LT -v- Department for Communities (DLA) [2025] NICom 14

Decision No: C1/25-26(DLA)

**SOCIAL SECURITY ADMINISTRATION (NORTHERN IRELAND) ACT 1992**

**SOCIAL SECURITY (NORTHERN IRELAND) ORDER 1998**

**DISABILITY LIVING ALLOWANCE**

Application by the claimant for leave to appeal

and appeal to a Social Security Commissioner

on a question of law from a Tribunal’s decision

dated 6 June 2016

DECISION OF THE SOCIAL SECURITY COMMISSIONER

**Preamble**

1. There has been a significant delay in the promulgation of this decision. I have set out, in the body of the text below, details of the factors which have led to that delay. It is important, however, to record, at the outset, my apologies to the appellant, her representative Mr Reid, and Ms Coulter on behalf of the Department.

**Decision of the Social Security Commissioner**

2. I grant leave to appeal and proceed to determine all questions arising thereon as though they arose on appeal.

3. The decision of the appeal tribunal dated 6 June 2016 is in error of law. The error of law identified will be explained in more detail below. Pursuant to the powers conferred on me by Article 15(8) of the Social Security (Northern Ireland) Order 1998, I set aside the decision appealed against.

4. For further reasons set out below, and despite the longevity of the proceedings to date, I am unable to exercise the power conferred on me by Article 15(8)a of the Social Security (Northern Ireland) Order 1998 to give the decision which the appeal tribunal should have given. This is because an appeal tribunal which has a Medically Qualified Panel Member (MQPM) is best placed to assess medical evidence and address medical issues arising in an appeal. Further, there may be further findings of fact which require to be made and I do not consider it expedient to make such findings, at this stage of the proceedings. Accordingly, I refer the case to a differently constituted appeal tribunal for re-determination. In referring the case to a differently constituted appeal tribunal for re-determination, I direct that the appeal tribunal considers the guidance set out below.

5. It is imperative that the appellant notes that while the decision of the appeal tribunal has been set aside, the issue of her entitlement to Disability Living Allowance (DLA) which is likely to be for a defined period from 27 October 2015, remains to be determined by another appeal tribunal. The newly constituted appeal tribunal will be undertaking its own determination of the legal and factual issues which arise in the appeal.

**Background**

6. On 14 January 2016 a decision maker of the Department decided that the appellant was not entitled to either component of DLA from and including 27 October 2015. An appeal against the decision dated 14 January 2016 was received in the Department on 25 January 2016.

7. On 21 April 2016 a detailed written submission, accompanied by additional documentation, including a medical report and some jurisprudence, was received in the Appeals Service (TAS) from the appellant’s representative, Mr Reid.

8. The appeal tribunal hearing took place on 6 June 2016. The appellant was present, was accompanied by her father and was represented by Mr Reid. The appeal tribunal disallowed the appeal and confirmed the Departmental decision of 14 January 2016.

9. On 23 September 2016, an application for leave to appeal to the Social Security Commissioner was received in TAS. The appellant was represented in this application by Mr Reid. On 2 November 2016, the application was refused by the Legally Qualified Panel Member (LQPM).

**Proceedings before the Social Security Commissioner**

*The period up to the end of March 2020*

10. On 2 December 2016 a further application for leave to appeal was received in the office of the Social Security Commissioners (OSSC). The appellant was, once again, represented in this application, by Mr Reid.

11. On 9 January 2017 observations on the application for leave to appeal were requested from Decision Making Services (DMS). In written observations dated 9 February 2017, Ms Adams, for DMS, opposed the application on the grounds advanced the application on the grounds advanced by Mr Reid.

12. The written observations were shared with the appellant and Mr Reid on 9 February 2017.

13. The application was assigned to Commissioner Stockman on 2 May 2017.

14. On 8 June 2017, Commissioner Stockman made a direction in connection with aspects of the medical evidence which was forwarded to Ms Adams and Mr Reid on 15 June 2017. A reply to the direction was received in OSSC from Mr Reid on 27 June 2017.

