

**IN THE UPPER TRIBUNAL
ADMINISTRATIVE APPEALS CHAMBER**

Case No CDLA/1920/2018

Before UPPER TRIBUNAL JUDGE WARD

Attendances:

For the Appellant: Ms Ciara Bartlam, pro bono, instructed by
Merseyside Law Centre

For the Respondent: Ms Alice Richardson, instructed by
Government Legal Service

Decision: The appeal is dismissed.

REASONS FOR DECISION

1. The claimant, born in 1961, has learning disabilities. He has Down's Syndrome. He is also deaf and blind. He also has a number of significant physical disabilities. The appeal is brought on his behalf by his sister, who is his appointee for benefit purposes. She is also his Deputy for welfare purposes, pursuant to an order of the Court of Protection dated 29 March 2010, under which her responsibilities included (subject to the detail within the order) making the following decisions on his behalf that he is unable to make for himself when the decision needs to be made:

- (i) where he should live;
- (ii) with whom he should live;
- (iii) decisions on day-to-day care, including diet and dress;
- (iv) consenting to medical or dental examination and treatment on his behalf;
- (v) making arrangements for the provision of care services;
- (vi) whether he should take part in particular leisure or social activities; and
- (vii) complaints about his care or treatment.

2. The claimant had been in receipt of disability living allowance ("DLA") at the highest rate of each component¹, since 6 December 1993. On 29 June 2016 he was admitted to Walton Hospital, from which he was discharged on 1 July 2016. On 23 July 2016 he was admitted again to Walton Hospital and on 21 September 2016 was transferred to Clatterbridge Hospital, from which he was discharged to a care home or nursing home on 26 August 2017. Both Walton and Clatterbridge are NHS hospitals.

3. The appointee did not report the hospital admissions to the DWP until 28 March 2017. On (or around) 10 April 2017 the DWP took a decision that DLA

¹ The mobility component was transferred to Motability and a vehicle provided by that organisation remained available for the claimant's benefit through to the time when, following his discharge from hospital, DLA once again became payable. This, though, was a matter for the discretion of Motability, rather than a matter of right.

was not payable after the 28th day as an inpatient i.e. from 24 August 2016.² The DWP was relying on regs 8 and 12A of the Social Security (Disability Living Allowance) Regulations 1991/2890 (“the DLA Regulations”) which in the case of adults provided (and still do) that (to summarise) neither component of DLA is payable after a cumulative 28 days have been spent as an in-patient in a publicly-funded hospital.

4. Prior to amendment by SI 2016/556 with effect from 29 June 2016, the DLA Regulations made provision to similar effect where a child under 16 was such an in-patient, albeit the period which triggered non-payability was longer, at 84 days. However, in *Mathieson v SSWP* [2015] UKSC 47, the Supreme Court concluded that that infringed the rights of Cameron, the child concerned, under art.14 and article 1 of Protocol 1 of the European Convention on Human Rights and, applying s.3 of the Human Rights Act 1988, fell to be disapplied. As regards children, the relevant regulation was then repealed in consequence. As regards adults, it was retained. Those who were 16 but under 18 were moved so as to fall within the regime applicable to children. In the present appeal, the appointee submits that, for reasons similar to those in *Mathieson*, the DLA Regulations are similarly an infringement of the claimant’s human rights.

5. Article 14 of the European Convention on Human Rights provides:

“The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.”

It is common ground that Article 1 Protocol 1 is engaged by the provision of DLA and thus that Article 14 is potentially applicable. As regards “status”, the Secretary of State concedes, by analogy with the Supreme Court’s ruling on Cameron’s status in *Mathieson*, that the claimant had the status of a severely disabled adult in need of lengthy inpatient hospital treatment. However, Ms Bartlam submits that there are two other statuses to which the claimant may properly lay claim, namely:

- (a) an incapacitous severely disabled adult in need of lengthy in-patient hospital treatment; and/or
- (b) a severely disabled adult who lacks capacity to make decisions about care and medical treatment in need of lengthy in-patient treatment.

