# Charlotte Written Reflection and Interview Transcript

*This document contains the transcript of a semi-structured interview conducted online on 9 July 2020. Charlotte was a Welfare Benefits Adviser at a UK-wide sensory loss Charity in Scotland. The transcript and written reflection have been anonymised, with identifying names and places removed, or replaced with pseudonyms.*

## Interview Transcript

I = Interviewer P = Participant

I Hello, I can’t hear you? You can’t hear me either [laughs]. Ok let me just…

P Ok I can hear you now… I put 11 till 1 in my diary, is that right?

I It’s been a real range so it’s really up to you, how much you want to talk, how long you can sit for. If it finishes early or goes on a bit, it’s completely fine.

P Ok.

I As well, if you need to get up, go to the loo or take a phone call or anything that is totally fine as well, we can always pause it if you need anything.

P Ok.

I And let me just check so I'll just give you a bit more information before we get going. So, I know you'd said you, you work with people with sight loss and mental health, sort of issues and other things?

P Yeah, primarily it’s sight loss because I work for [a sensory loss charity], but then of course if the sight loss can be as a result of an eye condition or they may have had a stroke or traumatic head injury. And then can have other health complications as well, as people… it’s from babies to right through to any age. So, learning disability, global developmental delay. And with that, what I often find with adults, often there may be anxiety and depression as a result of their eye condition.

I There's quite a, quite a wide range that you get.

P Primarily, they have to have sight loss, a degree of sight loss to use our service but clients can have a lot of other issues, health issues.

I And so what I'm looking at is, basically when I first started looking at invisible disabilities, the more and more I looked at the statistics, the more it seems that it's, it's huge. The variety of what people have that could be classed as hidden or invisible, and even fluctuating conditions. And this doesn't really fit in with what our, probably general, understanding of what disability is, we think of it as being very stable, very physical and very visible. And what I'm looking at is how this impacted on people's access to our welfare state. And in particular, sort of the PIP process in the hearings and how maybe you… if you've not got an invisible disability, you maybe have to present yourself in a certain way or you have to really make what is invisible visible. And I think that probably covers quite a lot of your, do you call them clients or services users?

P Well I think we are supposed to call them customers, but I call them clients. They are customers of [the sensory loss charity] but they are clients for our service.

I Yeah, okay, well, so that's sort of what I'm focusing on and it's just gonna be a very sort of light touch semi-structured conversation really, so I've got… I always show people my pad, if I'm looking down, it’s because I'm taking notes. Okay. And just to quickly…if you could confirm for me, you've had the information sheet and the consent form?

P Yes

I And you're voluntarily participating in this?

P That's right.

I Thank you. And so, how long have you been at the [sensory loss charity]?

P It will be 15 years this September.

I Wow, that's a long time.

P [Laughs] Yeah, I know, I’m a bit shocked. It’s the longest I’ve ever had a job. It’s not been… the job’s changed over time. Um… Initially, I was just funded to work with older people with sight loss, funded through the pension service. And that was very much a home-based… um benefits, Welfare Rights service. Used to get referrals from social workers, rehab team, and from the Eye Hospital, but I only covered a small geographical area. But it was quite a big area actually, but it was quite specific areas that I covered in, in, in [Scotland], and the surrounding [local area]. So, I did that job for quite a number of years, and then in 2017, the organisation restructured. So when I did that job, I wouldn't just do appeals, I would do claims, benefit checks, tribunal work, and everything else, and referrals in and out services and then in 2017 the service was restructured and I was made redundant, and [the charity] have moved to a more, um… a more… they didn't want people to have the kind of postcode lottery of services so if at the time if you lived in the areas that I covered you could get everything, but if you lived in another area of Scotland, maybe 10 miles outside of the postcodes I covered, it was limited what you could get. So, in they launched a new sight loss advice line, and within that, that took in the legal rights team, and then they created a sort of specific team that just deals with appeals and mandatory reconsideration so it's a telephone based service, and it's UK wide, so I cover all of the UK now. But we just do it by phone.

I How has that change been?

P Um, it's been alright actually, I think that's one of the things… I mean, I do miss a face-to-face service, but I was chatting about it with my husband, and I was saying, the thought of actually going into somebody's house now, just with their name and address, just to do everything that I used to do… I would be… I don't know if I could do it. I mean, I'm sure I could do it, but the thought of doing it makes me nervous, I haven't done it for such a long time. And literally just you turn up at the person's house, they've lost their sight. They’ve… or they're in the process of having lots of treatment, they've got other illnesses. You don't know who's gonna be there, you don't… you really didn't know very much. I mean you'd have a risk assessment and then you would be doing the claim, all of the benefit checks. I don't do that now, we just really pick it up when things have gone, gone wrong. So, I miss that, but I realised that actually for this particular piece of work that we do with people, um, it doesn't need to be face-to-face at all. Once it's got to MR and tribunal, it's, it's about written responses to the DWP um…

For clients, we can respond really quickly, within five days of their referral. And I think that they don't have to wait for an appointment, they don't have to go out, which has been great, particularly now. Or, I mean it's not that they don't want to go out, but it means you’re not having to go out for something like this and not having to wait a long time and in a waiting room obviously. And I think it works well. I mean it's not a new model because the legal rights team used to deliver it UK wide, so it was… it was already a model that worked. Um, you know, and I work with clients just all over the UK and we get the outcomes. And so, um… there's parts of the other jobs that I miss but I think this service works well. It's good. It works well for clients; the model works well for them.