15. On 28 September 2017, Commissioner Stockman directed an oral hearing of the application.

16. The oral hearing was listed for 21 November 2017.

17. On 15 November 2017 further correspondence, with attachments, were received in OSSC, from Mr Reid.

18. On 20 November 2017, an application for a postponement of the oral hearing, listed for 21 November 2017, was received in OSSC. The application was shared with the Department on the same date and a request was made for an indication as to whether the Department had any objections to the postponement. A handwritten note, also dated 20 November 2017, states that in a telephone call, the Department had signaled that it had no objections to the grant of a postponement.

19. This application was then forwarded to Commissioner Stockman on the same date with an indication from an administrative office in OSSC, that the Department had been informed of the application, asked for their views, and stated that they had no objections to the application. The postponement application was granted by Commissioner Stockman on 20 November 2017 with a further direction that the case should be relisted.

20. There then followed an exchange of email correspondence between the administrative officer and the appellant on direction from Commissioner Stockman. This exchange involved a request to the appellant as to whether she was content to wait until Mr Reid had indicated that he was ready to participate in an oral hearing before it was relisted. On 20 December 2017, the appellant confirmed that she was content to wait until Mr Reid was ready to attend a hearing but wanted the opportunity to review matters at the end of January 2018.

21. The case then forwarded from Commissioner Stockman to me.

22. In March and April 2018 there was an exchange of email correspondence and telephone calls between the administrative officer and the appellant. As part of that exchange the appellant was provided with details of organisations which may have been able to represent her. During this period, Commissioner Stockman forwarded the case to me.

23. On 6 June 2018, and at my direction, the administrative officer wrote to the appellant indicating that I was minded to direct an oral hearing of the (then) application for leave to appeal and that she would be advised of the date and time of the oral hearing in due course.

24. On 2 July 2018, I issued a formal direction for an oral hearing. The oral hearing was listed for 1 August 2018 and that Case Summaries would be required. A Case Summary was received from Ms Coulter on 24 July 2018. At the hearing I acceded to an application for an adjournment made by the applicant and her husband. The reason for the adjournment was to allow the applicant to consult further with her solicitor. Following the hearing, I directed that the applicant would require some time to consult with her solicitor and I directed that the hearing should not be re-listed for a period of two months.

25. There then followed an exchange of email correspondence and telephone calls between the appellant and officers in OSSC concerning the release of documentation to her. Subsequently, certain documentation was released to the appellant.

26. There followed a further exchange of email correspondence between the appellant and officers in OSSC concerning the release of the name of the officer in OSSC who had been dealing with her case. In email correspondence dated 3 September 2018, the appellant was informed that the name of the relevant officer could not be released to her.

27. In email correspondence dated as received in OSSC on 25 September 2018, the appellant indicated that she had not engaged her solicitor due to the costs involved. She submitted that she saw herself as having two options going forward. The first was ‘… to let the case go’. The second was to request that the case should be determined on the basis of all of the submissions and evidence which had been provided to OSSC by Mr Reid and her. The appellant added some further submissions of her own.

28. The Legal Officer (LO) to the Commissioners wrote to the appellant on 10 December 2018 asking whether she wished to avail of the opportunity to attend an oral hearing and asked her to clarify her intentions within a week. There was no response from the appellant to this correspondence.

29. On 25 February 2019 all of the recent papers were forwarded to me. I directed that I was content for the application to be determined without an oral hearing but invited a further submission from the appellant.

30. Further correspondence to that effect was sent to the appellant on 27 March 2019. On 24 April 2019, I was informed that there had been no further response from the appellant.

31. On 30 May 2019 I asked the LO to review the file and provide an update. The update was provided by the LO on 30 March 2020.

*The period from 30 March 2020*

32. In the period from 30 March 2020 to the date of the promulgation of this decision, several factors have contributed to the delay in this appeal’s final promulgation.

33. The first, and most obvious, was the impact of the Covid-19 crisis which impacted across all sectors of society including the justice system.