The comparators are said to be a severely disabled child in need of lengthy inpatient treatment or a severely disabled adult with no such requirements. A third alternative is provided by the situation of a severely disabled adult in

² There are suggestions in the papers that decisions were also taken regarding recoverability of the overpayment and the imposition of a civil penalty. However, they are not before me.

need of lengthy inpatient treatment but who does not lack capacity. In this last case, the discrimination is said to consist of a failure to treat differently people whose circumstances are relevantly different i.e. so-called *Thlimmenos* discrimination.

6. Both the above alternative forms of status are resisted by Ms Richardson, essentially on the ground that because issues of capacity are issue-specific and because capacity may come and go, they lack a sufficient quality of durability to constitute a status and that a court should be slow to find a status based on lack of capacity because of the administrative difficulties to which it would give rise.

7. I accept that there is no easy proxy for determining whether or not a person is lacking in capacity, whether for decisions about care and medical treatment or otherwise. In the present case, a Deputy has been appointed, with functions which make the question relatively straightforward to answer. Others may have given a lasting power of attorney in respect of personal welfare decisions, in which case the Office of the Public Guardian should have been informed if it is suspected that a person is losing capacity. In yet further cases, no such formal arrangements will have been put in place and whether a person has capacity for a particular decision or not will have to be assessed on the spot in accordance with the provisions of the Mental Capacity Act. Whilst it may be the case that assessments of the capacity of a person who is in hospital but who does not have a Deputy nor has given a power of attorney for personal welfare may have to be carried out and should be recorded, not only would it be a considerable burden on the DWP to obtain that record and on NHS staff to provide it, but more fundamentally, if lack of capacity is the trigger for finding that there has been a breach of a claimant's human rights, a breach which is not present when the person does have capacity, there is a risk of people moving in and out of being the subject of a breach of the ECHR on a virtually daily basis.

8. In *Mathieson* Lord Wilson, having reviewed the authorities, said:

“22 ... It is clear that, if the alleged discrimination falls within the scope of a Convention right, the ECtHR is reluctant to conclude that nevertheless the applicant has no relevant status, with the result that the inquiry into discrimination cannot proceed.

23. Decisions both in our courts and in the ECtHR therefore combine to lead me to the confident conclusion that, as a severely disabled child in need of lengthy in-patient hospital treatment, Cameron had a status falling within the grounds of discrimination prohibited by article 14. Disability is a prohibited ground (*Burnip v Birmingham City Council* [2012] EWCA Civ 629, [2013] PTSR 117). Why should discrimination (if such it be) between disabled persons with different needs engage article 14 any less than discrimination between a disabled person and an able-bodied person? Whether, as in Cameron's case, the person is born disabled or whether he becomes disabled, his disability is or becomes innate; and insofar as in the *RJM* case Lord Walker seems to

have had three circles in mind, Cameron's case falls either within the narrowest of them or at least within the one in the middle.”

9. Ms Richardson accepts, rightly in my view, that a fair degree of refining down the group considered to have a “status” is permissible, as in the case of, for instance, the single parent of a child under three in the “benefit cap” cases. Those who had received a particular type of sentence were found to have a status in *R(Stott) v Secretary of State for Justice* [2018] UKSC 59; [2018] 3 WLR 1831, reflecting the “generous meaning” and “liberal approach” to the question of “status” encapsulated in the judgment of Lord Hodge at [185].

10. Nonetheless, while mindful of that approach, I prefer Ms Richardson’s submissions on the unsuitability of capacity as a key element in identifying a “status”. I derive no assistance from Ms Bartlam’s reliance on the decision of the European Court of Human Rights in *Siddarbras v Lithuania* (Case 55480/00). While it illustrates that a status may be acquired based on past events (past membership of the KGB), it does not help with whether a status can be defined by reference to anything as potentially evanescent as a loss of capacity (as in some cases it will be, even if in others it is anything but)

11. Also, for reasons to which I return at [32] having examined the evidence, I am unpersuaded as the appropriateness of the comparators put forward by Ms Bartlam. However, mindful of Lord Wilson’s view and lest I be wrong on those matters, and also because the claimant is conceded to have one “status” in any event (one which is not defied by reference to any lack of capacity) I prefer to proceed by considering the question of justification.

