R(JM) v First-tier Tribunal (respondent) & Criminal Injuries Compensation Authority (interested party)
[2023] UKUT 267 (AAC)

IN THE UPPER TRIBUNAL **Appeal No.** UA-2021-000716-CIC
ADMINISTRATIVE APPEALS CHAMBER

Judicial review proceedings in respect of a decision of the First-tier Tribunal (Social Entitlement Chamber)

Between:

JM

Applicant

- v –

The First-Tier Tribunal

Respondent

&

Criminal Injuries Compensation Authority

Interested Party

Before: Upper Tribunal Judge Mitchell

Decided on consideration of the papers.

DECISION

Decision: This application for judicial review SUCCEEDS. Under section 15 of the Tribunals, Courts and Enforcement Act 2007, I make a QUASHING ORDER in respect of the decision of the First-tier Tribunal taken on 16 November 2021 (reference CI/005/19/00040). Under section 17 of the 2007 Act, I REMIT this matter to the First-tier Tribunal and DIRECT as follows:

(1) the First-tier Tribunal is to re-determine JM's appeal against CICA's determination of her application for compensation under the 2012 Criminal Injuries Compensation Scheme;

(2) the tribunal panel that re-determines JM's appeal must not include any member of the panel whose decision has been quashed in these proceedings;

(3) the First-tier Tribunal must hold a hearing before determining JM's appeal.

Direction (3) may be varied by direction given by the First-tier Tribunal.

REASONS FOR DECISION

Background

1. The grounds on which the Appellant (JM) was granted permission to bring judicial review proceedings, and the background to this case, were described as follows in the Upper Tribunal's permission decision:

> **"[JM's] grounds**
>
> 4. [JM's] written application for permission to bring judicial review proceedings argues that the Tribunal failed to deal with her criticisms of a Dr Cardoza's opinion as to the period of her disabling mental injury, and overlooked evidence about her tinnitus. The application also explains why [JM] thinks she is entitled to a greater award, but I shall not address that because my role is not to decide the amount of compensation; it is to consider the lawfulness of the Tribunal's decision.
>
> 5. At the [permission] hearing before myself, [JM] further argued:
>
> (a) the Tribunal failed to take into account her oral evidence that she was still waiting to see an Ear, Nose and Throat specialist;
>
> (b) the Tribunal overlooked medical evidence about her tinnitus and therefore made a flawed finding that her medical records made no mention of that condition before March 2020. In particular, the Tribunal failed to take into account that tinnitus was referred to in 2017 GP records and that she had a hospital appointment for tinnitus in 2019;
>
> (c) the Tribunal overlooked medical evidence that she had been diagnosed with severe PTSD;
>
> (d) the Tribunal did not give her the opportunity to put the evidence about her lifestyle in its proper context. Had she been asked to do so, she would have

informed the Tribunal that her ability to do things varied day-to-day, the Asda supermarket referred to by the Tribunal was very close to her home as was the school mentioned in its statement of reasons.

Background

6. In this section of my reasons, I focus on those background features of this case that are of particular relevance to [JM's] grounds of challenge.

[JM's] application

7. [JM's] application to CICA, dated 4 January 2018, related to an incident on 2 September 2017 in a public park attended by herself, her daughter, sister, and mother. The incident was preceded by a dispute about some children's use of play equipment and culminated, in [JM's] words, with their parents threatening and then "attacking us". The incident was reported to the police on that same day.

8. [JM's] application included amongst her ongoing symptoms "memory loss" and "tinnitus". She wrote that, one the day of the incident, she was admitted to A&E and also underwent dental surgery. [JM's] A&E discharge summary stated, "minor head injury (adults)" and "discharged – no follow up".

Medical evidence before CICA

9. On 4 September 2017, [JM] consulted her GP. The notes stated, "assault by fight…punched in the face and kicked on the floor Left with haemorrhage in the eye and black eye…now complaining of back and side pain…". [JM] saw her GP again on 8 September 2017 and the notes included, "some pressure feelings in ears – comes and goes" and "advised re looking after mental health after something like this".