34. The second was that in the latter part of 2020 and into 2021, and due to an administrative issue which had arisen, priority **had** to be given to a large group of cases in the office of the Social Security Commissioners. This meant a manifest delay in the judicial management of other cases including this one.

35. The third was that from 1 April 2023, the judicial complement within OSSC reduced from 2 Commissioners to 1.5 with consequent parallel drop in judicial capacity.

36. Finally, the general workload in OSSC is substantial and each application/appeal requires a written determination/decision with reasons. Over the period under consideration, the average disposal rate was of 150 determinations/decisions each calendar year which is notable given the factors outlined above. Notwithstanding that, there have been delays with a small number of cases, including this one and it is regrettable that this is so, particularly given the significance of the issues to individual applicants/appellants.

**Errors of law**

37. A decision of an appeal tribunal may only be set aside by a Social Security Commissioner on the basis that it is in error of law. What is an error of law?

38. In *R(I) 2/06 and CSDLA/500/2007*, Tribunals of Commissioners in Great Britain have referred to the judgment of the Court of Appeal for England and Wales in *R(Iran) v Secretary of State for the Home Department* ([2005] EWCA Civ 982), outlining examples of commonly encountered errors of law in terms that can apply equally to appellate legal tribunals. As set out at paragraph 30 of *R(I) 2/06* these are:

“(i) making perverse or irrational findings on a matter or matters that were material to the outcome (‘material matters’);

(ii) failing to give reasons or any adequate reasons for findings on material matters;

(iii) failing to take into account and/or resolve conflicts of fact or opinion on material matters;

(iv) giving weight to immaterial matters;

(v) making a material misdirection of law on any material matter;

(vi) committing or permitting a procedural or other irregularity capable of making a material difference to the outcome or the fairness of proceedings; …

Each of these grounds for detecting any error of law contains the word ‘material’ (or ‘immaterial’). Errors of law of which it can be said that they would have made no difference to the outcome do not matter.”’

**Analysis**

*Representation*

39. I am very grateful to Mr Reid and Ms Coulter for their carefully prepared written submissions setting out their detailed and constructive observations, comments and suggestions. I have, of course, taken into account, the appellant’s own submissions on issues which are of significance to her. I mean no disrespect in not addressing, in detail, all that has been commented on but, instead have concentrated on one ground of appeal.

*The statement of reasons for the appeal tribunals decision*

40. In the statement of reasons for its decision. The appeal tribunal set out the following:

‘The tribunal made no award of DLA principally because on considering the evidence of the level of treatment intervention and taking an objective view of the appellant's level of activity, it did not accept her account of the extreme impact of ME on her ability to function physically and mentally.

Specifically –

-It did not accept her account of brain fog or impaired mental function. She is able to research her illness online, shop on-line, manage the family meals, focus on needle work and presented as intelligent focused and capable. Her GP also confirmed on the factual report that that her level of insight and awareness is normal.

-Her pain relief is moderate and not in keeping with the level of pain described.

-She is able to attend a weekly two hour sewing class, drive, and commit to the school pick-up on a Thursday. Despite the qualifications the appellant made about these activities they indicate a degree of ability to function both physically and mentally, and to commit to regular activity which is inconsistent with the general picture of debility which she gave.

-The letter in 2010 from Dr McCluskley set out the background. The tribunal considered it carefully and concluded that it was descriptive of the history given by the appellant and contained no clinical findings or opinion which added to their deliberations.

-The report from Dr Weir 17/4/16 was also considered carefully. The tribunal found that it was largely relating the appellant's own account. It contained no objective assessments or clinical findings. The tribunal specifically disagreed with the account of her mental function as it found her in person to be alert and able to deal with the hearing and process. The letter from Dr Weir to the GP on 15/5/16 was also considered. The tribunal was concerned at Dr Weir's confidence in ascribing expertise to himself in this area. His level of confidence about the nature and treatment of the illness appeared inconsistent with the general medical caution in the diagnosis and treatment of ME. The tribunal did not attach weight to his opinion.