12. There is in evidence a witness statement by Ms Louise Phillips, who works for the DWP as the Head of Disability Living Allowance and Personal Independence Payment Policy. Her evidence explains that it is a “fundamental principle of Government” to prevent duplication of funding for the same contingency out of public funds, though it is applied with modifications so as not to withdraw DLA in the first 28 days of hospitalisation for adults and (following *Mathieson*) so as not to withdraw it at all when a child is hospitalised. She relies on the duties of the NHS under section 3 of the National Health Service Act 2006³ to argue that the NHS is responsible for meeting the day-to-day costs of an individual’s accommodation, board, care and treatment free of charge whilst they are in hospital. The amounts involved are significant: when the 28 day limit was imposed on the mobility component

³ (1) A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility –

- (a) hospital accommodation,
- (b) other accommodation for the purpose of any service provided under this Act,
- (c) medical, dental, ophthalmic, nursing and ambulance services,
- (d) ...
- (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness [as the group considers]³ are appropriate as part of the health service,
- (f) such other services or facilities as are required for the diagnosis and treatment of illness.

of DLA (previously it had remained payable no matter how long a person remained in hospital), the saving was estimated as £40 million in 1997/98 (the first full financial year following the change). The change reflected an evolution in the pattern of hospital care, where provision was increasingly being directed towards acute treatment and rehabilitation, where opportunities for independent mobility were limited. The annual cost of removing the rule which restricts payability in the case of those who have their care needs met by the NHS is estimated at £100m.

13. There is also in evidence a witness statement by Dr Clare Leris. Dr Leris is a medical doctor now working for the DWP as a Medical Policy Advisor. Relevant extracts from her evidence as to how the care needs of a person with disabilities are met by the NHS are as follows:

“6. During admission to hospital a care plan (a written record of care needs and how they will be met) is created. This can be done before admission or, at the latest, on the day of admission. The care plan communicates what care is required for a person during their stay and what is required to enable them to safely leave hospital after treatment. The care plan details all needs: physical, psychological, communication, maintaining dignity and spiritual needs as examples. Care plans are normally co-created by individuals and their nurse based on the person’s own perception of their needs. In the case of a severely disabled person their carer may help to co-produce the care plan as well, as they may help the person to communicate their needs or rarely explain on their behalf.

7. Clatterbridge Hospital has a learning disability liaison nurse to help with this process and this claimant may have had a passport detailing his needs which could be incorporated into his acute hospital stay care plan. The role of the learning disability liaison nurse will be to ensure that where people with learning disabilities are admitted for treatment not related to their learning disability that their needs related to learning disability are met, in addition to their needs related to treatment of their particular condition.

8. The care plan should always be sufficiently prescriptive in detailing the specific care to be delivered, it should provide clear outline of the goal, the interventions and the intended outcomes to be achieved. The care plan should include reference to any evidence underpinning the care being prescribed.

9. The care plan should be based on assessment, the aim of any planned intervention, who is responsible for each intervention (where and when) and evaluation of the care.

10. During each admission a patient will have a named nurse and for each nursing shift a patient will have a responsible nurse who will be responsible for that person’s care, even if they aren’t delivering the care themselves. The responsible nurse will review the care plan when

coming on shift and take a handover of issues from the previous shift's nurse. The care plan is updated daily and at each changeover to ensure any issues are recorded and the care plan adapts as needs change. The named nurse has overall responsibility for the care plan and will ensure that care is assessed, planned and delivered from admission to discharge even though he or she is not there all the time.

11. It is not expected that a carer will meet basic needs of adults in hospital. All needs will be detailed in the care plan along with how the needs will be met.

12. The carer's role will generally be to provide support that any friend or relative would supply to an adult in hospital: washing clothes, providing small change for the hospital trolley or TV, keeping the phone topped up, providing entertainment or special dietary items, social contact and solace. If the carer wishes to do more than this, for example washing, dressing wounds or applying cream then they may be able to do so, with the agreement of the nursing staff, but this is their choice rather than an inability of the hospital to provide the care.

