

## Written evidence from Mr Philip Prydderch HAB0134

This document combines copies for my letter requesting a PIP Mandatory Reconsideration, and the subsequent letter requesting a referral to a Tribunal.

As both letters show, I had major concerns with the health professional report, and the decisions based on that by DWP assessors. There were contradictions by the health professional, lack of use/reading of the evidence I provided in my application, and failure to take note of what was said in the evidence and during my telephone interview itself.

(Letter to Tribunal follows on Page 16)

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### **Request for PIP Mandatory Reconsideration**

13<sup>th</sup> June 2020

Dear Sir/Madam,

I would like to request a Mandatory Reconsideration of my recent award for Personal Independent Payment.

As explained to the assessor, I would like it to be noted that my Father sadly passed away on 28<sup>th</sup> May 2020, just before the assessment took place.

I was recently awarded Standard Daily Living, and Standard Mobility in the award letter dated 4<sup>th</sup> June 2020.

I have now read the Atos Healthcare Consultation Report Form PA4, and consider that in making their recommendation, a number of important factors and evidence have not been taken properly into consideration, which I believe could affect the accuracy of the outcome.

Additionally there are a number of contradictions and inaccuracies in the report, which draw into question its credibility, and is of concern.

Furthermore it concerns me that a large amount of evidence submitted has not been considered. On page 1 of the PA4 form, only two items are listed – the PIP Questionnaire (with an incorrect date), and a consultant letter with a date given which also seems incorrect (and therefore unclear which consultant letter it refers to, and whether this is even relevant).

I therefore have very grave concerns about the credibility and reliability of the PA4 form and its recommendations.

I would also contest the length of the award, which has been set with a review/renewal at a date of 30<sup>th</sup> November 2022. As my PIP questionnaire shows, I have had these symptoms since early 2018, and they have got progressively worse, with no improvement. The evidence also shows reports from the Occupational Health GP which state:

15<sup>th</sup> January 2020:

*Fibromyalgia is a poorly understood condition. There are no definitive and curative treatments for it. Instead treatment approaches are in the main aim at helping the affected patient manage the impact of their symptoms.*

17<sup>th</sup> October 2020:

*The problem is that there is considerable unpredictability still with Phil's symptoms. By this I mean that, without any obvious warning, he may find it very difficult to undertake the activities outlined in the previous paragraph on a particular day.*

I would therefore suggest that as my condition has been worsening, and is widely considered to be a long-term, or even life-long, condition, that a longer award would be more suitable.

I would also like to take this opportunity to note that since my PIP telephone assessment, I am now being investigated for further health issues regarding my abdomen (possible bowel conditions, such as IBS or IBD – yet to be determined). I am seeing a GP (Dr Rebecca Hollington, Ship Street Surgery, East Grinstead), and am due to have an abdominal ultrasound at my local hospital on Tuesday 16<sup>th</sup> June 2020. The symptoms related to this cause severe pain, bloating, and worsen some of the other pre-existing symptoms.

I outline my disputes, reasons, and reference to evidence on the following pages, please also review this alongside the original letter and evidence pack.

I would be grateful if these could be considered in a Mandatory Reconsideration.

### List of evidence considered

On the PA4 form page 1, the section "*List of all evidence considered alongside the consultation findings*" only lists two items (of 24+ items of evidence over 100+ pages):

- PIP Questionnaire 20/02/2019
- Consultant Letter 23/10/2019

There are errors with the only two items noted:

- PIP Questionnaire 20/02/**2020** (year is incorrect on PA4)
- Consultant Letter: **23**/10/2019

I have provided no evidence from a consultant which is dated 23/10/2019, and am unclear as to which consultant report has been considered in making recommendations in the PA4 form.

Some possibilities are:

- Occupational Health Report from Dr Fox 17/10/2019
- Fit Note from GP for Phased Return 29/10/2019

- (not really a 'report')
- |                                     |  |
|-------------------------------------|--|
| - Cardiology Letter                 | 24/10/2019<br>(but with clinic date of 23/10/2019) |
| - ENT Letter                        | 15/10/2019   |
| - Sussex MSK Report & Diagnosis     | 18/11/2019   |
| - NHS Time to Talk Discharge Letter | 17/12/2019   |

The most likely possibility, would be the cardiologist letter of 24/10/2019. However, this is only a minor piece of background evidence showing investigations which have taken place. It is a less important item of evidence, and I have not referenced it in my PIP submissions and written answers.

I would therefore suggest that a large amount of evidence submitted (100+ pages), has not been properly considered, making the PA4 report unreliable, inaccurate and not credible in its recommendations.

### History

#### Page 2

- ***“Seen MSK Physiotherapist and had multiple sessions in the past which did not help”***

Whilst I have seen multiple MSK Rheumatologists and Physiotherapists for face-to-face discussions/consultations, I have not had physiotherapy provided by Sussex MSK. I would suggest that the comment that I have seen multiple *“MSK Physiotherapists which did not help”* is made due to the 9 MSK Reports provided in evidence - and that these have not actually been read, as it would have been clear that these were consultations and not physiotherapy sessions.

I have had a number of physiotherapy sessions which have not fixed/“cured” my condition, but as my PIP questionnaire and evidence makes clear, these were by NHS Physiotherapists, Private Physiotherapists, and Occupational Health Physiotherapists. This last one is acknowledged in the PA4.