*The specific ground of appeal*

41. Mr Reid’s second ground of appeal was as follows:

‘Expert Medical Report Rejected

The Tribunal did not give weight to Dr Weir’s expert report, apparently believing he lacked expertise in ME, which they seemed to view as a challenging medical condition:

*“The tribunal did not attach weight to his opinion.”*

*“The tribunal was concerned at Dr Weir’s confidence in ascribing expertise in this area. His level of confidence about the nature and treatment of illness appeared inconsistent with the General Medical caution in the diagnosis and treatment of ME.”*

Given Dr. Weir is an acknowledged UK ME medical expert; And given that the tribunal demonstrated its marked unfamiliarity with ME [see below **Section 4**], these comments are insupportable, I respectfully suggest.

* Dr. Weir is listed among other experts in the GB Chief Medical Officer’s 2002 Report on ME.
* He is recognised in Case Law as possessing expertise in ME: (CSDLA 265/97).
* He holds weekly and monthly clinics for ME patients in London, Belfast and elsewhere;
* He constantly updates his clinical knowledge by attendance at international ME research conferences, most recently in June 2016 in London.
* The opinions he expressed in his expert report on the Appellant are entirely consistent with NHS NICE guidance published in 2007, and with the most recent MRC funded medical research published in the Lancet in 2011 and subsequently.

42. Mr Reid made further references to Dr Weir in his grounds of appeal as follows:

CSDLA 265/97

Commissioner Walker, Expertise of Dr Weir.

In 1997 in the GB jurisdiction, Commissioner Walker confirmed that Dr. Weir possesses expertise in ME, and ruled the tribunals must take his expert opinion into account.

However in the Appellant’s case the LQM and the MQM summarily dismissed Dr Weir's report. The LQM and did so without making any reference to Commissioner Walker’s ruling and I respectfully submit without giving adequate reasons; ‘see (**Section4**) below.

…

The LQM and MQM further complained that Dr Weir’s report was reliant on information provided by the appellant.

*“ … it was largely relating the appellant’s own account.”*

In the absence of objective biomedical tests for ME, medical personnel have no other option than to assess such patients by a detailed history of subjective symptoms. Official NHS guidance published by NICE stipulates that ME patients should be diagnosed and assessed by careful painstaking history-taking.

…

Accurate history checking - complying with NICE guidance - is actually evidence of Dr Weir's competence, and I respectfully submit the tribunal should have not have inferred the reverse.

History taking is a long-established skill, essential in all medical disciplines. There is no question of Dr. Weir's report lacking objectivity. ME patients have impaired concentration, and are notoriously poor historians. Diagnosis in ME is made by an experienced NHS consultant, knowing which questions to ask, and slowly coaxing the required information out of a confused patient. The diagnosis is made if and when the doctor can correlate features of the history obtained, with a template of subjective symptoms defined by NICE.’

43. Mr Reid attached a copy of the ‘Report of the CSM/ME Working Group to the Chief Medical Officer’ referred to in his grounds of appeal.

*Ms Coulter’s response*

44. In her written observations on the application for leave to appeal, Ms Coulter made the following response to the specific ground of appeal:

‘*The tribunal failed to give reasons or any adequate reasons for findings on material matters.*

Mr Reid contends that the tribunal has erred in failing to attach any weight to the medical report from Dr Weir who he states is acknowledged in the U.K. as an expert on ME and refers to CSDLA/265/97 in support of this. Mr Reid stated the principles of adjudication should be transferred from one benefit to another and refers to decision R(IB) 2/99 where he states incapacity benefit (IB) guidance was subsequently migrated into ESA handbooks. He further states the failure to consider ESA or PIP guidance resulted in an unfair outcome for the appellant, however, it is submitted that whilst the tribunal was not obliged to apply ESA or PIP guidance when assessing (the appellant’s) entitlement to DLA, had they adhered to same, the appellant would not have been deemed able to “*mobilise and attend to her bodily functions most of the time*”.