13. Where a person is very seriously ill, anxious, or has difficulties communicating a friend or relative may spend time at the hospital helping with communication around care and treatment, comforting them through scary medical procedures and providing emotional support. This support would be detailed in the care plan with the friends and relatives contact details who could provide the support, so the hospital could call on it when it was required. The times it would be required are likely to be predictable in advance. It would not be required 24 hours a day and probably not every day. This is the sort of support this person would be likely to require from his carer.

14. Accommodation for relatives is very limited to non-existent for family of adult patients in hospitals. There will be few bed spaces where a carer can stay with a person (the needs of everyone on the ward have to be considered) and usually there is no room for a bed of any kind. The carer would have to stay in the bedside chair. Some wards have side rooms and may have a fold up bed for a relative to use but this is unusual and would only be provided in the very short term where, for example, the patient was dying.

15.

16. The total lack of facilities or minimal facilities available in UK hospitals for adult carers is in complete contrast to children in hospital where overnight accommodation for parents is integral to the design of wards."

14. Dr Leris goes on to examine what she treated as the appointee's evidence as to the claimant's care needs (see [16] below), concluding that other than washing the claimant's clothing, all the asserted needs are needs which could

and should be met by the NHS in accordance with an agreed care plan, while the washing of clothing she regarded as part and parcel of caring for a loved one in hospital, disabled or not. A need for communication with a patient and how to achieve it are matters one would expect to find in a care plan.

15. The lack of evidence to counter this on behalf of the claimant is striking. Any care plan there might have been is not in evidence, so I am unable to infer that any requirement was placed on the appointee via the care plan process. Nor is it in evidence that the system which, according to Dr Leris's evidence, is intended to be in place was not. There is no evidence that there was no care plan with the consequence that the appointee had to step in. Nor was there any evidence that the role of the Learning Disability Liaison Nurse at Clatterbridge had in some way not functioned as it should. Ms Bartlam says that is not a caregiving role; but it seems to me that that submission overlooks that a nurse performing that role (as to which see para 7 of Dr Leris's evidence, set out at [13] above), by reducing gaps in NHS provision will be reducing the need for the involvement of family members. Ms Bartlam further submits that the creation of the role of Learning Disability Liaison Nurse was but one of a number of recommendations made by the Confidential Inquiry into Premature Deaths of People with Learning Disabilities which Dr Leris had cited, but even if that is so, it does not help her unless the failure to implement the remainder can be shown to demonstrate a need for care by family members, which it has not been.

16. Evidence from the appointee herself was limited. In addition to brief submissions made by the appointee to the FtT and her oral evidence there, the Upper Tribunal had a document of, on its face, uncertain provenance but referred to as a "factsheet", which was said to set out how the tasks carried out and the expenditure incurred by the appointee could be equated to those carried out by Cameron's parents in *Mathieson*. I was told at the hearing that it was compiled by an unnamed law student, based on consultation with the appointee.

17. Also in evidence was a letter written by Sophie Snow, a social worker, which, though addressed to the DWP, appears to have been written in support of the appointee's application to be permitted to continue to use the claimant's Motability vehicle while he was in hospital. It repeats information obtained from the appointee and her husband and does not add any view from Ms Snow herself about the necessity for the various actions reported – in particular for the visits "more than once a day" that were said to occur - and, as regards the matters listed, is unspecific and lacking in any indication of frequency.

18. There is also in evidence a letter from Professor Barrett, a consultant in the Department of Stroke and Older People's Medicine, but it relates to the subsequent periods, when the claimant was in the nursing home, and I derive little assistance from it. So far as it goes, it is consistent with the appointee's role being one of oversight, rather than of active delivery of care.