I mean, previously we could attend a tribunal face-to-face, in person. When I was in, in my other job, any hearing was always heard in [city], I went to every tribunal. And we always encourage clients to attend in person, not to have a paper hearing, they got a higher chance of success. Um, but obviously during the COVID-19 crisis and we were still doing that, up until the COVID-19 crisis, but we weren't always able, because of our services, UK wide we couldn't go to every tribunal. So, we only went to cases that… where we identified that the person didn’t have anybody to go with. They were vulnerable and to the point where they… we thought they would not give a good account of themselves. And if it was a complex case, or we were looking to make some case law from the case. So, quite often clients would just, we would do all the written submission, prepare the client, but then they would go into the tribunal themselves, or taking somebody with them. Um, but now because they, actually First tier tribunals have moved to telephone hearings. So, we're now dialled into every telephone hearing, so we're actually taking part in the hearing again now through conference calls. So, we were talking about that yesterday… and because we've got capacity to do that now. You know, I couldn't, I had been…. I was always doing maybe four or five actual face-to-face hearings a year. The complex cases, for children's cases, for whether it's a lot of mental health issues. But obviously for the telephone hearings I can diary in to take part in every telephone hearing. And I think we've done about nine… done about nine since April.

I Wow, that's quite a lot isn't it since, just a couple of months.

P Yeah. Yeah, probably do about 50…. Last year I think, it was for 52 I think, and the year before it was 65 appeals… that… cases that ended up at tribunal that were not revised at the mandatory reconsideration stage.

I How are they going, with the telephone ones?

P We were talking about that yesterday, I think overall, um, it seems to be going quite well. We're getting the outcomes that we want, um, there are some issues with one of the regional centres in that they won't give people an allocated time for their hearing. So, they'll say your hearing is going to be heard between 10 and 1, or it’s going to be heard between 2 or 4. And we've kind of put in a complaint about that and just said that we don't think that's acceptable for the client, or for our service, and you know, other areas of the UK aren't doing that so why, why is the [regional] office basically. Because then your clients in a state of high anxiety just waiting for the phone to ring. Overall, so far, um the telephone hearing seems to be going quite well. I think… my view is that, because it's a conference call and we’re all dialling in, the whole issue of the hierarchy of the tribunal, the intimidation of the physical setting, because quite often if they're in England, they’re in a magistrate’s court, which just makes people feel criminalised. In Scotland they’re not, but in, in England, they are, and clients are always like ‘oh I've never been to court’ and it’s not a court of law, it’s just a tribunal hearing and they’re a part of HMCTS so they use the venues. But it's really off putting, you know, when you say your appeal will be heard at [a] magistrate’s court… client’s just freak out, I would. So that’s gone and that whole conversation about having to say to people, it's not criminal court…

So it seems, it seems that some of that pressure has been taken away and it feels more equitable, we're all in the conference call, you know, um, and people can't be put off by the atmosphere in the room or the body language or sitting around while other people are waiting for their appeals to be heard, seeing people come out who are upset as a result their hearing, seeing someone come out and be told that they haven’t got it. You know, that they haven't because you see the reps talking. So that's gone and the client can be in the, sort of, security of their own home. The downside is… some sometimes tribunals, well tribunals are observing people from the onset. So, you know, perhaps that they're missing, they're missing that element of how somebody who even though has disabilities and invisible it, it can present physically for our clients, you know. They have a cane with them, or they have dark glasses on, or the guide dog, or they quite clearly can't see the people in the room. They have to, we have to have the light, the blinds closed, that kind of thing that has been… that's been taken out. How much the tribunal took that in, we’ll never know but… now they can't do that at all.

I Is that something that your customers or clients are aware of, that being observed when they're there?

P Um… yeah, because we try to tell them that. You know, if you were attending an appeal, even when we’re not attending, we try to prepare a client as much as possible to say… well really to let them know that they've got, they have… it's important that they feel that they've got the right to, um, sort of be treated properly, and their disability acknowledged within the tribunal setting. So, you know, if they need to be guided in, they can be guided, and they should be guided in. But they'll need to take the middle seat but if somebody needs to help them to find that seat, it's alright for their friend, partner or whatever to do that. That it’s important that they say to the clerk that the lighting needs to be right, you know, because if somebody has got an eye condition that's sensitive to glare and they're sitting in a room with a street… Um so, they were aware, and I think like feedback from… I’ve had my clients as well as, they pick up very quickly on how they think the person is perceiving them. You know there's a real, there's a very clear hierarchy in a tribunal. Um…

I Could you just, maybe go into a bit more detail of times when you've sort of picked up on that hierarchy.

P Ah…. Well, every time really, I mean for, for us. You know, the tribunal chair is called a judge, they're a qualified lawyer with like 15 years standing, they just used to be called the tribunal chair, now they're called the judge. You have to say to people, well they’re not a judge with a wig on, but they are a judge. You know, anybody who thinks they're sitting in front of a judge that's, that's… intimidating. So, they say ‘I'm judge so and so’, they're very well spoken, very confident, they’re very upper middle class, you've got a doctor, you've got a disability member. You have good judges… you have good panels, and you have bad panels. You have panels where you feel the client um… and you as the rep are um… I wouldn’t say you… well I mean they are; their role is inquisitorial and we always say that, you know, they’ll ask lots of questions and say that they're not responsible for making the decision and the only way that they can make a new decision, which has to be justified and evidenced to the department, is by asking a lot of questions. But it's how the questions are put and some, some judges have a fantastic manner, and can really sort of bring the, the atmosphere, down in a tribunal. To, to put a client at ease, and other tribunal judges and panel members they don't have that skill, or they're not interested in using those skills. And it's very intimidating…

I What is it that they do that would put people at ease, or not, in some cases?