- ***“No thoughts of self/suicide”***

Worryingly given the nature of this statement, this is entirely untrue, which is a major concern from a Health Professional.

I made clear reference in the interview to a period of suicidal thoughts, and went into detail regarding a particular episode where I drove away from home towards the coast, noting I was unsure what I would do. I also noted that this episode spurred me to speak to my GP who referred me to NHS Time to Talk to discuss my mental health and thoughts, which is a key set of evidence provided.

This is also mentioned in my detailed answers on my PIP Questionnaire (pages 3 & 13).

Stating “*No thoughts of self/suicide*”, suggests that the questionnaire answers were not fully read and considered. It also suggests that the answers I was providing during the telephone interview were not being fully taken on board.

This is particularly upsetting as my wife was audibly upset when discussing this period. Preparing for and undertaking the assessment, even over the telephone, required a lot of preparation (mentally as well as practically), and to have such a serious point as this glossed over or not noted is galling.

This again draws into question the reliability of the telephone interview and the PA4.

## Page 6

- Managing therapy or monitoring a health condition

No mention of CBT, which was outlined during the call (as well as at length in the questionnaire and evidence). CBT, as taught and advised by an NHS Therapist, is an important method used in managing my condition.

No mention of physio stretches.

No mention on meditation/mindfulness.

Both of which were also advised by medical professionals.

Again, draws into question how much of the PIP questionnaire and evidence provided has been considered.

## Page 7

- Reading and understanding signs, symbols and words

Notes “*uses reading glasses*”.

I do not use glasses.

Again, draws into question how much of my answers during the telephone interview were being listened to – and how much of the PIP questionnaire and evidence provided has been considered.

## Page 8

- Planning and following journeys

***“now only gets anxious when children makes a lot of noise....”***

This is not true and gives a false impression. I did state that I get anxious and my symptoms can be triggered badly at times, when there is a lot of noise and stimulation, such as, for example, when the children make a lot of noise. However, I did not state that this is the only time I get anxious. There are many other triggers. This is a misrepresentation of what was said.

### General appearance and informal Observations

*“Able to recall medication names, the dose and reason for taking them, he was able to speak and hear in the telephone assessment without difficulty, unaided, not breathless”*

We had a list of the medication printed out and in front of us, so recalling the medication was not difficult. When discussing the medication, I asked my wife to take over and she provided the majority of the medication detail, as I was getting breathless. This can be heard on the call.

### Mental State

*“MSE in telephone assessment showed he answered all questions, not anxious, did not sound low”*

This is in contradiction to the note made in the previous question (general appearance and informal observations), where it is stated that I was feeling low due to the recent passing away of my Father (which was days prior to the interview), as well as the fact that this condition has been life-changing for me and my family.

As a professional in my career, I pride myself on properly preparing for meetings and interviews, and I made sure that I was suitably prepared to answer any questions clearly and concisely.

Again, I do understand these are only personal observations and views, but the contradiction suggests facts and information is not being fully considered in coming to recommendations and considering circumstances, and that the interview and PA4 are unreliable.

### Health Professionals Opinion – Daily Living Activities

#### 1 – Preparing Food

b) Needs to use an appliance to be able to either prepare or cook a simple meal.

**I believe, that given I am unable to cook more than half of the days each week, and that even on the occasions where I can, I am unable to do so without pain and fatigue, that the descriptors of (e) or (f) are more appropriate.**

In the answer provided in my PIP Questionnaire I noted that 3-4 days a week I am unable to cook at all as my symptoms are so severe, I am in bed all day, only getting up to go to the toilet. Therefore, for over half the week, I am unable to cook at all.

On page 5 of the PA4, the Health Professionals (HP) notes:

*“been months since he last cooked”*

and that even on the occasions I have been able to cook, that

*“might try to push himself but states he has fatigue”* and

*“ sometimes when his wife is not back from work he will try to cook for his sons – but he cannot stand for long due to pain and breathlessness”*. and

*“states is shaky in hands when feels fatigue”*.

These comments made by the HP all show an inability to cook without suffering symptoms, and therefore should point more to descriptors (e) or (f).

Some of the other comments made to justify the recommendation also do not seem reasonable conclusions to draw:

- Much is made of my mental health and cognitive abilities in the HPs notes. However:
  - Elsewhere in the report it references my foggy cognition and mental health anxiety
  - The main difficulties I have with preparing food are physical, not mental or motivational
- Reference is made to my ability to speak
  - I am unsure how this is evidence of being able to prepare food

My ability to cook is very unreliable – some days I can attempt to cook a meal but I will need to take breaks in the middle of cooking due to pain and fatigue, and also rest for a long period (1 hour, or sometimes many hours) immediately afterwards.

Most days I cannot cook at all due to the pain, fatigue, shortness of breath, and am in bed all day.

Sometimes I have tremmors, can mean that I sometimes struggle to cook within a reasonable time period, and also safely.

I cannot cook repeatedly (i.e. cook at lunchtime and then also at dinner time), as the fatigue and pain will wear me out.

There are **no** days where I cook the meal and feel ok and normal afterwards or during cooking. I always need rest immediately after or during cooking (or cannot cook at all and need my wife to do it, which is most of the time).

See diary excerpts in evidence for examples.