19. There was also evidence of a more general character. An article from the Journal of Clinical Nursing⁴ conducted a review of existing literature published between 2006 and 2015 and identified a number of respects in which there was scope for improvement in nursing care for people with learning disabilities. The paper's authors were based in an Australian institution and the paper was based on experiences in a range of countries, so it could not necessarily all be applied to the UK; moreover, it was based substantially on material of a few years previously. In any event, the focus of the paper was on how to equip nurses to be more confident and competent in their dealings with people with learning disabilities, not on getting family or other carers to supplement NHS care. The same is true of other material which was in evidence. A practice note published by the Royal College of Nursing and various training materials for nursing students were all targeted at training of nurses to provide better care, not at getting others to supplement that care. The papers do refer to the desirability of nurses approaching carers to provide information about the patient and in facilitating communication and the vital role of families and carers for people who have both a severe learning disability and multiple physical difficulties.

20. By contrast with the position in *Mathieson* by the time it reached the Supreme Court, there is (a) evidence from the DWP about how the system is intended to operate where adults with learning disabilities are in hospital and (b) a lack of evidence on the claimant's side to cast doubt on it. The evidential basis for the claimant in *Mathieson* was further strengthened by the evidence from Citizens Advice at Great Ormond Street Hospital (see *Mathieson* at [35]) and the evidence of the campaigning charities.⁵

21. I am therefore, not satisfied that, in general, family members are required to assist in providing care to a person with learning disabilities who is in hospital. Their experience of the person may well be a valuable resource for medical and nursing staff to draw upon, but would not necessitate the very high degree of attendance claimed in this case. Family members may wish to attend to support the patient, as they might for anybody who was in hospital, but that does not make out an equivalent situation to that which prevailed in *Mathieson*.

22. Nor do I consider that it makes a material difference that a person is acting as Deputy. Whilst anyone acting as Deputy, or indeed under a welfare lasting power of attorney, would need to have an understanding of the patient's needs and wishes, I agree with Ms Richardson it does not follow that it has to be acquired from a hands-on caring role. The reports submitted to the Court

⁴ *A narrative review of acute nurses' experiences nursing patients with intellectual disability: underprepared, communication barriers and ambiguity about the role of caregivers* Lewis, Gafney and Wilson (2016)

⁵ I record here that Ms Bartlam asked me at the hearing to permit the subsequent filing of further evidence. I indicated I was not minded to; *Mathieson* (with its emphasis on the evidential basis) had been in the public domain for some years and in the present case the essence of the Secretary of State's case had been apparent from November 2019, (including as to Dr Leris's evidence, which although a formal witness statement had only been prepared recently, had been reflected in Ms Phillips's witness statement at the earlier date).

of Protection by the appointee are not in evidence and there is no evidence permitting me to conclude that acting as Deputy carried with it responsibilities to provide care to the extent claimed. The responsibilities of the Deputy are cast in terms of taking decisions, rather than the direct provision of care.

23. There is some limited evidence suggesting that in this particular case, the appointee was required to become involved in certain respects. In a statement appended to her appeal form to the FtT the appointee explains that:

“Deputy/ carers required all times of day/night to be included with Multi Disciplinary Team in all decisions affecting [the claimant]. Medical staff require attendance of Deputy/carers to advise/allow them to carry out all procedures. To attend NUMEROUS meetings to discuss treatment, sign official forms and Medical/Social Services re care or treatment or transfer of [the claimant].” (emphasis in original).

It is clear that those requirements were principally those which flowed from the function of the Deputy to take decisions on the claimant’s behalf, which would be far more limited than a requirement to assist in the actual provision of care. Her oral evidence to the FtT as recorded in the FtT’s Record of Proceedings in my judgment showed her involvement in consenting to procedures which the claimant had to undergo, plus the sort of involvement based on personal knowledge of the patient which up to a point the relatives of any person in hospital would have, but which will be particularly important in the case of a patient with learning disabilities.