10. An entry in the GP notes dated 17 October 2017 included, "…was seen by max fax and had X ray after assault happened – no facial bone #...adv likely post concussion syndrome. likely would gradually self resolve…". On 7 November 2017 the notes included, "assaulted in early sept. since then been unwell…getting headaches and facial pain attack too". On 14 December 2017, [JM] consulted her GP about headaches which were "ongoing since reported assault". An entry for 18 December 2017 stated, "…assaulted in park in

sept…ongoing facial pain so ref for review. initially headaches marked but are improving to 1-2 a week. main issues are occasional dizziness, bad dreams with interrupted sleep, emotionally labile, short tempered and inc sound sensitivity, no flashbacks as such but dreams of fighting a lot which is distressing…warrants ref to counselling re ongoing sx, neuro and ct brain".

11. On 2 January 2018, [JM's] GP referred her for counselling: "…she suffered an assault in September and has been markedly affected by this emotionally…having a lot of anxiety and she is short tempered, related to the incident and I would appreciate some counselling help to enable her to move on from this". On 6 April 2018, the GP made a separate referral for one-to-one counselling because [JM] had not 'got on' with group therapy.

12. On 5 February 2018, [JM] attended A&E complaining of chest pain. On 6 February 2018, she consulted her GP about palpitations, and did so again on 8 February 2018 "feels very anxious and tearful".

13. [JM's] GP records describe a consultation for "reactive depression" on 12 February 2018: "CT normal referred to neurol – suggested onward referral to head inj…most problematic is getting to sleep…admits not getting out as much after assault last yr…re sleep – advised re difficult with meds and addiction. advised psych approach to post trauma more likely to help…".

14. On 21 February 2018, [JM's] GP referred her to an oral surgeon: "…ongoing problems post this assault with her face in that she is suffering quite a lot of facial pain…she is also suffering from post concussion symptoms and I have already referred her to the traumatic brain injury service…".

15. On 1 March 2018, [JM's] GP referred her to a cardiologist to investigate palpitations: "she is under a lot of stress and anxiety at the moment, owing to an attack on herself…in September". The cardiologist wrote to the GP on 17 May 2018. I am not certain about the medical terminology used in the cardiologist's letter, but I think he reported no concerns with [JM's] heart.

16. [JM's] GP notes include a consultation for "reactive depression" on 27 March 2018: "…visited by brain injury worker. offered group counselling…but on waiting list…feels would prefer face to face counselling. will ref to pmht again. headaches ongoing…also waiting for appt from max fac re ongoing odd sensation left face. some memory issues and irritable at times but is improving". There was another consultation for "reactive depression" on 25 April 2018: "mood stable, good days and bad days…waiting for pmht…not within my area

of expertise to comment on how long her concussive sx may last. more specialised medical opinion needed…".

17. On 26 June 2018, [JM's] GP's notes included a consultation for "reactive depression". The consultation entry describes domestic difficulties.

18. [JM's] GP records stated that, on 14 September 2018, she was seen at a maxillofacial clinic for "zygomatic complex of bones". The specialist's letter to the GP stated, "she has been left with a degree of ongoing intraorbital nerve paraesthesia…there is little we can offer in terms of improving her symptoms. Fortunately, things appear to be self-resolving in this respect".

19. On 5 April 2019, [JM] attended A & E and was admitted to hospital. Her GP records (dated 9 April 2019) stated, "went in with severe headache – had ct scan and lumbar puncture – nad…was told occipital myofascial neuralgia…wants to try neuropathic medication for pain". The hospital discharge summary records that no brain abnormality detected but notes "occipital myofascial trigger point positive".

20. On 18 June 2019, [JM's] GP supplied CICA with her medical records "from 2014 to date".

CICA's decisions

21. CICA's initial decision of 17 September 2019 was to refuse to make any award under the 2012 Criminal Injuries Compensation Scheme because police evidence indicated that [JM's] sister instigated the altercation and [JM] "pushed one of the alleged offenders who has then retaliated". [JM] disputed the reported police evidence, which she had not seen, and asked CICA to review their decision.

22. On 15 October 2019, CICA reviewed their refusal decision and informed [JM] that they were "satisfied that your own conduct did not cause or worsen the incident" and made an award. The award was £1,500 for "scar neck significant disfigurement" (A2 within the Scheme's award tariff).