In the Occupational Health report of October 2019, provided in the evidence, Dr Fox notes the unpredictability and variability of my symptoms and that I may be able to carry out activities on one day, and then suddenly not be able to carry them out at all.

The Sussex MSK Report by the Rheumatologist who diagnosed me, provided in evidence (November 2019), also notes all the symptoms I have and the effect and impact they have on my life and activities I am able to carry out.

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2 – Taking Nutrition

- a) Can take nutrition unaided

I do not dispute the recommendation.

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3 – Managing a therapy or monitoring a health condition

- a) Either (i) Does not receive medication or therapy or need to monitor a health condition, or, (ii) can manage medication or therapy or monitor a health condition unaided.

**I suggest that in managing my condition using four different therapies (medication, CBT, Physiotherapy, Meditation), requiring several hours per week to do so, the descriptor (d), or possibly (e) would be more accurate.**

Although mentioned in History section, no mention is made of CBT, Physiotherapy, or meditation in justification here. Three of the four therapies I use to help manage my condition have therefore not been considered.

I believe I have provided detailed information in my submission to show that I spend several hours per week managing my condition, and at times need prompting to do so.

1) Medication

This is the only therapy taken into account in justifying the recommendation of the (a) descriptor.

The justification notes that:

***“Although reports requires reminders. FH shows this is only twice a week”***

This sentence alone would suggest that descriptor (b) would be more appropriate as it states:

*(b) Needs any one or more of the following: (i) to use an aid or appliance to be able to manage medication. (ii) supervision, prompting, or assistance to be able to manage medication. (iii) supervision, prompting or assistance to be able to monitor a health condition.*

As noted in my submission, I take a variety of medication, both prescription and supplements recommended by the diagnosing Rheumatologist. In order to manage these I require a crib sheet/notes, which details which medication to take at which time of day. My wife also has to prompt me to take these (as acknowledged by the

HP), and my wife also sometimes has to manage the medication for me – which was mentioned during the phone call, but has not been noted in the justification.

2) CBT

Although mentioned earlier in the PA4 form, this has not been taken into account in the justification for the descriptor here.

I undertook a course of telephone therapy with NHS Time to Talk and was given training/advice/therapy in using pacing techniques as part of my Cognitive Behavioural Therapy.

This is an ongoing process and I spend 1-2 hours a week in planning my activities and rest periods as part of the pacing behavioural therapy I was given. I would suggest that the weekly planner I complete is an aid used to manage my condition.

Whilst I do not need prompting on every occasion to fill in my CBT weekly planner/spreadsheet, my wife does on a daily basis check that I am doing it to ensure I am planning in rest time each day and each week and not overdoing it.

3) Physiotherapy

I have seen several physiotherapists in order to help manage my symptoms (NHS, Private and Occupational Health). All have provided similar stretching and physiotherapy techniques to help manage my condition, with advice and guidance sheets showing the stretches to use at home. I was also advised to purchase a foam roller to aid with these stretches – which is an aid to manage my condition.

I was advised to carry out these stretches 3-4 times daily, at 15mins a time (up to 1 hour a day, or 7 hours a week).

I frequently forget or am unable to carry these out. On the days I am well enough my wife reminds me to try and do them.

4) Meditation

I have been advised by several medical professionals (GPs, MSK Rheumatologist) to practice mindfulness and meditation.

I have purchased an annual subscription for the “Calm” app (approx £35pa) to help me do this – I would suggest that this is an aid in helping me manage my condition.

I spend 1-2 hours a day (7-14 hours a week) doing this, and use it every night to get to sleep.

**Taking all four therapies into account I spend up to 14 hours a week, likely more, managing my condition. Whilst I do not need prompting for all of these, all the time, I do for many of them, as detailed above. I would suggest therefore that descriptors (d) or (e) are more appropriate.**

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4 – Washing and bathing

- b) Needs to use an aid or appliance to be able to wash or bathe.

**I would suggest that descriptor (c) is more appropriate, as I have needed prompting by my wife to shower.**

I noted on the phone call that I have recently (since completing the original submission), started to shower less. This is due to my symptoms being so severe that I am in bed all day for 3-4 days a week, on which days I do not shower due to fatigue and pain. Whilst I do not need assistance to actually wash and shower, my wife has begun prompting me to do so.

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5 – Managing toilet or incontinence needs

- b) Needs to use an aid or appliance to be able to manage toilet needs or incontinence  
I do not dispute the recommendation.
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6 – Dressing and undressing

- c) Needs to use an aid or appliance to be able to dress or undress.

**I would suggest that descriptor (c) is more appropriate, as I have needed prompting by my wife to dress.**

I noted on the phone call that I have recently (since completing the original submission), been staying in my pyjamas more frequently. This is due to my symptoms being so severe that I am in bed all day for 3-4 days a week, on which days I do not get dressed (or shower) due to fatigue and pain. Whilst I do not need assistance to actually dress myself, my wife has begun prompting me to do so.

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7 – Communicating Verbally

- a) Can express and understand verbal information unaided.

**I would suggest that descriptor (c) is more appropriate, as I can need support to be able to express or understand complex verbal information.**

As written in the justification box on the PA4 form - the justification given is purely an ***“informal observation”***, with no further information or evidence referenced to justify descriptor (a).