P I think it’s their tone of voice, it's just their manner, it’s just how they kind of introduce the whole proceedings. So they can either put that… they've all got to get the same information across, that they're independent of the DWP, that they’re there to look at the person's case again, you have to confirm your name because the proceedings are being recorded, so all tribunals have to say the same things, but it's how it's put across to that tribunal, to the appellant, and the rep makes all the difference. So that's, you know, all reps know who the good judges are or the judges that you want to sit in front of, and the ones that you don't. You know, the ones that are maybe more officious, um… um I mean, obviously tribunals, and I say this to clients, they have to be quite poker-faced, they're not there to be friendly and if they… because if they were like that, they're going to give a false presentation, they’re going to raise people's expectations. That's not what they're there to do, they're there to find out the facts, but some tribunal members are skilled at doing that and others aren’t. And you know when tribunals are very, um… you get a sense, um, because they're looking for consistency and credibility, you know, you will get tribunal decisions where they'll say, ‘the witness wasn’t credible’. It's not credible what they're saying and they're very… um… They don't believe that the client has the difficulties that they say they have. So, it isn't just simply that they think, well you don't meet the criteria for the benefit, they think that the person’s exaggerated. What's wrong with them? And that's difficult for somebody to [inaudible]… and clients pick up on that. It's subtle but you know, you know it, they can't say that they can say that they think you… that the evidence wasn’t credible in the statement. They can't say to the client when the hearing’s going on, what you're saying isn’t credible, you know, does that make sense? But they do that, and you know that that's how it's going. Um, and you know when clients are so nervous that they just cannot um… give a good account of themselves, um, or they're just repeating back, they’re so nervous they think they’ve got to tell the tribunal what the tribunal wants to hear, so they just start to repeat back what the tribunal has said to them. And, you know, you can't coach your client, but you can tell them what you, we know what the arguments are going to be or what is most likely to come up, but sometimes, nerves just get the better of the person and…

I Can you think of any sort of particular times where you've had someone that you're with that’s been found to not be credible?

P Oh yeah. [laughs] Yeah, I mean, as you, as you know, you lose appeals, or you've had, or you've had clients where the… perhaps the panel member has said, ‘Well, why can't you see them?’, ‘Why can't you… Why can't your wife just do X, Y and Z for you?’, ‘Why, um… why don't you use an electric razor if you can't shave your face?’. But you know, you just think well that's not the issue, they kind of challenge, how that person handles, their, their disability or, um you know, ‘but your certificate of visual impairment didn't say that you… that, you know, needed help with mobility’ and then you maybe say well, the person was registered 10 years ago, they didn't need it then but they need it now.

So, you definitely, I think, when those kinds of issues come up, they come up from the medical members. They start to question the person's… um, eye condition, because they're not eye specialists, you know, they're not a specialist in any one particular field. Although they'll look at the drugs that the person takes, um and then kind of get, sort of, they'll go down that rabbit hole, if you like, of medical... I mean, it's a holistic panel so they’re having to look at the medical condition but then they start to look, they don't look at the social model of disability at all, if that makes sense, if you get panel members that are like that. And they um… yeah, they… they sort of… appear to relish a little bit of cross examination, you know, they, it doesn't feel… you… I have been in appeals when you feel that it hasn’t, the medical member hasn't been appropriate. We've complained about it, or they've made suggestions about, um, the treatment that the person has or hasn't had, um… yeah.

I How do you manage that situation?

P It’s difficult in a hearing because um… the rep can't talk to the client, you can't break out and start talking to your client, you have to let the panel, do their…. their job. If you feel it's going badly, you've got to try and pull it back for your client but you can't, you know, if your client begins to sort of dry up or, um panic, you know, I have had clients that just start to panic, they just start to repeat back what they think the tribunal want to say, or they go off on a completely different tangent and they're not asking the question. You really just have to wait your, your turn, until the panel have asked all of their questions, and then begin to… address it at the end, and not in a way that's, well for me, not in a way that is… you have to be respectful, you can't openly criticise the panel member. So, you will probably just try to draw it back to the particular point that you've made in your submission. And then if you feel that the person has been treated particularly badly, if you feel it the panel members… um hasn't treated the client with respect or has raised an issue that's not really a kind of legal issue about what's in the submission, about the matter then, you know, you can complain.

I Have you complained?

P Yeah. Yeah. Not for a long, long time but we did complain about two, um, on two occasions where a panel member, a medical member was inappropriate and was challenging the diagnosis and the diagnosis was in the papers. I mean, those kinds of issues, they’re really for the tribunal judge to have control of, he's chairing the meeting, you know, he's chairing the tribunal. But there certainly have been cases where you feel that, um, we were saying to the client, the tribunal are non-judgmental but, you know, that they've, they're making a judgement. If a person works, for example, because you know, you're allowed to work and have PIP. Um, if they've talked about mobility and then they’ll ask which area of the town that they live in, and they'll start to kind of quiz them a little bit about the distance from that shop and yeah. I mean I've never had a complaint upheld. The view is always if you have a bad panel member, if enough people complain, then it will be looked at…. internally, and there are tribunal user groups as well, so don't… there are other avenues for things and...

I So, before, were you sort of more involved in the whole process, so say some form filling to apply, right up to the end?

P Yeah.

I How's that different, sort of, coming in it now maybe at the later stages of MR and appeal?