Subsequent medical evidence

23. More recent medical evidence was obtained by the First-tier Tribunal.

24. On 30 October 2019, [JM's] GP referred her to an audiologist: "she had a serious assault some years ago and has complained of bilateral tinnitus

since…feels that this is worsening over recent months in her right ear. It is now affecting her sleep. She has no objective tinnitus".

25. On 30 October 2019, [JM's] GP sought to expedite neurological investigations following a recent headache episode of "quite marked pain".

26. On 6 December 2019, a pain consultant asked for a clinical psychologist's opinion on whether [JM] had "some mild PTSD symptoms". On 12 February 2020, the clinical psychologist wrote to [JM's] GP: "…she explained that she has had chronic pain, which has been diagnosed as occipital myofascial neuralgia, since being assaulted in September 2017…not currently working but is trying to remain active. She goes to college once a week in the evening. She is a parent governor at her daughter's school and she regularly walks her dogs…she described feeling low and has had suicidal thoughts…We completed a Post-Traumatic Stress Disorder Checklist [see p.C143] and she does have significant symptoms of PTSD…it would be helpful to address her ongoing symptoms of PTSD…she had a preference for EMDR…".

27. On 6 December 2019, a pain consultant wrote to [JM's] GP, "…since [the assault] she has had pain in her neck and shoulder bilaterally…headache is present nearly every day…discussed…whether she is getting flashbacks from the assault. She is having dreams where she is waking up feeling quite panicky...".

28. On 10 December 2019, a senior audiologist wrote to [JM's] GP: "…Tinnitus afterwards [September 2017 incident]. Thought it would get better but still there…Pulsing, buzzing and humming…**Tinnitus – yes**. Bilateral. Onset: Sept 17…". The letter was accompanied by various graphs showing the results of tests of [JM's] hearing.

29. On 7 August 2020, [JM's] GP sought pain clinic advice on whether further scans were required to investigate her headaches, as she had requested, but informed [JM] that further neurological scans or investigations were unlikely to be called for.

30. The medical evidence also records delays in beginning EMDR therapy for PTSD symptoms due to pandemic-related restrictions.

Proceedings before the First-tier Tribunal

31. [JM] appealed to the First-tier Tribunal against CICA's decision of 15 October 2019. Her notice of appeal, dated 11 November 2019, argued that:

- CICA had failed to take into account ongoing neck pain and headaches;

- after many tests she had been diagnosed with “occipital myofascial”;

she had been referred to a pain clinic and had an appointment on 6 December 2019;

- she was taking medication for anxiety and sleep difficulties;

- she continued to suffer from tinnitus caused by the attack and had consulted her doctor and been referred to audiologist;

- her low mood and depression had been exacerbated by the attack;

- the mental effects of the attack had affected her ability to look after her disabled daughter.

32. On 30 July 2020, the Tribunal directed production of medical reports, one from a consultant clinical psychologist or psychiatrist and another from a pain consultant. At the same time, The Tribunal directed disclosure of [JM’s] medical records “from 1 May 2019 to date”.

Medical reports produced for the First-tier Tribunal

33. A consultant psychiatrist, Dr Cardoza, produced a report dated 2 December 2020. It was preceded by a video-link consultation with [JM] on 25 November 2020. The report included the following:

- “3.04. Within a few weeks…began to experience significant levels of anxiety during the day associated with intrusive thoughts of the incident…avoided going outdoors without her husband and was “always on alert”…social life declined and she got little pleasure from her usual leisure activities…had nightmares…and would wake up with palpitations and sweating…difficulty falling asleep and experienced tinnitus…and headaches…interfered with her usual daily activities such as household chores and continued for a period of 8 to 12 months, at a significant intensity…”;
- “3.07…February 2020…It was felt that she had symptoms of…PTSD…Currently, she does experience low mood at times…sleep is variable…worsened by...tinnitus that she experiences…able to do household chores, look after her children…take her children to school and drive to the shops…”;
- “3.08. In March 2020 she had tinnitus…”;