My original submission, with reference to medical reports, shows that I find communicating verbally difficult at times.

In my submission I note that I have cognitive issues with “foggy” thoughts (i.e. fibro-fog, a known symptom of Fibromyalgia) – indeed this is noted as a symptom in the “History” section by the HP. These cognitive issues make it very hard to concentrate in longer complex (or sometimes even simple) conversations.

I also noted that my manager has commented that on every occasion he has spoken to me since the onset of this condition, I have sounded breathless (this is in person when he has visited my house, or on the phone).

In the evidence provided - my Occupational Health GP noted in the most recent report (see evidence and OH Report 15/01/2020), that if I do manage to have a trial visit to the office, I should be allocated a quieter desk as I have difficulty with too much noise, stimulus, concentrating – and long complex conversations - and need to be able to sit quietly.

I found the assessment to be very draining and had to spend the rest of the day in bed.

**Therefore due to the foggy and cognitive issues, difficulty with long complex conversations, and need for quiet space along, I would suggest that descriptor (c) is more appropriate.**

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8 – Reading and understanding signs, symbols and words

a) Can read and understand basic and complex written information either unaided or using spectacles or contact lenses.

**I believe the descriptor (b) is more appropriate.**

The written justification has contradictions and inaccuracies, and does not reference any evidence or information provided, using purely informal observation:

- *“Shows no diagnosed cognitive/learning difficulties”*

This is incorrect, and even contradicts HPs own notes earlier in the PA4 form, as I do have diagnosed anxiety (i.e. cognitive) issues – hence the medication and referral by my GP to NHS Time to Talk to undertake “Cognitive Behavioural Therapy”

- *“Therefore he can complete the task with spectacles”*

I do not wear spectacles, I am unsure where this reference has come from. It was not mentioned on the phone call, and is not mentioned in my submission.

My condition causes “foggy” cognitive issues which can cause me difficulties. This can make it difficult to read and concentrate on documents and information for long periods. I begin to have difficulties concentrating, remembering what I’ve read, or even remembering what it is I am attempting to do and what actions to take. My thoughts become foggy.

When completing this MR request, I have had to do this over several days, and with my wifes support, due to these symptoms, as I struggle to concentrate, and have found reading, referencing, and writing this document very challenging.

On severe occasions, I need to lie down in a dark room, and remove all stimulus. Whilst working I often have to stop early, as I cannot concentrate on the documents/emails/work any longer (see diary excerpts).

My Occupational Health GP has noted in his reports (in evidence provided), to my employer that my symptoms and condition is so variable and unpredictable, that there will be times

where I cannot work (and the effect of my symptoms on my ability to read, as part of my cognitive issues, is a factor in this).

**I believe the descriptor (b) is more appropriate. I believe the use of CBT to pace my activities (working periods) appropriately to manage my condition and cognitive issues, could be considered an aid.**

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- 9 – Engaging with people face to face  
a) Can engage with other people unaided

**I suggest the descriptor (c) is more appropriate. I believe my submission and evidence show that I have a cognitive issue, with anxiety and brain fog, and that I have difficulty in engaging socially without support (from my wife).**

The written justification has contradictions and inaccuracies, and does not reference any evidence or information provided, using purely informal observation:

- *“Shows no cognitive condition”*

This is incorrect, and even contradicts HPs’ own notes earlier in the PA4 form, as I do have diagnosed anxiety (i.e. cognitive) issues – hence the medication and referral by my GP to NHS Time to Talk to undertake “**Cognitive** Behavioural Therapy”

- *“In the telephone assessment showed he answered all questions, not anxious, did not sound low”*

On the PA4 form the HP noted that I had an anxiety issues, hence being on medication for it, and therapy. I am not sure how the HP could determine as a fact that I was “**not anxious**”, without seeing me, as I was highly anxious in the build up to the telephone interview, and had just lost my Father and was (and am) very low.

As noted in my submission, my manager has commented that I sound breathless on every occasion I speak to him – which causes problems engaging with people, as it is a regular occurrence (both face to face or on the phone).

I get very anxious and need the support of my wife in many social or face to face engagements, and my wife needs to act as a social support and encouragement.

My Occupational Health GP advised (see reports in evidence) that should I attempt to visit an office I should be allocated a quiet desk away from noise and other stimulus, as engaging regularly and continuously with other people (colleagues) can cause symptoms to flare up. During the single office visit I have made since June 2019, I felt some anxiety whilst meeting colleagues, and as noted earlier, was breathless in my conversations with my manager (which he commented on), and the meeting was mentally draining, resulting in worse fatigue, and cognitive “foggy” thinking and concentration issues.

I would therefore say that I cannot repeatedly, and reliably engage with people face to face, in a timely manner. I need to use CBT, meditation, and medication to manage my condition and cognitive issues, and my Occupational Health GP has advised my employer on these issues.

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10 – Making budgeting decisions

- a) Can make complex budgeting decisions unaided

I do not dispute this recommendation.