P Um… well you don't know the client, so you have to learn about the client really quickly. Um, and you're coming in when everything has gone, gone wrong. So, probably, um… yeah, you’ve got to kind of like start from that point and getting the clients trust straightaway which, if you've done the claim, you've probably had a chance to prepare them, and you've got an idea of where it's going to go. Um, but other than that, generally speaking, I don't think it's that different. Um, I think clients are used to just meeting an advisor at the time when things have, you know, have gone wrong, and they're just looking for appeal help, rather than, you know, help with the whole thing.

I How do you help prepare people for the appeal, I know you'd mentioned a little bit earlier about having to sort of talk them through what it means?

P Well, from the… from the beginning from the MR stage, we always let the client know that this is just one stage in the appeal process, so it might be successful, it might not. So, they know that they've got a right of appeal. Um, some clients have been to tribunal before, they know… they've been for another benefit, you know, they’ve been stuck in the system a few times. Other clients, you may be trying to encourage them to challenge the decision and letting them know how the panel’s constituted, what it involves, that they're going to have to be asked a lot of questions, that… I always say to clients, you know, they're the expert in the room, nobody knows better than they do, but that they need to be prepared to talk about their disability and… and be open about it and say things as they really are not, not how they'd like them to be. Particularly for PIP, because clients have already been assessed, they know, they’ve had that kind of experience. It's kind of saying to people, it's not like the assessment, because they think, ‘oh, what am I gonna have to go back to the assessment room?’ So, it's making that clear division between, it's not the assessment and it's not the assessor, and it isn't the people on the panel… the tribunal panel haven't been involved in any of the decision making up till now.

So, you’re trying to sort of explain it's a second opportunity, it's a second chance for somebody new to look at all the evidence again. And obviously we've assessed the merits of their case and we think it's got a high chance of success, otherwise we wouldn't take it on, but we have to say, it isn’t guaranteed, you know, we're not going… we're not going to make the decision. So, sometimes, you know, if you, if you haven't done a mandatory reconsideration even and you're just taking it at appeal stage, we would lodge the appeal and then I would say to clients well, when we get the bundle, I will look through it, and if it looks as if… um, based on the bundle we think it's not likely to succeed, or we're not going to, or we're going to have to change what we're arguing for. I always explain to the client that the bundle is going to be big, don't be intimidated by it, a lot of it is information you've already sent to the DWP. You don't have to read it all, we can read it with you, we can read it to you. So quite a lot of conversations around, what's going to happen.

And then, um, when we've written the submission, we ring the client and read it through, see if they're happy with it, um, let them know that we're sending it off and that we're going to send a copy to them, talk about gathering evidence, see why we think there's gaps. You know, sometimes the claim comes back, and you know exactly why the person hasn't got it because the form was really badly filled in. They didn't have the information that they needed, and we sort of say now, at appeal, now's our chance to find all of that, you know. Why was it, why did you tick ‘no’ when really the answer's ‘yes’? And, you know, sometimes, no one helped me, DWP filled it in, they weren't listening. We look at the medical report, and sometimes we see, look the person has got your eye condition wrong, they've got the readings wrong, we can get all of that. So, it's a lot of… a lot of conversations. But really, the actual tribunal, um…, I mean different advisors do it different ways probably and we, we have to call the client before the hearing, and have quite a chat with them before we send it, but I suppose what we'll say is, we've got a clear idea of the arguments we want to make.

And this is how the tribunal normally work, but it's up to the tribunal judge, you know, normally it goes tribunal judge introduces a panel, the medical member then disability member, but they could mix it up. And even though a client may have already scored points for that particular activity, nothing’s safe at tribunal. It can go up, down, stay the same. So, there is that risk that people can lose things. If they don't have anything to lose it's easier, if they've already got something, it's harder. Um, and sort of saying, you know, be prepared to have to repeat yourselves again. But trying to sort of make clear that it's not going to be like the assessment. Um and that we've already made all our arguments on paper. So, what… what they're looking for is, they're looking for credibility and consistency, that's what I'm always saying to the client. Think of a typical day, and start to, you know, give the minutiae of every day because when, when you're chatting, then it's easier to get that kind of information out and relate it to an everyday example that you perhaps can't… in conversation you can do that but it's hard to write that down, so yeah. We sort of go along those lines with the client, and there’s sometimes you say look, don’t say that, you know, or try to stay focused if a client starts to bring something in, you know, say the tribunal is time limited. Don't take, try to… don't go… try not to go off on a tangent. If you're nervous, ask for a break. Don't, you’re not on trial, take the time to answer the question, take as long as you want. If you're not sure about something, we're there to ensure you get a fair hearing, but we can't answer the questions for you. We can't do that bit, we can do everything else to support the client, but they do have to feel that they can answer the questions. Some clients are brilliant and other clients you think, you're not going to… you’re going to struggle to do this, but actually the case is so strong on paper that you think a good panel are going to be able to, to see it and understand it.

I What is it that people struggle with that would maybe make you feel a bit nervous?