- "3.12. Mental state examination on 25th November 2020…happy to speak with me…no evidence of disorganisation to her flow of thought…mood was occasionally low with tearfulness and a congruent affect…"
- "5.01. Yes, [JM] did suffer from a disabling mental illness (**mental disorder**) which was directly attributable to the index incident on 2nd September 2017";
- "5.02. The diagnosis is **Post Traumatic Stress Disorder**…";
- "5.03…the PTSD is likely to have been disabling for a period of 8 to 12 months from…September 2017. She continues to have features of PTSD but they are currently not disabling";
- "5.04. For a period of 8 to 12 months…experienced intrusive memories of the index incident, associated with significant anxiety symptoms, poor sleep and nightmares…social life declined…got little pleasure from her leisure activities. She avoided going outdoors without her husband and was "always on alert"…nightmares…would wake up with palpitations and sweating…sleep was of poor quality…complicated by tinnitus…and headaches";
- "5.05…she may not require more than eight sessions [of EMDR]…Given that her PTSD has not been disabling since 2018, the prognosis is likely to be good…";
- "5.07…the injury sustained…has not exacerbated or accelerated a pre-existing condition…";
- "5.08…there are no other life events that have played a part in the appellant's mental capabilities".

34. Dr Searle, consultant in anaesthesia and pain management, provided a report dated 11 July 2021, preceded by a video-link consultation on 7 July 2021. Dr Searle's report included:

- "…states that she can manage most activities of daily living such as hoovering, cleaning and cooking…she admits to feeling weepy, angry, depressed and irritable…admits to anxiety and has not visited Cardiff since the attack. She reports that her social activity is markedly reduced…" (p.7 of the report);
- "I am not a Psychologist, although I have worked in close association with Psychologists for many years. It is my opinion that this has been a significant psychological event; [JM's] reaction to the attack is understandable to me, and I

strongly suspect that a Psychology expert would make a diagnosis of Post-Traumatic Stress Disorder" (p.12).

Criminal Injuries Compensation Scheme (2012)

35. Paragraph 4 of the Scheme provides as follows:

"A person may be eligible for an award under this Scheme if they sustain a criminal injury which is directly attributable to their being a direct victim of a crime of violence…".

36. It was not disputed that [JM] was the 'direct victim of a crime of violence'.

37. Paragraph 32 provides that "a person is eligible for an injury payment under this scheme if (a) their criminal injury is described in the tariff at Annex E…". The amount of a payment "will be determined in accordance with the tariff…" (paragraph 33). Rules for determining the total award where "the application relates to more than one criminal injury" are contained in paragraph 37.

38. The Annex E tariff provides that "mental injury" does not include "temporary mental anxiety and similar temporary conditions". "Mental injury" is defined as follows:

"A mental injury is disabling if it has a substantial adverse effect on a person's ability to carry out normal day-to-day activities for the time specified (e.g. impaired work or school performance or effects on social relationships or sexual dysfunction)."

39. The tariffs for "disabling mental injury" are set out as follows in Annex E:

"Disabling mental injury, confirmed by diagnosis or prognosis of psychiatrist or clinical psychologist:

- lasting 6 weeks or more up to 28 weeks	A1	£1,000
- lasting 28 weeks or more up to 2 years	A4	£2,400
- lasting 2 years or more up to 5 years	A7	£6,200
- lasting 5 years or more but not permanent	A9	£13,500

"

40. There are separate tariff entries for "permanent mental injury, confirmed by diagnosis or prognosis of psychiatrist or clinical psychologist". Where the permanent injury is moderately disabling, the tariff award is £19,000 (A11) and, if seriously disabling, £27,000 (A13).

41. The tariff includes entries for "tinnitus (ringing in ears)". If this lasts for 13 weeks or more, the tariff award is £1,500 (A2). If it is a permanent condition, the awards are £6,200 (A7), if the condition is "other than very severe", and £16,500 (A1) where it is "very severe".

First-tier Tribunal's decision

42. The Tribunal allowed [JM's] appeal and decided that the following tariff entries applied: headaches lasting more than 28 weeks (A2); neck scarring – significant (A2); disabling mental injury lasting 28 weeks or more up to two years (A4). After applying the 2012 Scheme's rules for multiple tariff awards, the total award directed by the Tribunal was £3,075.