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11 Planning and following journeys

- a) Can plan and follow the route of a journey unaided

**I would suggest that descriptor (b) is more appropriate, or potentially (d) or (e).**

**As noted in the information I have provided in my submission, and references to evidence – my anxiety and cognitive issues, cause me to have difficulties and anxieties in undertaking journeys when the symptoms are severe. I either need reassurance and prompting to undertake journeys, or ideally, support of my wife in accompanying and driving me on journeys.**

The most recent, and highly distressing, example of this is during recent weeks with the passing of my Father. My Dad was suddenly rushed into hospital, and was discovered to have late stage 4 cancer (which until that point was undiagnosed). It was clear his condition was deteriorating, and I attempted to make plans to visit him (I live in Sussex, he in North Wales – 220 miles and 4 hours away). I knew I was unable to drive myself to see him due to my condition, and my wife helped me in trying to put in place childcare and plans so that she could drive me. However – unfortunately my symptoms became so severe that I was unable to even make the journey as a passenger, and was in bed for 2-3 days. My wife believes I had a panic attack, which flared up all my symptoms. I was therefore, sadly, unable to travel on a journey to see my Dad before he passed away.

I believe this particular incident fits with (e) – *Cannot undertake any journey because it would cause overwhelming psychological distress to the claimant*. It wasn't only my Father's situation that was causing me distress (though it was of course), but the thought of even getting into the car and undertaking the journey itself, was causing me severe anxiety.

In other examples and evidence previously submitted:

- See comments in evidence, in Occupational Health report 17/10/19, where Dr Fox notes that without obvious warning, I may not be able to carry out a range of described day-to-day activities (i.e school runs, manage my children, walk the dog, basic chores), due to the unpredictability and severity of my symptoms.
- I am often in bed 3-4 days a week and unable to move any further than going to the bathroom – therefore I am unable to undertake any journey because it would cause me physical problems, but also due to cognitive issues with my anxiety and brain fog. I have missed out on many family trips and activities (see dairy excerpts in evidence provided).
- I am not able to go out reliably and repeatedly, and often have to change plans at short notice if not well enough to go out. I am not able to go out in a timely

manner, as my variable fatigue, pain, shortness of breath, can mean that I cannot go out when needed.

- On days when I have severe symptoms of fatigue and pain, it can affect me cognitively, and affect my concentration and causes me increased anxiety. This can cause me difficulties with going out, navigating, and driving. My wife accompanies me on medical appointments in order to drive me there and provide support.

## 12 Moving around

C – Can stand and then move unaided more than 20 meters but no more than 50 meters.

**I would suggest that a more appropriate descriptor for this would be (e), due to the large variability in my condition, with majority bad days where I am restricted to being in bed all day, and walking no more than 5 meters or so to the bathroom to use the toilet, and am in bed all day. Occupational health report provided also gives guidance on this.**

The HP's own justifications contradict each other and themselves point to descriptor (e) being more appropriate:

***“FH shows he can walk indoors on bad days, and up to 50m outdoors on good days. Variability shows he has majority of bad days”***

Therefore, the majority of the time I am restricted to being indoors and unable to walk 20-50 meters due to severe symptoms. As the HP notes earlier in the PA4 form on page 9:

***“on bad day he can walk to toilet 5mts, or walks 1 min indoors, walks unaided, walks in slow pace, on bad days he can only walk indoors from room to toilet.....”***

This again, from the HPs own notes, points to descriptor (e).

As noted in my submission, for 3-4 days each week I do not leave the house, and for most of those days I am in bed due to severe symptoms, only walking to the toilet.

In Occupational Health report 17/10/19, Dr Fox notes that without obvious warning, I may not be able to carry out a range of described day-to-day activities (i.e manage my children, walk the dog, basic chores), due to the unpredictability and severity of my symptoms.

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## In Summary

I would suggest that a number of descriptors were recommended based on informal observations only (with the HP even stating that was the case in the justification box itself), and that not all the evidence was considered or even read before making a justification - indeed, the front of the PA4 form states that only the PIP questionnaire and a report on a date which doesn't tally with the evidence provided, was used.

The health professional seemed in a rush and interrupted me on a number of occasions, which meant that when answering a number of the questions I was cut off and did not get

time to fully explain and provide my answer and evidence. The HP was also distracted towards the start of the call, presumably by her children who could be heard in the background. Furthermore I struggled a few times to understand some of the questions being asked due to the quality of the call and HPs accent.

This may explain why there are factual inaccuracies in the report (i.e. the wearing of spectacles, and reference to a report on a date which does not seem correct or properly referenced). As above, it also seems that some answers I did provide during the interview were not correctly recorded and considered in the justification.

I believe I have provided detailed and referenced evidence in the MR that supports a review of the descriptors awarded which could justifiably result in a total of 12+ points in both Daily Living and Mobility.

Also, as noted in the covering letter, I believe the length of the award is also unsuitable.

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**9<sup>th</sup> August 2020**  
**Social Security and Child Support Tribunal**  
**Personal Independent Payments**

### **Reasons for dispute/disagreement**

#### **1) Preparing a meal**

In the Mandatory Reconsideration reply from the DWP, where I was awarded 2 points, the letter notes that as I have good memory and concentration, am able to drive a car (therefore have good range of movement), can use a chair as an "aid" to sit down whilst preparing food (when the fatigue and pain cause me problems), and that I can make cups of tea, sandwiches and fried eggs, it shows I am able to prepare food without assistance and by using an aid.

However I would dispute this decision and suggest that descriptors E or F are more appropriate.