P Um, they can't stick to the questions, they'll start talking about things that just aren't relevant. You know, more everyday things. Um, they’ll be a little bit angry, and they’ll think it’s the tribunal’s fault that they haven’t had the benefit. So, you're trying to sort of diffuse any of that. Um, they… are just very, very emotional about their eye condition and they're not going to be able to talk about it. Um, they feel that, um I mean… it is personal to them, but they're very, very angry at the DWP, they feel that they're calling them a liar. You know, clients will say that ‘I'm not a liar’. And I say, you know, the tribunal don't think that, it's not about that. But, you know, you're trying to diffuse it a little. But we have had clients where we think, you know… but that's the role of the chair as well, you know, they know that people are coming in, highly charged, they’ve lost their benefit, you know, especially with PIP, if they’ve moved from DLA to PIP, it's not a new claim it's a transfer, they've lost thousands of pounds a year, they’re in debt. They may be going through an ESA appeal as well. Their vision is getting worse. There's everything else that's going on in the background for that person and it comes to… it can come to a head at a tribunal hearing. You know, because clients are waiting a year maybe longer. Um, so, it's trying to sort of get them to keep focusing on why we're there, which feels a bit clinical but, you know, the PIP descriptors, because it's time limited and this is the one chance we've got. You know there are other things you can do if the appeal isn't successful, but, you know, so it's very focused and intense period of time to put right what somebody has been maybe waiting a year, a year and a half to get sorted. And a good chair can get… bring all that together and understand, but a bad tribunal, the tribunal where you feel that there's no empathy for the client… you, it can just go really wrong, you know, regardless of whether they qualify for the benefit or not. There's no empathy for them and their situation.

I Are there any cases that sort of really stuck out to you, where that's happened?

P Um… there will be, yeah, I’m just having to think. Um… Yeah, I have had cases, I mean to be fair, not recently… but yeah, I have had cases, I've had cases where, you know, they’ve adjourned for more medical evidence, which a tribunal can do. But you think, well you saw the bundle, you could have given a direction notice, the clients been all built up to have this appeal heard. We've gone in and adjourned it, um… or a client has, yeah, I’ve had a client’s who's… had quite severe mental health problems and had been sectioned and on several occasions and that, that wasn't approached in a sensitive way at all… Um, and they did end up adjourning that case. Um, and that was really difficult for the person because they, they were then asked to go and get medical notes from their GP, which was, was a really sensitive issue, so it has happened. It hasn’t happened recently, very much at all. Trying to think, trying to think back to cases that I did, sort of, face-to-face, when we went through the whole thing. I can’t think off the top of my head, I mean, in our office, because I do… and there are other people in our team that are based in [local area] as well, where they’ve had a particularly bad one about a judgement about somebody who was granted leave to remain and yeah, and then a lot of the issues started to be about why, why they'd left their country and, you know, that's totally inappropriate and irrelevant. Um, no, I'd have to think a little bit more but certainly, yeah, I've had appeals, where things haven’t gone well… you felt uncomfortable about, about the panel. It's not just the decision, itself, it's the… it's what's happened in the hearing.

I If we just go back a bit, I know you've mentioned a couple of times, the submission that you have to do for appeals. If you could just sort of talk me through what you need to do for that, and what you're looking for at that stage?

P Um, well, when you get the bundle, if you've taken the case on and you’ve lodged the appeal or you've agreed to be the rep so you get the appeal bundle, so that's the big bundle of papers, can be anything from 70, 80 pages to 300 pages, you know, it can be massive. And what the DWP have a habit of doing, is if somebody has made a claim for PIP before and it's been unsuccessful, they put both claims in. So that takes it up, you know, so your clients got 350 pages of appeal submission because there's submissions… there’s the DWP’s written response, it has a copy of the appeal form, a copy of the medical assessment, the assessment providers form, a copy of any medical evidence used, just everything that relates to that claim’s in there. So, the first thing that you would do is, is look through that and think, right. So, where's the medical evidence, the clients said this and is there any, is there any at all? No, well, we need to get some. You look at the assessment providers report. You look at the DWP’s written response. And you look to see where they've…um, how they've reached their decision, on what basis and quite often, they just cut and paste two or three set phrases from the assessment providers report about the person's sight loss and they've really ignored, maybe 80% of what was on the claim form and just made a very clear judgement. ‘The client made good eye contact’, ‘the client was able to travel to the assessment independently’, ‘the client did not use any aids’, ‘the client’s visual acuity is X, Y, Z’, when you know that it's not that. You know that they did get a lift there, they didn't go into assessment on their own, you know that they do use a long cane, you know that they do have aids. You know, such huge things that have just been missed so that's the starting point is to look at everything the clients told you, everything you know about the client’s eye condition already, which won’t have been addressed. So, things like the fact that they have a loss of peripheral vision which just gets ignored all the time, you know, they think it's just about solid central vision. So, for clients who have like… glaucoma, or retinitis pigmentosa or clients who have nystagmus… you know, they, it's very difficult, you know, the DWP, the assessment provider won’t see that as just… not as a significant visual impairment.

Um, so that's, that's, that's one thing. Then we look at what the clients actually said, and we’ll look at what aids they have, look to see about any other health conditions that they have, diabetes, for example, um, they’ve had a stroke. I’ve had clients lose their sight a result of a stroke. And so, we look to see what, how the DWP have reached their decision. And then I will look at the claim form and see what the client has said, and who filled it in, what evidence they’ve sent and then look at the assessment providers report. And then we would write our written response to everything that's in the submission, um, in the DWP’s appeal bundle and just to build our arguments, identify the descriptors, identify where, why we believe the client meets the criteria, and where the DWP has either not applied their own guidance or the legislation correctly or they've misrepresented the clients eye condition, or failed to understand it. And we write that and then I would ring the client and read it back to them or email it to them. Somebody else reads it or client does it themselves, enlarges it. I say, what do you think, do you think that this… is the right presentation, do you think I've missed anything, do you think I've explained things the way they are for you? And clients will go, ‘yeah, I think you've said everything’, or ‘no, I can't, I can't do that’ and, you know, ‘can you kind of put in more information’, or I don't… ‘I do use a microphone, I have got microphone, I do use a cane’. So, you’re finding things out all the time.

