999 (SI 1999/991) but had not subsequently "considered an application for revision of the decision". In other words, there had been no "mandatory reconsideration" such as there had been in the cases that were considered by the First-tier Tribunal. The consequence was that, by virtue of regulation 3ZA(2), the First-tier Tribunal sitting on 11 September 2018 simply had no jurisdiction to consider those prescribed diseases and so it did not err in not considering whether to do so.

73. However, having had her attention drawn to the terms of the claimant's letter of 19 May 2017 (pages 96 to 99 on file CI/1000/2019) insofar as it related to those prescribed diseases, the Secretary of State is now prepared to treat that letter as an application for "mandatory reconsideration" of both the decision of 11 May 2017 in respect of Prescribed Disease C26(b) and the decision of 18 May 2017 in respect of Prescribed Disease C30(a). The claimant will now have a right of appeal if he is dissatisfied with either of the resulting decisions.

74. The position is different in relation to Prescribed Disease C29. At the time when the claimant submitted his appeals to the First-tier Tribunal, the Secretary of State had not issued any decision in respect of this prescribed disease. It seems that the claimant had first raised the point that Prescribed Disease C29 might be prescribed in relation to him at the end of 2016, following the decision that Prescribed Disease C6 was not prescribed in relation to him. The prescribed disease in both cases is "peripheral neuropathy" but the relevant occupations involve exposure to different chemical agents. In any event, the Secretary of State appears to have taken no action either to consider the issue or to tell the claimant that he had to submit a formal claim. There is no copy in the documents before me of the letter in which the claimant raised the issue – if it was received, it might be in the file relating to Prescribed Disease C6 – and it is possible that he did so in the same sort of oblique manner in which he sought "mandatory reconsideration" of the decisions in respect of Prescribed Diseases C26(b) and C30(a) in his letter of 19 May 2017. Indeed, in that same letter of 19 May 2017, he referred to having asked for Prescribed Disease C29 to be considered and there he clearly repeated the request. Again, that did not prompt any action. However, it seems that the claimant's second letter to the First-tier Tribunal of 4 October 2017 (see paragraph 34 above) may, when it had been sent to the Secretary of State, have prompted her to send the clamant a claim form. In any event, I am told that he made a claim in respect of Prescribed Disease C29 on 1 December 2017. It was apparently accepted that the claimant had been employed in a relevant occupation (issue (a)), but the claim was disallowed on 13 April 2018 on the ground that the claimant was not suffering from the prescribed disease (issue (b)). On 18 July 2018, the disallowance was upheld on "mandatory reconsideration".

75. The claimant had a right of appeal against the decision that had been upheld on 18 July 2018 but did not exercise it. The First-tier Tribunal sitting on 11 September 2018 was unaware of the decision and of the "mandatory reconsideration" and, anyway, even if it had been aware of those decisions, I cannot see any ground on which, in the absence of both parties and therefore of representations from them, it could properly have treated the claimant as having appealed rather than leaving him to bring a separate appeal if he was still dissatisfied. Accordingly, I am satisfied that it did not err in law in not considering whether to treat the claimant as having appealed. It is now too late for him to bring an appeal because more than 13 months has elapsed since 18 July 2018 (see rule 22(8)(b) of the Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008 (SI 2008/2685), read with rule 22(2)(d)(i)).

76. Had disablement pension been awarded in respect of Prescribed Disease C29, it might have been necessary for the Secretary of State to give some

consideration to whether the claimant should be treated as having made his claim in respect of that prescribed disease in 2016 rather than in 2017. However, because disablement pension was not awarded, the point is academic.

Remittal and comments regarding the re-hearing of these appeals

77. As the First-tier Tribunal erred in law in relation to its decisions in respect of Prescribed Diseases C2, C5A and C21, I set aside its decisions. The cases need to be re-decided. I remit them to the First-tier Tribunal because it has medical expertise that the Upper Tribunal does not.

78. If the claimant is dissatisfied with either of the new decisions made on "mandatory reconsideration" of the 2017 decisions in respect of Prescribed Diseases C26(b) and C30(a) (see paragraph 73 above) and he appeals, he should, when appealing, ask the First-tier Tribunal to hear the appeal(s) with the appeals that I have remitted, quoting the First-tier Tribunal's case numbers.

79. However, as matters stand, the First-tier Tribunal will be unable to consider Prescribed Disease C29.

80. It is of the utmost importance that the claimant take part in a hearing if at all possible. In the current circumstances of the Covid-19 pandemic, a hearing is likely to be by video link or by telephone.

81. He has said that he is too ill to attend a hearing but he has also said that he is prepared to be examined by a specialist. I suggest that he consider the medically-qualified member of the tribunal in the same way as he would a specialist, since he or she will ask the same questions for much the same purpose and even has the power to examine the claimant. It is necessary for questions to be asked at a hearing because it is important to ascertain the probable causes of the relevant prescribed diseases and the extent of their resulting disablement and that may require a detailed understanding not only of his symptoms but also of the way in which, and the extent to which, he was exposed to the relevant chemical agents. That sort of questioning cannot reasonably be reproduced in writing because there are too many questions and many of them depend on the answer to the one before. It is therefore necessary to talk, but it should be perfectly possible to conduct the questioning by telephone or by a video link.

82. The claimant has also expressed anxiety about being questioned but, as I have said, he can regard it in the same way as he would regard questions asked by a consultant at a hospital. The First-tier Tribunal has plenty of experience in carefully asking questions of anxious claimants and so the experience should not be as he might imagine being cross-examined in court. Moreover, he is perfectly entitled to have someone with him – a relative or friend, perhaps – to provide moral support and, indeed, practical help, although he must, of course, answer questions put to him himself.

83. The claimant is not entitled to assume that, because he has succeeded in these appeals, he will be successful if he participates in another hearing before the First-tier Tribunal. However, the First-tier Tribunal is likely to be able to make much

more informed decisions if he participates in a hearing and, if he has a good case, that will be to his advantage.

84. I remind the First-tier Tribunal that an assessment of 100% disablement represents serious disablement but does not represent total disablement. Care must therefore be taken to ensure that lower percentages reflect that so that a claimant is not under-assessed, particularly where the claimant is seriously disabled by conditions that are not to be taken into account so that a gross assessment of all his or her disablement could amount to over 100% (see R(I) 30/61).

Mark Rowland
22 October 2020