In my letter requesting an MR I note that for the majority of the week (more than half) I am spending all day in bed due to my symptoms, and am only able to get up to go to the toilet. The Health Professional noted this in their report in the notes for the "moving around" section where they state "on bad days he can walk 5mts to the toilet 5mts, or walks 1min indoors.....on bad days he can only walk indoors from room to toilet...." And also "Variability shows he has majority bad days".

Therefore for more than half the week I am unable to cook as I am in bed, only getting up to go to the toilet – and therefore for more than half the week descriptor F would apply.

The HP report on the Preparing Food section notes "been months since he last cooked", again showing that for the last few months descriptor F has been the case.

The DWP guidance advises that a person should be able to carry out an activity reliably to be considered able to do that activity – explaining that “reliably” should mean being able to do it safely, to an acceptable standard, repeatedly and in a reasonable time period. As I explain in my original application and again in my MR request, on the few days I am able to cook, it causes me so much pain and fatigue that I need to rest for many hours afterwards – sometimes it can cause me to be in bed for the rest of the day. This means that I cannot carry out the activity repeatedly, as if I were to make a sandwich for lunch, for example, I would likely not be able to cook dinner as I would need to be resting.

Where the DWP MR decision letter states that I displayed adequate concentration at the assessment – leading to a decision that I have no cognitive restriction which stops me from cooking, I would dispute this as I have explained in my submissions that I often have “fibro-fog” which causes me difficulty in thinking and concentrating, and remembering what I need to be doing. On some of the few occasions where I have attempted cooking, when I have had “foggy” memory/thoughts, I have found myself standing in the kitchen trying to remember what it is I am trying to do.

The Occupational Health GP advice letter to my employer of October 2019 (provided in evidence) notes the variability in my symptoms and condition:

“Phil advised that on most days he will be able to do the school run and sort out his children. He will also normally be able to do some household chores and can walk the dog for a few miles. Any more excessive physical activity is beyond him. He is usually able also to manage some basic admin tasks on the computer, for example emails.

The problem is that there is considerable unpredictability still with Phil symptoms. By this I mean that, without any obvious warning, he may find it very difficult to undertake the activities outlined in the previous paragraph on a particular day. “

I would note that since the October 2019 advice letter (which was prior to my PIP application in February 2020), my condition and ability to carry out such activities has progressively reduced. By the time of my application in February 2020, “most days” being able to carry out these activities had become most days being unable to carry them out. The Sussex MSK Rheumatologist report written following my diagnosis consultation in November 2019 (also provided in evidence) already notes that my wife was now carrying out all the dog walking, as my activities had reduced further.

The diary excerpts and the copies of my Cognitive Behavioural Therapy diary (completed as part of my NHS Time to Talk therapy), which were submitted as evidence, show examples of how often I have been in bed most of the day, how I have been unable to carry out activities, and how my symptoms have affected me.

On a minor note, the paragraph on page 3 in the DWP MR letter related to preparing food seems to mix up this activity with another, where towards the bottom of the page it says “You are prescribed a moderate dose of pain medication which you

report is helpful. As a result, I have decided that you can go out without needing prompting or assistance....”.

I believe the examples I provided both from my own evidence (CBT diary and diary excerpts) and the notes from the OH GP and Sussex MSK, show how limited my activities are and the variability in my condition, and show that for more than half the time I am unable to cook at all.

## 2) Therapy & Medication

In the DWP MR decision letter it notes that there is no evidence that the activities I am carrying out at home are prescribed by a registered healthcare professional and that they are something I am only carrying out myself – and that this is the basis for the award of 0 points.

On this point, as explained in my original application, and repeated in my MR request letter, the stretches and exercises were advised by 2 different physiotherapists – a private physio (Portland Physiotherapy, East Grinstead), and an NHS Physiotherapist (Queen Victoria Hospital, East Grinstead). Whilst I did not include it in my original evidence, I have attached a photo of the leaflet provided to me by Portland Physiotherapy showing the advised exercises and the recommended times to carry them out daily. These are the same exercises advised by the NHS physio – whom I saw at a later date, and showed the leaflet from Portland Physio to. I was also asked by Portland Physiotherapy to buy a foam roller (an aid) to use alongside the exercises. I therefore believe this shows that these exercises and stretches were prescribed by 2 separate qualified healthcare professionals. The advice was to carry these out 3-4 times daily, at approx. 15mins a time (7 hours per week). As noted in my application and MR request, I often forget to carry these out, and am often in need of prompting and guiding by my wife to do so.

Also, although it does not specify stretches, the MSK diagnosis report of November 2019 (provided in evidence), does state that “...regular activity is key in managing symptoms of Fibromyalgia...”. Therefore this is also advice from a healthcare professional on use of activity/exercises.

The letter from the DWP does not mention any of the other three therapies and medications which I use and which were advised by healthcare professionals.

As explained in my MR request letter, the HP report also does not mention CBT, Physiotherapy or Meditation in its justification for suggesting 0 points.

My application in February, and my MR request letter, both explain the importance of the 4 different therapies I have been using to help manage my symptoms.

The CBT – as guided by NHS Time to Talk (healthcare professional) – is important in helping me pace my activities to try and avoid causing a flare of symptoms. This is also mentioned in the MSK report of November 2019. This takes around 1-2 hours per week.