But once they're happy with it, you know, a client might say well I want to argue for points for toileting and we’ll say, well, you might have difficulty finding your way to a toilet but that's not covered in the regulations so we're not going to argue for that because, no you won't get points. So, you know, it's just a bit of toing and froing… Once the client is happy with everything that's in the submission, then we would email it to the tribunal and wait for a hearing date, and send a copy to the client and, and obviously, if we look at the bundle and say, look, you've told me this, all this information but we need some evidence. The evidence that is in the bundle is too old, your vision’s deteriorated since then. You've told me that, but we need to be able to evidence that, so can you get something from your GP… or, and the client will say ‘oh yeah I have all those letters, but I didn't think… I thought the DWP would get in touch with my GP’ and we say no. They're not gonna, they're gonna look at the assessment provider’s report. They're not gonna, they're not gonna look for any evidence on your behalf. We've got to do that. So, yeah. That's what we would do and that takes time.

I mean that takes a day, just to read the papers. If you've done the mandatory reconsideration for the person then you know a lot more already, because you've done the kind of first bit. If you haven't done the MR, and you're just taking the appeal. you don't know anything until you get that bundle really, other than what clients told you and you think, yeah, the case has got merit, and you know then that, that takes longer. So normally about a day to read the bundle and a day to kind of start making the submission up. Um, you can have the bundle for quite a while I mean, in an ideal world, you would start to do your submission as soon as you get the bundle. But, you know, there's always other things to do so… um, the other thing is to check all the dates are right. You know, that do the DWP actually have the right date of claim, that they refer to the right person in the submission and sometimes, you know, that's clearly somebody else they’re talking about it. So, you're looking for, you know, practical errors as well.

Um, sometimes the client has just swamped the DWP with medical appointment letters and things like that and you're trying to sift through and think… that… we've overloaded them and that's kind of detrimental as well because they're not going to look. So, you're trying to say to the client, we just want to focus in on the evidence that we really need, we don't need to give them 5 years of GP notes or whatever. And sometimes we get, you see things in there that you shouldn't see. You don't need to see, um you know, from a GP, say for example, the GP sent you the medical notes and they’ve sent you everything for the client, then it's not relevant. You know, I've seen things that have been really sad and really personal, and you think that’s in someone's GP notes, they could have redacted that. So, you know, if that's come up, I maybe would say to the client, but you know, I'm sorry but there was this issue um…. You know, like your clients had a stillborn baby or something and it's in the notes and you think, you know, I'm so sorry… I, because they're gonna see that. I'm sorry that's in your notes and to make clear that's not gonna be an issue for the panel. You know, things like that, it doesn't happen often, but it does happen. Um, or a client’s been the victim of an assault or, yeah, something that you think… that’s out there now. Or, you know, another one the client has alcohol problems they haven't told you, and you say right now, I can see it's in the papers. If it's an alcohol problem, you think, the tribunal might ask about that. How do you feel about that? Do you want me to mention that in the, in the submission, is there something about that? But often clients will go, ‘I don't drink anymore’, or ‘yeah, it's still a problem’. We can talk about it, you know. But they’re quite uncomfortable conversations, they’re uncomfortable conversations because a client hasn't told you that. And they’re… they’re the types of things that come out of asking for GP notes or the GP, the client’s asked for their GP notes and the GP just prints off everything.

I And it must be quite difficult to manage those conversations, especially when it's additional information that's not necessarily relevant to their claim or what they've chose to disclose to you?

P Yeah, yeah, I think it is, um, I think you have to have them, and I think clients appreciate it, they respect it if you, you know, this is… you don't want them to walk into an appeal and that come out. You just can't let that happen to somebody. But yeah, I think that is difficult but hopefully by the time you've got to, to that stage you've had quite a lot of conversations with the client already, um, you know, to get their trust for them to tell you all about, you know, the difficulties they have with washing, bathing, toileting dressing, you know. They've been… they’ve opened up quite a lot. If I was concerned about it, and about raising it, like you know, client’s who've attempted suicide, self-harm. Had quite a few clients where that's been an issue. But we've got safeguarding, it's not an issue that they've raised with you now but it's an issue from their history, from their medical history…um, then I maybe would talk to my manager first, but I would talk to them and talk to the client as well. Yeah.

So yeah, I think. Yeah, they’re difficult conversations but you've got to… you’ve got to be sensitive to it and aware of it that when the bundle comes in there might be something in there that you're just not expecting. The client needs to know it's in there, you know, quite often clients don't read their bundle. They’re like, ‘I can't read it, it's huge’. So, yeah, I haven’t, it hasn't been a problem, I mean it's been a problem because they’ve found it there, it has come up, but it hasn't been something that's ended badly for the, for the client. I don’t think a client has ever reacted badly to me having to say, um, I'm worried… if it's something that's way, way back in client's history and it's not relevant now then you know that, um, the tribunal aren't going to address it. If it's something that's still ongoing, um, or is still having an impact or its likely to push the trigger for their depression, say or anxiety. It's not just about the sight loss, then you would say that I think the tribunal might… sensitively and they do generally, bring that up. If it was a client where, our client had been assaulted and the GP notes had come to me, before we forwarded them on, we just redacted it and we just put a line through it, blacked it out and I just put… redacted on client’s request.

I It's tough isn't it, because I think this is… it’s quite a difficult line in what you need to share in order to prove yourself to a panel?