43. The Tribunal's statement of reasons includes the following:

(a) [JM's] criticisms of Dr Cardoza's report were described, in particular her disagreement with his opinion about the progression of her PTSD (paragraph 13);

(b) "it is reported several times within the medical records, that the PTSD is mild" (paragraph 33);

(c) "the Tribunal notes [JM's] ability to act as a full time carer for her daughter, to go shopping alone; to go on a foreign holiday; to undertake a college course in law, and to apply and to become a parent governor. It finds, on the balance of probabilities, that Dr Cordoza is correct; that the main disabling symptoms of the diagnosed PTSD lasted for a maximum of 12 months…the appropriate award is that of A4 £2400.00 for a disabling mental injury lasting 28 weeks or more up to 2 years" (paragraph 35);

(d) "at no point is tinnitus mentioned in her medical records, until March 2020…There is no formal diagnosis of tinnitus contained in the medical records. At no point has the onset of tinnitus been linked with the index incident. No opinion or evidence has been provided which could lead to a finding that the tinnitus is likely to be permanent…" (paragraph 38).

Why I have granted permission to bring judicial review proceedings

Ground 1 – evidence that PTSD was mild

44. The Tribunal found that it was reported "several times" in the medical records that [JM's] PTSD was mild. I have spent some time looking through [JM's] medical records (I do not think Dr Cardoza's report may be considered part of her medical records) and I cannot find any clinical opinion that she had mild PTSD.

45. A pain consultant referred [JM] to a clinical psychologist on 6 December 2019 for an opinion whether she had "some mild PTSD symptoms". I very much doubt that this could properly have been construed as a finding that the pain consultant had diagnosed mild PTSD. It seems to me that the far more tenable interpretation was that one clinician was asking another clinician to investigate and, when that clinician did so, a diagnosis was made of "significant symptoms of PTSD".

46. Arguably the Tribunal erred in law by making a finding for which there was no supporting evidence or, alternatively, overlooked relevant evidence. I grant permission to bring judicial review proceedings on that ground.

Ground 2 – period of disabling mental injury

47. I have found elusive the basis for Dr Cardoza's opinion that [JM's] PTSD was likely to have been disabling for only 8 to 12 months. The report does not, for example, identify lifestyle changes that occurred some 8 to 12 months after the incident (that is between May and September 2018) which were indicative of a lessening of symptoms. Dr Cardoza's clinical opinion was that her symptoms were not currently disabling (i.e. at the time of his examination) but that was more than three years after the incident. The report does not explain why PTSD symptoms were considered not to be disabling 8 to 12 months after the incident despite the clinical psychologist's finding in early 2020 of significant PTSD symptoms. For my part, the only medical evidence I have been able to identify of symptoms potentially easing some 8-12 months after the assault concerned facial pain (see the entry in GP records for 14 September 2018).

48. In paragraph 35 of its reasons, the Tribunal accepted Dr Cardoza's opinion. It did so after reciting evidence about activities that [JM] was able to undertake. The process of reasoning appears to be that, if [JM] could do these things, Dr Cardoza must have been right. [JM's] case, as I understand it, was that she had

adapted her lifestyle to accommodate the difficulties of living with PTSD. The problem for [JM's] on this application is that the Tribunal's statement of reasons does not record, in any great detail, [JM's] arguments on this point and I cannot locate any relevant written submissions that she provided to the Tribunal. I do not therefore grant permission to bring judicial review proceedings on the ground that the Tribunal failed to deal with [JM's] argument that her lifestyle, if put in its proper context, did not indicate a lessening of her PTSD symptoms (although the ground below, on which I have granted permission, partly addresses [JM's] complaint that the Tribunal failed to put her lifestyle activities in their proper context).