I take a number of medications each day – prescribed by my GP, and also supplements advised by the MSK Rheumatologist (a healthcare professional), as noted in the MSK Report of November 2019. As explained in my application and again in my MR request letter, I use a crib sheet/notes to help me manage my medication – to remind me which ones to take at which time of day – as on bad days, when I have Fibro-Fog for example, it can be hard to remember. This crib sheet is also important for my wife to use, as on some occasions she needs to prepare the medication for me.

I also use meditation techniques to help with some of my symptoms, such as anxiety, managing stimulus (when noise and light can be overwhelming), and to help me sleep (which is important in Fibromyalgia management, as too little sleep can cause the symptoms to be worse – some of my medication also helps with sleep). Use of meditation was again advised by a healthcare professional (see MSK Report November 2019), and was also advised by my GP, and Private GP (Spire). I have purchased a subscription to the Calm app (£35pa) to help me with my meditation – which I would describe as an “aid”. I carry out 1-2 hours a day using this meditation app (7-14 hours a week) – not counting the time used during the night to help me sleep.

I believe the use of all four of these therapies, all advised and guided by healthcare professionals (with evidence showing this), means that descriptors d or e are more appropriate.

### 3) Communication

The DWP MR letter notes that I was able to speak and hear unaided with no one to support me. Also that I use a mobile phone unaided. For the reasons I was awarded 0 points.

This is incorrect however, as I had my wife with me for support throughout the assessment, and she introduced herself at the start, added to some of the answers, and answered 1-2 questions for me when I became breathless due to anxiety.

I would also suggest that being able to use a mobile phone does not definitively show that I have no issues with communicating. It does not show the effect that holding lengthy or complex conversations can have on my condition and the difficulties I experience.

As explained in my application and in my MR request, I experience Fibro-Fog – cognitive difficulties, which can cause me difficulties in concentration, thinking and communicating. I can often find long and/or complex conversations difficult.

I also experience breathlessness – as noted in my submissions, this is something commented on by my manager during phone conversations, and face-to-face when he visited me at my house whilst I was on sickness absence. The MSK report of November 2019 also notes the breathlessness. This is now being investigated further, and my GP has referred me to a respiratory clinic (appointment 19<sup>th</sup> October at Queen Victoria Hospital), due to low blood oximeter readings (90-95%).

I also have very loud tinnitus, which is also being investigated, and I recently had an open MRI of my head and ears at Croydon University Hospital. I am now awaiting a follow up with the ENT doctor at East Surrey Hospital. The tinnitus is worse when my other symptoms are bad, and can affect me during conversations at times.

The HP report that the justification for awarding 0 points was purely an “informal observation”, which does not seem a sound basis considering all the reports and other evidence provided with my application.

The Occupational Health report of January 2020 notes that if I did manage to have a trial visit to an office that I would need to be provided with a quieter desk as I have difficulty with too much noise, stimulus and in concentrating – long and complex conversations would be stimulus. I would note that I only managed one single office visit since October 2019 when I began my attempt to phase back to work, and have been unable to visit since.

On some occasions even more simple or less complex communications and engagement with others can cause me difficulties. During a recent meal out with my family and parents-in-law, I had to leave the meal early and go home, as sitting at the table and engaging in conversation for a long period began to cause me fatigue and pain and fogginess, and I needed to lie down.

#### 4) Reading

The DWP MR letter notes that I have reported no cognitive learning impairments and am able to read and understand appointment letters and work documents, and was able to complete DWP questionnaires and respond to letters – and therefore can read unaided.

As noted earlier, and in my application and MR request letter, I experience Fibro-Fog – which is a cognitive impairment. When I experience this I have difficulty in concentrating, thinking and also reading. Whilst I have been attempting a phased return to work, I have been unable to progress beyond 2 days a week since October 2019. This is because concentrating on work for long periods (which includes reading documents, emails etc), causes me difficulties as I begin to lose concentration and the ability to take in what I am reading, and end up having to re-read documents over and over as I forget what I have read. I have to spread the 2 days of work over the whole week as I cannot work and concentrate (including reading) for long periods.

In completing the PIP application and responding to letters, I have to carry this out over several sessions as I cannot carry it out in one go – again due to fogginess and not being able to read and concentrate over long periods. I also have help from my wife.

In the Occupational Health report of October 2019, the GP notes that due to the variability in my condition there are days when I will not be able to carry out certain activities (which in the previous paragraph included admin tasks of reading and responding to emails on a laptop).

In the diary excerpts provided in evidence, there are examples shown of when I have had to lie down in a dark room, using the meditation app, as I needed to remove all stimulus. At times like this I cannot even read basic/simple information or even watch tv. I simply need to listen to calming meditation music/noise in a dark room.

#### 5) Engaging with People

The DWP MR letter noted that there was no evidence of prompting required through the assessment and that I could manage without support, and therefore awarded 0 points.

This is incorrect however, as I had my wife with me for support. My wife added to some of the questions as I was answering, and also answered 1-2 of them for me when I became breathless with anxiety. Given that it was a telephone assessment, it would not have been visible that my wife was offering me support throughout. Support can be a presence and visible emotional support, not only answering questions or speaking for me. Without my wife present I would have found the assessment far more difficult and produced far more anxiety and strong symptoms in me.

The HP report noted "shows no cognitive condition". As noted earlier, I do have a cognitive impairment with the Fibro-Fog, which can cause concentration issues, and issues with thinking and holding conversations.