24. When one turns to the “factsheet”, the format and content of this make it difficult to place heavy reliance upon it. In broad terms, it explains that the appointee and family had a role in interpreting communication. It provides a lengthy list of items under the ambiguous and unclear heading “Things NHS did or could do where [the appointee] and family facilitated or took over”. As it is followed by a further list under the heading “Things that [the appointee] and family did that NHS could not do”, I interpret the former list as comprising things which the NHS did do, albeit the appointee may have provided input at the outset. The second list is relatively small – cutting the claimant’s nails, monitoring possible ear infection, bringing in Coke to drink, checking for tooth loss, washing clothing, monitoring and alerting staff to sores. If anything, this tends to confirm that such gaps as there may have been in NHS provision were relatively small ones in the overall scheme of things.

25. There is no doubt that the appointee’s sense of responsibility and love and concern for her brother led her to perform her duties as Deputy assiduously and to provide a very considerable level of support, in person and/or by other family members, but the lawfulness of the hospitalisation rule cannot be determined by what may come to be done in an individual case, irrespective of what is objectively required.

26. Ms Richardson further submits that, in contrast with *Mathieson*, in the present case it is relevant that other benefits continue in payment:

- (a) in the case of ESA, flat rate element - £73.10pw – throughout a period of hospitalisation;
- (b) in the case of severe disability premium (£61.85 per week), for the first 28 days of hospitalisation; and
- (c) in the case of enhanced disability premium (£15.75 per week) and support group component (£36.20 per week) – for the first 52 weeks in hospital

(all are shown at 2016 rates).

27. She submits that unlike in *Mathieson*, where there was evidence that the ceasing of payability of DLA caused Cameron’s parents to sustain a loss of some £7,000, in the present case there is no indication that expenditure rose by an amount which could not be contained within the means-tested benefits remaining available to the appellant. Ms Bartlam contests this on the basis of the financial information in the “factsheet”. As to that, certain items are disputed anyway in the evidence of Dr Leris: the cost of syrup of figs for instance, on the basis that there would be an equivalent suitable mild laxative available in an NHS hospital. The greater part of the expenditure is caused by the meals taken by the appointee at the hospital and by petrol, parking and other costs associated with hospital visits, but this does not assist the claimant greatly, as the evidence does not show that such frequent visits were required. Clothes may also have been a significant item, but that item is unquantified. I agree with Ms Richardson that the appointee has not succeeded via this material in demonstrating expenditure that could not be contained within the means-tested benefits remaining available, even allowing for the fact that they diminish over time as set out above.

28. In applying art 14, Ms Bartlam invites me to have regard to the UN Convention on the Rights of Persons with Disabilities. It is common ground that it is appropriate to do so for such a purpose. However, I do not consider that it materially assists Ms Bartlam. Her complaint in essence is that, contrary to articles 1,4 and 25 of the Convention, consideration has not been given to the specific needs of incapacitous severely disabled people. Ms Richardson counters Ms Bartlam’s submission by referring to paras 29.2.2 to 29.2.4 of the Department’s Equality Impact Assessment on retention of the hospitalisation rule. This document is undated beyond referring to the year 2019 but as it includes a pie chart using data as at 31 July 2019 must have been prepared after that date. So far as its content goes, I agree that (in particular by para 29.2.3) it rebuts the criticism made by Ms Bartlam. Using the inexact – and inappropriate in its application to people with learning disabilities - terminology of the Department’s very broad classification systems, it noted the high prevalence of “mental health conditions” and “psychiatric disorders” among those claiming PIP and DLA before continuing:

“29.2.2 Broadly, it is considered that the more severe the health condition/disability is, then it is more likely the disabled person might be to stay in hospital for prolonged periods of time. Therefore, we could expect that claimants with the most severe disabilities and/or health conditions are more likely to be affected by the policy.

29.2.3 We have considered whether severely mentally impaired claimants who are unable to act for themselves and need help from support workers should be exempt from the policy. However, in addition to the double funding issue, this would be extremely difficult to administer and would introduce different treatment by disability type.

29.2.4 More broadly it is arguably unfair to discriminate on specific mental health grounds and the ability to effectively identify and award such cases would be complex. In conclusion, we have no evidence to suggest that the NHS is not able to provide the right types of services for patients and no grounds therefore to continue to award care and mobility components.”