49. I do, however, grant permission on the ground that the Tribunal arguably erred in law because it gave inadequate reasons for finding that [JM's]

PTSD symptoms were no longer disabling 8-12 months after the incident:

(a) arguably, adopting Dr Cardoza's opinion did not supply an adequate reason because his report did not explain, by reference to lifestyle changes or evidence with [JM's] medical notes, the basis for his opinion that symptoms were no longer disabling 8-12 months after the incident;

(b) arguably, the mere fact that [JM] could perform the activities described in paragraph 35 of the Tribunal's reasons did not adequately explain why her PTSD symptoms ceased to be disabling 8-12 months after the incident. The Tribunal made no findings as to whether [JM] had always been able to perform those activities and, if not, when she started to do so. Furthermore, the Tribunal's reasons do not explain why performance of those activities was incompatible with the existence of a disabling mental injury. Arguably, more detailed findings of fact were required in order to supply a sufficient reason. For instance, findings about what was involved in [JM's] shopping activities and why that was incompatible with disabling PTSD symptoms.

Ground 3 – tinnitus

50. The Tribunal made some very clear findings about tinnitus. There was no formal diagnosis of tinnitus and no evidence had ever linked [JM's] tinnitus with the index incident. Arguably, the Tribunal erred in law by overlooking relevant evidence (in fact, evidence that directly contradicted the Tribunal's findings). I grant permission to bring judicial review proceedings on that ground. On 10 December 2019, a senior audiologist diagnosed bilateral tinnitus, recorded that it began after the index incident and gave an 'onset date' of September 2017.

The audiologist's diagnosis followed tests, and graphs setting out the results of those tests were appended to the audiologist's diagnostic letter. I recognise that I have no professional medical expertise but, nevertheless, I find it difficult to see how a diagnosis of tinnitus could be any more formal than this.

Conclusion

51. [JM] is granted permission to bring judicial review proceedings on the grounds described in paragraphs 46, 49 and 50 above.

Disabling mental injury evidence

52. The case management directions given below require CICA's written submissions to address the question whether, without further medical evidence, the First-tier Tribunal, if it ends up reconsidering [JM's] appeal, would be able to make a disabling injury award in excess of the A4 tariff award of £2,400. The issue is whether the requirement under the tariff scheme for "confirmation of diagnosis or prognosis by psychiatrist or clinical psychologist" applies only to the existence of a disabling mental injury, or whether it also applies to the period of the disabling mental injury.

53. My provisional view is that (a) the 2012 Scheme only requires a psychologist or psychiatrist to confirm the existence of a disabling mental injury and that (b) the period for which it lasts does not need to be so confirmed, which would allow a tribunal to depart from a psychologist/psychiatrist's opinion as to the period of disabling mental injury if it saw fit. The practical benefit of that approach in [JM's] case would be that the Tribunal would not have to seek a further medical report if it were minded to make a disabling mental injury award in excess of A4. More generally, the First-tier Tribunal may be assisted by the Upper Tribunal's views on this point in other disabling mental injury cases.

54. I should point out that the above observations do not indicate that I have already decided that [JM's] application for judicial review succeeds. I have not done so and will not decide this case until I have received and considered CICA's submissions."

Arguments

2. As is conventional, and appropriate, the First-tier Tribunal takes a neutral stance in these proceedings and makes no comment on JM's grounds for judicial review.

CICA

3. CICA support these judicial review proceedings and concede that the First-tier Tribunal's decision should be quashed.

4. In relation to ground 1, CICA submit that JM's medical records contained no clinical opinion that JM had mild PTSD and, in finding otherwise, the First-tier Tribunal either made a finding for which there was no supporting evidence or overlooked relevant evidence.

5. In relation to ground 2, CICA accept that the First-tier Tribunal erred in law as described in the Upper Tribunal's permission determination.

6. In relation to ground 3, CICA submit that the First-tier Tribunal erred in law by overlooking medical evidence regarding JM's tinnitus diagnosis or by disregarding such evidence without explanation.

7. In relation to the issue whether, under the 2012 Criminal Injuries Compensation Scheme, the role of a clinical psychologist or psychiatrist is confined to diagnosing disabling mental injury, CICA's view is that the role is so confined. While a psychologist or psychiatrist might express an opinion as to the period of disabling injury, neither CICA nor the First-tier Tribunal is bound by such an opinion. A clinical opinion as to prognosis may often be persuasive, but in an appropriate case it would be open to a CICA claim officer or tribunal to reach "a different conclusion on the balance of probabilities using other adminicles of available evidence, if there was good reason to do so".