With regards to Dr Weir’s evidence, on the second page of the reasons for decision, the tribunal has recorded the following:

(as noted above)

The tribunal has recorded that it reviewed (the appellant’s) medication which was attached to the GP factual report and was deemed appropriate for her conditions by the medically qualified panel member. Furthermore, it has noted she had not been referred to a pain clinic, an occupational therapist or a physiotherapist. Upon perusal of all the evidence in the round, the tribunal concluded “the level of treatment intervention and taking an objective view of the appellant’s level of activity, it did not accept her account of the extreme impact on her ability to function physically and mentally. In respect of Dr Weir’s evidence the tribunal has highlighted that this was based on the (appellant’s) account of her condition as opposed to any assessment or clinical findings. I respectfully submit that the tribunal has provided adequate reasoning on why it placed little weight on Dr Weir’s evidence, as it was entitled to do and it has taking account of the variable nature of the appellant’s condition but found no entitlement to DLA. I therefore I respectfully submit no error has occurred here.

In support of this I would refer to reported decision R2/04(DLA)(T) where a Tribunal of Northern Ireland Commissioners dealt with the issue of conflicting medical evidence and stated at paragraph 20(5)

*“The decision as to whether or not a claimant suffers from a disablement is for the adjudicating authorities (including in particular tribunals which hear appeals against decisions) not for any doctor. Doctors, whether they be consultants, surgeons, general practitioners or examining medical practitioners give evidence. Tribunals make decisions on the basis of that evidence. In some cases the medical evidence will point in one direction only and the task of the tribunal will be light. On other occasions there will be a conflict of material medical evidence which the tribunal will be required to resolve. Where that conflict is acute, its task will not be an easy one. In such an event, the tribunal must explain how it has resolved the conflict and, where this is not already evident, why some parts of the evidence have been preferred to others.”’*

*The relevant jurisprudence*

45. I begin with the decision of the late Mr Commissioner Williams in *CDLA 925 2002*.

46. The Commissioner was hearing and determining an appeal against a decision of an appeal tribunal which decided that the appellant was not entitled to either component of DLA. Both parties to the proceedings were in agreement that the decision of the appeal tribunal was in error of law. The Commissioner stated the following, at paragraphs 4 to 6:

‘4 Both parties agree with the indication I gave on granting permission to appeal that this decision has to be set aside. This is because of the inadequate reasoning of the tribunal in its statement of reasons. The statement includes the following:

There were three medical reports before the tribunal, some of which were very extensive and which appeared to have been prepared with a view to litigation. They were dated between 1988 and 1997. There were also data sheets dealing with various drugs …

The only independent evidence before the Tribunal and the only recent medical evidence was the examining medical practitioner report. In view of its recent date and independence the Tribunal gave preferential weight to the findings of the examining medical practitioner report.

Following this, there are six further mentions of the examining medical practitioner report in the statement and none of the other medical evidence. The evidence rejected by the tribunal includes:

a detailed letter from the general practitioner dated in 1997;

a full report from a consultant orthopaedic surgeon dated in 1988 with 1997 update;

a full report from a consultant psychiatrist dated in 1991 and further report in 1998; a general practitioner’s drug schedule dated 26 September 2001 with dates of prescription renewals from September 1999.

5 The main reason for allowing this appeal has occurred in too many other appeals. It is wrong to dismiss evidence of a medical practitioner from one party as not “independent” without indicating why while at the same time accepting medical evidence from the other party as “independent”. What this tribunal appears to conclude is that the medical evidence from all but the examining medical practitioner is totally lacking in credibility. That is the only conclusion I can draw from the way the tribunal totally ignores the “non-independent” evidence. In that way it dismissed without consideration the evidence of a consultant specialist at a major British hospital who specialises in precisely the problem from which the appellant is suffering, and who is in addition fully recognised as an expert medical witness. That is plainly absurd.