The report also noted "In the telephone assessment showed he answered all questions, not anxious, did not sound low". As I explained in my MR request letter, I am not sure how the HP could definitively determine I was not anxious without seeing me, as I was very anxious and needed my wife there for support – and also as I had sadly lost my Father only days before the assessment, and was very low and anxious, and had been suffering panic attacks.

As I explain in my application in February, I routinely need the support of my wife when out, and she accompanies me to all my medical appointments – both to drive me there, but also as support during consultations.

As explained earlier, on some occasions even more simple or less complex communications and engagement with others can cause me difficulties. During a recent meal out with my family and parents-in-law, I had to leave the meal early and go home, as sitting at the table and engaging in conversation for a long period began to cause me fatigue and pain and fogginess, and I needed to lie down.

#### 6) Following Journeys

The DWP MR letter notes that my functional history shows I can drive, and therefore have good levels of concentration, thinking and processing ability. Also that I have recently returned to work and drive myself to work without restriction. Therefore I can start and finish a journey by myself, and can plan and follow a journey unaided.

As explained earlier, although I started a phased return to work in October 2019, I work exclusively from home, with only one trial visit to the office since October 2019. I therefore do not drive myself to work, as I would find it very difficult to do this reliably and repeatedly and safely, due to the impact it would have on my symptoms.

My wife drives me places whenever I need to drive any distance, both as the physical aspect of driving would likely be difficult over a long distance, and also due to the concentration difficulties over a long distance. As I noted in my MR Request, when my Father was in hospital in the week prior to passing away in May, I was too distressed to make a journey either driving myself or as a passenger, and had panic attacks.

As explained earlier, my wife drives me to all my medical appointments as I would find it difficult to drive myself (and also as support for me during the consultations).

In the Occupational Health report of October 2019 it notes that due to the unpredictability of my symptoms I can be unable to carry out a range of activities with no obvious warning – one of these activities being driving my children on the school run (where we often have to rely on my parents in law if my wife cannot take them).

Also as noted earlier, I am often in bed more than half the week due to symptoms – some of which are fatigue and cognitive issues – which would cause me difficulty in planning and following a journey.

## 7) Moving around

The DWP MR letter references my ability to drive to work, as evidence of having good level of power and movement in my legs. This is something I would dispute as a good indicator of being able to move around in any case, as it is clearly not a good comparator to being able to walk long distances. Regardless, as noted earlier, I do not drive myself to work as I now have to work from home, being unable to drive a long distance (my office is 36 miles, 1 hour away by car).

The DWP letter also does note itself that “on a bad day you can walk 5 meters unaided”, which is an example of descriptor e. The HP report also stated “on a bad day he can walk 5mts, or walks 1 min indoors, unaided....indoors to the toilet” and also “...Variability shows he has majority bad days”.

Therefore based on the notes in the DWP letter and in the HP report, I have a majority of bad days, more than half the time, where I can only walk 5 meters to the bathroom as I am in bed all day – descriptor e.

As the Occupational Health reports and the MSK report state, my condition is very variable, and some days I might be able to walk to the nearby shop, but on others – and the majority of the time – I cannot, and am often resting in bed and only walking indoors, to the toilet. Whilst I had in the past attempted to walk the dog (as noted in the OH report from October 2019), my condition has progressively worsened, and my wife does this now as I cannot (as noted in the MSK report of November 2019).

## Other

There are some further errors and concerns I have which I would like to use this opportunity to highlight.

I would suggest that the length of the award (to November 2022) is also short, and that it should be a longer award. Since I began having the symptoms of this condition in 2018 (leading to 6 months off work prior to my attempted phased return to work, which is still ongoing), they have progressively worsened rather than improved. The fact that I have been unable in the 10 months since I began my phased return, to return to full time working, shows that the condition is not improving. The two Occupational Health GP reports from October 2019 and January 2020 also note that it is a poorly understood condition with no curative treatments, and that it is highly variable, show that it is a condition that is not likely to improve, and can only be managed, not “cured”.

I would also like to note my concern that the HP only considered a single letter (alongside the application form), in evidence when writing the report. The front page of the PA4 form has a section instructing “List of all evidence considered alongside the consultation findings” – where the HP has listed one consultant letter. As my MR Request letter notes, this consultant letter is likely to be a cardiologist letter, which is a minor piece of evidence. It therefore seems to be the case that the more important Occupational Health reports and MSK reports, along with 24+ items (100+ pages) have not been reviewed and considered. I feel that when carrying out the MR review, the DWP have also not viewed this evidence when reviewing the decision, despite my detailed letter drawing attention to certain reports, as they are not mentioned anywhere in the decision letter.

There are further causes for concern with the report used to award points. It is stated “No thoughts of self/suicide”. I find this upsetting as I spent some time during the assessment describing a period of suicidal thoughts, and in particular one specific episode. My application went into detail in this area, explaining how it led to the prescription of anti-depressants and a referral to NHS Time to Talk for therapy. This again seems to show that all the evidence was not fully read, and also that some of what I said during the assessment was not taken on board.

It is also said that I “uses reading glasses”, which I do not (and did not mention).

There are further errors which I note in my MR Request letter, which I have attached to the appeal.

***May 2022***