P Yeah, Yeah definitely. You share everything and more that they don't really need. Yeah. Yeah, it is difficult. And I suppose, as far as clients… I don’t think always appreciate what you're doing, because it’s all the time, you don't always think. It is difficult but you, you forget, you know, because you focus in on… on what you want. So, some clients are kind of just devastated by the whole process, and other clients are just like well, ‘it’s happened to me before, you know, I know I'm entitled to it, um and I'm just gonna keep going’ and you know… it really just depends. Sometimes they’re angry, sometimes they’re absolutely distraught and some, some clients more than others are in a real financial difficulty. And that, that’s the hardest thing. You know not every client is really… is reliant on their PIP as an income. I mean they, they need it, they know they're entitled to it, it's additional income or they'll say that, you know, ‘look I'm okay my partner can support me’ or, you know, ‘I've got savings or a job’ and, you know, and then there are other clients where this is literally their only source of income.

I Do you do other benefits as well, so you're involved in sort of the, I guess, ESA and Universal Credit and stuff?

P Yeah, and Attendance Allowance and DLA. So, yeah and it's the same process for all of the benefits. Because we're always looking for ESA and Universal Credit, we're generally looking at the people who failed the Work Capability Assessment. And so, it's all about, all about disability. In my last job I would have done the Housing Benefit appeal or an overpayment, or right to reside, or um, what else would we have done? Whether somebody was cohabitating, things like that but we wouldn't be picking that up now, we’re just focusing on the disability elements. Yeah, yeah, so DLA, UC, Attendance Allowance… yeah, so it's all disability but different process and obviously for ESA, there's only two people on a panel so it's a different kind of hearing. But ultimately, it does come down to the person saying, ‘this is how my sight loss affects me’.

I And I know you'd said, a little bit earlier about people that have been to a tribunal before, are quite, may be more aware of the process, but how is it different between those sorts of customers or clients and ones are sort of fresh to the process?

P Um, I think it depends on whether their appeal was successful or not. If say… some people are more confident and they'll say, ‘well I got it on my last hearing, so I'll get it this time’. Or, you know, ‘the judge was really nice at the last one and I know what happens and yes I've been before’. Or you've got clients where you've done their ESA appeal and now, you're waiting for their PIP appeal. So, if they've had an appeal before, it's probably easier. Clients who've never been to tribunal before, um, you know, sometimes they're just terrified, they're ashamed, they just… yeah, they don't feel believed, they can't believe they’re having to go this far. They really want… you know, you've got clients that don't want to do it, they don't want to go, and we say well, you know, you can withdraw at any time, but we've got this far. Um… don't go if you feel you can’t, I mean, part of that's been taken out now, because clients can, it's all a telephone hearing, whereas before we would have said, look, you know, if you have a paper hearing, which you could, you have got less chance of success so we really would try and encourage you to go. Um, the worst that can happen is that things don't change, or yeah. I mean, ultimately, you just respect the client, if they can't go.

But sometimes I've said, you know, just go and do your best and you think the tribunal need to see what's happened to the person. I mean, it's not the tribunals fault but actually sometimes, you know, if a client goes and they are really struggling then maybe they will be able to see, you know, we've said that they're anxious, we've said that they're depressed, you can see that they're physically undernourished and not able to care for themselves. The clients will say, ‘well what should I wear’? And I just say wear what you normally wear. You know, you don't have to, you’re not on show. Um, so, I suppose that’s difficult, when you can't go… where I used to always be able to attend with the person before, if they were really distressed and, you know, you could be there, um, and up until it went to telephone you didn’t. I suppose, you were always trying to look for somebody to go with that person. And that they can be with that person afterwards if it's, you know, if the appeal hasn't succeeded. Um, it's just, everybody's different. Some clients can take it in their stride. Some clients are very confident, you know, they could represent themselves. You know, a lot of clients that… by [the charity] being involved, I think it gives, they’ve got a higher chance of success or that their case will be more credible because they've got the charity behind them, which isn't necessarily the case. You know, the credibility comes from your evidence and from the medical evidence. The fact that [the charity] puts a label on it doesn't guarantee, do you know what I mean? The, the tribunal won’t assume, well you’ve got [the charity] involved, you’re sight loss must be really bad, your appeals allowed, you know, it doesn’t work like that.

Um, I think it just depends, I think it's very, very difficult for older people to go through to appeal. I know you’re only looking at PIP, but like for Attendance Allowance say, for older people, you know, some cases, not many but we've seen more and more AA refused. You know older people just find the whole system… just awful. The stigma and for children, for carers, then it's just… it's just another burden, another thing that they're having to deal with… which is really, really difficult. But I mean, ultimately you can never get away from it, it's the financial pressure that's on the person, that is what’s at stake. That's where so much stress comes from. Or, you know, because the person is just being reassessed all the time, for ESA, for PIP, for ESA, for PIP. You know, there's no financial security in their life at all… and they’re maybe having lots of treatment, you know, as well. So, everything gets messed up in that, you know, lots of our clients are having, yeah, different kinds of procedures. I think, as I said before, I think all of those things can just combine and get caught in the journey and the appeal process. It's the tribunal that just triggers, trigger… pushes the person over really.

I Yeah, it must be a very strange space for people to come in and have to talk and all that swirling around.

P Yeah, yeah. In 40 minutes, in front of three people you've never met before, around a massive table surrounded by law books and you maybe have to wait because your appeal’s running late… it's…. I mean I've done hundreds of appeals, but I'm always nervous before an appeal. Always. I never think… it's in the bag and it's just… don't, you do not know, you can be 100% confident, you just can't really know.