6 Even if evidence was not “independent”, it should not be dismissed without any consideration at all. The appellant himself put his mental health problems directly in issue in the terms of his appeal to the appeal tribunal. It was also the reason that the appellant gave for not attending a tribunal hearing of this appeal. The tribunal should have considered the issue, but has not. To do so it would have weighed the consultant’s evidence against other evidence. Had the tribunal done this on the question of the appellant’s psychiatric condition, it would have realised that there was little other specific evidence on that issue. And what there was seemed consistent with the consultant’s report. The examining medical practitioner diagnosed anxiety and depression. The two lists of drugs are entirely consistent. The examining medical practitioner noted that the appellant “fulfilled the DSM (?) criteria for depression” and added that “long term (1970 -) history of depression, treated by several psychiatrists”. The 1998 report from the consultant itself reviews evidence of the appellant’s mental problems from various sources. It is singularly inappropriate to reject that report without even mentioning it.’

47. The emphasis here is my own.

48. I turn to the decision cited by Mr Reid – *CSDLA 265/97*. This case also involved an input from Dr Weir.

49. The decision under appeal from an appeal tribunal which had awarded the appellant an entitlement to the middle rate of the care component of DLA but which had disallowed entitlement to the mobility component. At paragraph 5, the Commissioner noted the following:

‘5. Mr Cobb presented his submission under four heads - first, that the tribunal had failed to state adequate reasons; second that no properly directed tribunal could have reached this tribunal's decision; third that the tribunal had made an erroneous statement of the law and, finally, that the tribunal had failed to observe the rules of natural justice in the course of the appeal.’

50. At paragraph 8, he noted:

‘8. This brings me back to the first two heads advanced by Mr Cobb which, in detailed submission, became amalgamated. The first branch of this argument, the first head of submission, was that the tribunal had failed to state adequately their reasons for rejecting evidence by a Dr Weir and further that they had failed to state reasons for taking into account the decision of an Adjudicating Medical Authority (AMA) which had taken place subsequent to the date of the decision of an AMA to which they did refer.’

51. In paragraph 13, he states:

‘Then there is the opinion of Dr Weir, a consultant physician who appeared to have some particular knowledge and experience of the syndrome, at document 115, where he opines upon the possible causal connection between an accident and the condition. After examination of the claimant he goes on to provide a full medical report at documents 118 to 122. There he seems to harden his view that there is a causal connection in this particular case between the trauma and the development of CFS. There is considerable evidence therein of the pain and other symptoms suffered by the claimant. He observes against there being a depressive component to the condition in this case and then at document 123 he opines that the syndrome:-

"... has an organic basis is now undisputed, particularly with reference to the immunulogical disturbances seen, together with consistently recognisable?abnormalities of the hypothalamic-pituitary-adrenal axis.

........the view, once held, that it was an atypical form of depression, is now no longer valid."

In the previous report, at document 122, appears the passage founded upon by the tribunal which is, in full:-

"The question remains as to whether the accident she suffered should be treated materially to the development of an illness. There is a clear temporal relationship between the onset of her CFS and her accident; from experience with other patients which this same sequence of events (following physical trauma), it is very difficult to assert that the two events are purely coincidental. Furthermore, other physicians working in this field, both in the United Kingdom and elsewhere, have observed this relationship in some of their patients.

Conversely, the full scientific argument describing the biological sequence of events leading from physical injury to the development of CFS is not yet available. Nonetheless, in my view, the balance of probability favours the proposition that there is a causal relationship between the physical trauma [the claimant] suffered and the development of her CFS. I am also certain that within the next 5 years, when more is known about the genesis of this condition, this proposition will be validated by full scientific proof."

In context, as it seems to me, what the tribunal were taking as supporting their conclusion about a non-physical disability in this case came from a passage dealing with the causal connection of physical injury which, in any event, the consultant physician was adamant to exist in this case. I suspect that the tribunal did not fully appreciate what Dr Weir was seeking to demonstrate in his opinion: in any event, as a matter of law, they were not entitled to take the passage quoted as supportive of their conclusion. The issue before them was about a physical disability and the passage quoted from document 123 seems to have been overlooked and was, in any event, against the tribunal decision. Its rejection, if it was rejected, has not been explained. Either way there is an error of law.’