This is not a judicial review challenging the vires of the Regulations so I am not concerned with process, but with evaluating the human rights arguments taking into account any consideration the Government has given to the matter. Ms Bartlam, correctly in my view, takes no point that it was prepared only in 2019. I was not told how that came about but do not overlook the possibility that it might have been prepared in response to litigation. Nonetheless, the Government’s consideration of the issue, even if belated, is entitled to carry some weight.

29. It is not in dispute that “bright lines” are not impermissible as such: see *R(Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37; [2006] 1 AC 173. Per Lord Hoffman at [41]:

”All that is necessary is that it should reflect a difference between the substantial majority of people on either side of the line.”

30. Ms Richardson submits that the appointee simply has not made out a requirement for carer input when the appellant was in hospital of anything like the extent claimed or that the personal and financial demands on the appointee or any carer are, to put it at its lowest, no less than when they care for the person concerned at home and that the art.14 exercise should be approached on that basis and *Mathieson* distinguished. In *Mathieson*, what the evidence showed was required of the parents meant there was not double provision by the State; in the present case, the position is different and there would be double provision but for the hospitalisation rule. If that position is not accepted and the amount of care was required in this particular case, then there is no evidence to support a generalised requirement for care at such a level in respect of a patient with severe learning disabilities and on that basis the present case should be seen as a “hard case”, falling the wrong side of the “bright line” but providing no stronger grounds for a successful art. 14 challenge.

31. It is common ground that the test is whether the Secretary of State’s approach in maintaining the hospitalisation rule in respect of DLA for adults can be said to be manifestly without reasonable foundation: *Humphreys v HMRC* [2012] UKSC 18; [2012] 1 WLR 1545. I accept that, as per Baroness Hale in that case, the question still needs to be looked at carefully. However,

in the present case, I conclude that there is no evidence that the NHS would require carer input to the care of a patient with severe learning disabilities of the extent claimed, or anything like it, and even where the person has a Deputy appointed. The basic rationale for the rule is the avoidance of double provision from public funds for the same contingency. On the evidence in this case the needs of the patient are being met by the NHS and the Secretary of State is entitled to have drawn the line where she did. I also accept Ms Richardson's fall-back position that if, contrary to the view I have reached, the appointee and others were required to provide care to the extent claimed, there is no indication that that is a frequent situation and that the case should be seen as a hard case, falling the wrong side of the bright line.

32. Returning to the question of a comparator, the position is different from that of a severely disabled child in need of lengthy inpatient hospital treatment, because of what is shown by the evidence about differing patterns of care for adults and children. That is unaffected by Ms Bartlam's efforts to persuade me, by considering the respective legal frameworks applicable to children and vulnerable adults, that they are in a similar position, which I do not find of assistance in the present context. Nor am I persuaded by her argument based on the particular position of 16 and 17 year olds with regard to the giving of consent. The position is different from a severely disabled person who is not in receipt of lengthy hospital inpatient treatment because the person who is not in hospital is not receiving publicly funded care via the NHS, while the person in hospital is. As regards the complaint of *Thlimmenos* discrimination by failing to treat the claimant differently from a capacitous severely disabled adult in need of lengthy in-patient treatment, this would depend on showing that the consequences of the claimant's lack of capacity were such that their situations were relevantly different. However, that has failed on the evidence.

33. In the present case, the Secretary of State is therefore entitled to rely on regs 8 and 12A of the DLA Regulations as they stand.

34. Ms Bartlam further submits that the FtT was in error of law for not engaging more fully than it (very briefly) did with the human rights argument put forward to it by the appointee (who was then acting in person). I can see that, given the duty under s.6 of the Human Rights Act and the inquisitorial nature of the FtT, especially when faced with a litigant who was not professionally represented. However, the matter has now been fully aired before me with submissions from Ms Richardson and Ms Bartlam, to both of whom I am grateful, from which it is apparent that though an error, it was not a material one. Whilst I could set the FtT's decision aside and remake it to like effect, that is a complication for which I see no need in the circumstances of this case.

**CG Ward
Judge of the Upper Tribunal
21 April 2020
Corrected under rule 42 23 July 2020**