8. CICA's submissions use the word 'adminicle', a Scots law term which, according to the Judiciary of Scotland website, means "any piece of evidence supporting a particular argument". CICA's offices may be located in Scotland but that does not render Scots law applicable to criminal injuries appeals in England and Wales. Scots law terms should be avoided in submissions for a case decided under the law of England and Wales. Their use runs counter to the need to make tribunal proceedings as accessible as possible. I trust I do JM no disservice, but I doubt whether, before this case, she had ever come across the word 'adminicle'. The present case is decided under the law of England and Wales, and I shall therefore take 'adminicles of available evidence', as used in CICA's submissions, to mean 'available, relevant evidence'.

9. I also record CICA's view that a fresh medical report is likely to be required before JM's claim for compensation under the 2012 Scheme is finally determined.

10. CICA invite the Upper Tribunal to remit JM's case to the First-tier Tribunal or, if considered appropriate, to CICA itself.

Conclusions

11. Neither party requests a hearing before the Upper Tribunal decides this claim for judicial review. A hearing is unnecessary because the claim is supported, and the parties' written arguments allow me to decide the claim fairly without holding a hearing.

12. This claim for judicial review succeeds. The First-tier Tribunal's decision involved the following errors on points of law:

(1) the finding that JM's PTSD was reported to be mild "several times" in her medical records had no supporting evidence. Mild PTSD was referred to once in JM's medical record but not diagnostically. It was mentioned when one clinician sought a specialist's opinion whether JM had mild PTSD symptoms, but the specialist did not subsequently diagnose mild PTSD;

(2) Dr Cardoza's opinion that JM's PTSD was likely to have been disabling for only 8 to 12 months was unreasoned. The Tribunal accepted that opinion on the basis, it seems, of evidence of JM's lifestyle. However, the lifestyle evidence could not, without some explanation, properly have supported a finding that JM's PTSD ceased to be disabling 8 to 12 months after her assault. The Tribunal therefore gave inadequate reasons for its decision;

(3) in finding that JM had never been formally diagnosed with tinnitus and that there was no evidence linking tinnitus with JM's assault, the Tribunal failed to take into account relevant evidence in particular a senior audiologist's December 2019 diagnosis of bilateral tinnitus with an onset date of September 2017.

13. I quash the First-tier Tribunal's decision and, in accordance with the directions given above, remit to that Tribunal for re-determination JM's appeal against CICA's decision on her claim for compensation under the 2012 Criminal Injuries Compensation Scheme.

14. There remains the issue which I directed CICA to address in their written submissions namely the role of a psychiatrist or clinical psychologist under the 2012 Scheme in determining a claim for compensation for disabling mental injury. It is clear that, under the 2012 Scheme, the existence of a disabling mental injury must be confirmed by a psychiatrist or clinical psychologist. Otherwise, the words "disabling mental injury, confirmed by diagnosis or prognosis of psychiatrist or clinical

psychologist" would be meaningless. It is less clear whether the period of disabling injury must also be confirmed by a psychiatrist or psychologist. While the relevant tariff entry does not unambiguously provide that the period of disabling mental injury must be so confirmed one would normally expect a prognosis, which is mentioned, to address the duration of a medical condition. That said, the tariff entry anticipates a clinician providing either a diagnosis or a prognosis and, if only the former is provided, someone else obviously has to address the likely period of disabling injury. This suggests that Parliament, in approving the 2012 Scheme (see section 11(2), Criminal Injuries Compensation Act 1995), considered that non-clinicians were capable, in some cases at least, of making determinations as to the likely period of a disabling mental injury.

15. Since Parliament had no principled objection to a scheme under which non-clinicians (i.e. CICA officials in the first instance) make at least some determinations as to the likely period of disabling mental injury, and the desirability of strictly construing provisions under which functions are sub-delegated to entities that fall outside normal governmental accountability mechanisms, I am inclined to agree with CICA that the formal role of a psychiatrist or psychologist under the 2012 Scheme is confined to confirming the existence of a disabling mental injury. I am unable to express myself in more definitive terms than this because the point has not been fully argued and, moreover, is not a point which needs to be resolved in order to decide these judicial review proceedings.

E Mitchell
Judge of the Upper Tribunal
Authorised for issue on
30 October 2023