*Conclusions*

52. The decision in *CSDLA 265/97* is not directly in point. What it tells us is that it is wrong for an adjudicating authority to reject the evidence of a consultant physician who appears to have some particular knowledge and experience of the medical condition under consideration without giving sufficient reasons for doing so. It should be noted that this principle is in stated in general terms, is not novel and is in keeping with previous jurisprudence on that issue. The fact that the consultant physician in that case was Dr Weir, is to that extent, not relevant.

53. The decision in *CDLA 925 2002* is more directly in point. What it tells us is that it was wrong for the appeal tribunal in that case, to ignore evidence which it considers to be non-independent, on the apparent basis that it was lacking in credibility. Where are there factors to suggest that the ignored evidence is from a consultant who specialises in the medical condition under consideration and who is a fully recognised as an expert medical witness then it cannot be dismissed without consideration. Once again, I would observe that this is a non-contentious principle noted in other jurisprudence.

54. It could be argued that the appeal tribunal in the instant case did not ignore the evidence of Dr Weir. There were two reports from Dr Weir before the appeal tribunal. The first was a report dated 17 April 2016. As noted above, the appeal tribunal stated:

‘… was largely relating to the appellant’s own account. It contained no objective assessments or clinical findings. The tribunal specifically disagreed with the account of her mental function as it found her in person to be alert and able to deal with the hearing and process.’

55. There are aspects of this conclusion which are problematic. The first is that I am of the view that there is weight to Mr Reid’s submission that ‘… history taking is a long-established skill, essential in all medical disciplines’ and particularly so in the diagnosis of ME and the assessment of its severity and impact on function. The second is that the appeal tribunal disagreed with the account of the appellant’s mental function given to Dr Weir and the basis for that disagreement was what it had observed and heard during the appeal tribunal hearing. There was no analysis of the clear variability with this condition and how the appellant’s functionality at the hearing compared with her routine daily life.

56. The second report from Dr Weir is dated 15 May 2016. The sole basis for the rejection of this report was the doubt cast on Dr Weir’s self-ascription of expertise in relation to ME. This is, in my view, full square with Commissioner Williams’ conclusions in *CDLA 925 2002*. Mr Reid, in his written submission to the appeal tribunal, had given some background to Dr Weir, his qualifications, standing in the medical community and expertise and had alerted the appeal tribunal to the decision in *CSDLA 265/97*. None of that is explored by the appeal tribunal. The blunt rejection of Dr Weir’s expertise in connection with the report of 15 May 2016 must carry over to the earlier report of 17 April 2016. The appeal tribunal asserts that it gave careful consideration to Dr Weir’s evidence but it’s rejection was not based on a detailed analysis of its weight but, rather, on a conclusion that it is not expert.

57. For these reasons, I have concluded that the decision of the appeal tribunal is in error of law.

**Disposal**

58. I direct that the parties to the proceedings and the newly constituted appeal tribunal take into account the following:

(i) The decision under appeal is a decision of the Department, dated 14 January 2016, which decided that the applicant was not entitled to DLA from and including 27 October 2015;

(ii) The Department is directed to provide details of any subsequent claims to DLA and its replacement benefit Personal Independence Payment (PIP), and the outcome of any such claims to the appeal tribunal to which the appeal is being referred. The appeal tribunal is directed to take any evidence of subsequent claims to DLA/PIP into account in line with the principles set out in *C20/04-05(DLA)*;

(iii) It will be for both parties to the proceedings to make submissions, and adduce evidence in support of those submissions, on all of the issues relevant to the appeal; and

(iv) It will be for the appeal tribunal to consider the submissions made by the parties to the proceedings on these issues, and any evidence adduced in support of them, and then to make its determination, in light of all that is before it.



(Signature): K MULLAN

COMMISSIONER

24 May 2025