I Have you ever [talking over]… sorry.

P Sorry I was going to say, you get appeals were you’re ready and then, and then the judge will say we'll call you in. It's happened on the telephone here as well, ‘we've reviewed the papers; we’ve already made the decision. We’re gonna give you X, X and Y’. Thank you very much [laughs]. We don't have to go in, you know, they've already decided, they ring the client up, we don't need to see him. So, they’ve looked at the papers and it's so obvious, with a lot of our cases and you think, the client is elated but then there's a bit of an anti-climax, you know, you feel quite angry, and you think this person has had to wait a year. How did it ever get this far? And I suppose as a campaigning organisation that's things that we kind of look at, well what is going on? Why are so many cases ending up here? You know, when we have a 96% success rate. That's 96% of overall decisions. Um, yeah. I mean, clients can be like totally over the moon… you could get a bouquet of flowers and chocolate and stuff and thanks very much. Not all the time, but they think… they do really appreciate the fact that they just could not do it on their own, you’re taking some of the strain off them. Not all the strain by any means but there is somebody there.

I Right, I think that's everything I was hoping to cover, if there's anything that's popping into your head, before we go?

P Um… no I don’t think so, I hope I haven’t waffled on too much.

I No, not at all it’s been great, thank you, I really appreciate it.

P Have you spoken with any of my colleagues, there’s a few of us doing it aren’t there?

I I don't know if they're from [the sensory loss charity], but I've definitely spoken to at least two other people that are involved in sight loss charities as well.

P Yeah, I suppose the thing for tribunal work is that it's, it's encouraging people to not drop out at MR stage. People think you know, well my MR hasn’t been successful, so that's it. I mean, we always used to laugh and say, you know, if you walk into a tribunal with a guide dog, you’ll win your appeal. They just go, ‘ooooh’, and you know… and they’ve got that, that’s their perception, you know, a visually impaired person has a guide dog. You know, we say we're gonna borrow someone’s guide dog, you know, it’s so patronising. But I… I mean, since we've gone to telephone hearings, I've had more like contact again with tribunals and um, I think overall, they do a pretty good job. But when things can go wrong, in terms of approach and attitude, more incorrect… I mean, more importantly incorrect decisions, and I think that is really difficult, like as an advisor, to take. Very, very difficult for clients, for all clients, but I always say, you know, they feel like… like the DWP have made them feel like a liar and I think that's like… they know that [the charity] believed them, and that's a big part of it, that we do understand sight loss, and as say you, it's not visible and I think tribunals or the DWP do not understand the psychological impact of sight loss. It’s huge… huge. You know, that whole degree of anxiety, they just think well someone who has mental health problems, somebody who's anxious, while you've never, you know, you’re not sectioned, you don't have any specialist input. No, but you’re living in a state of high anxiety, every day.

I Yeah, it seems a bit like, so you're saying about if you've got a guide dog or stick, if you've got something that's visible, I think there's something in managing well with your anxiety and how you get on that can… can make it a bit difficult too.

P Yeah, they, the way that they manage is that they've just reduced everything down to a manageable, manageable size which means they're not living the life they want to live. You know, I’ve had lots of clients during lockdown who've said, ‘you know what? it’s no different for me because I'm locked down all the time’. You know, ‘I feel locked down all the time’. ‘I've stopped going out since I fell and broke my ankle’, so many clients who go, ‘I’ve got my left ankle pinned’, ‘I’ve got my right wrist done and I did this and this’. And like, oh, no, would you be, I mean who wouldn't be anxious if they've like slipped on, fell on a mattress and broken their ankle? Or, you know, like a piece of street furniture? There's all those layers in there that you're trying to kind of get that across. So yeah, I think the anxiety, like I say that's not visible, depression’s not visible, sight loss is not visible, but they may, you know, they make a heady cocktail for somebody to try and like just get on. And people do get on, I mean, it's not… it's not being negative about people but it's, there's a, there's a lot to, um, process especially for clients who've got a deteriorating condition. Um, you know, they haven’t been born with the condition, they were born, and it has got progressively worse.

I I suppose that is quite different for someone who's been born with it and its sort of, in a way that’s all they’ve ever known rather than they’re gradually having to adapt and change?

P Yeah, yeah, but they’re still living with that challenge, with a busy built environment outside them. Yeah… yeah, so, some clients are very anxious, other clients aren't, but I'd say even clients who do have, who are born with a sight condition or who don't have, who are born, born blind even, they still, this is a huge impact on their life that's hard to… that… that's all they know, but you have to compare that with what… what you know other people can do, who don't have that eye condition. I think sometimes there’s more, not sympathy, but certainly medical members, um they think, you know, well the person should have adapted and adjusted by now. You know, it’s that like look at it on paper and yeah well… you know, you've got an aid, you've got, you know, why are you anxious if you've got your magnifier or your cane? So yeah, training issues for tribunals definitely. I'd like to see more visually impaired people on panels, or people with mental health problems on panels. It’s part of the, they have the medical disability members had a physical disability….

I Mm, I was gonna ask, how have you found the disability panel member?

P Um, up and down really. Some… some are very good. Some still think that they’re assessing a person for DLA, you know, I think when PIP, when we first moved over to PIP, they were still kind of asking things about night-time needs and I’m thinking, that's not relevant. Um, generally, I think that the tribunal panel is as good as the judge, if you have a good judge, they’ll keep the panel on track. Um, if there's going to be a difficult panel member, it’s normally the medical member. That's my view anyway.

I It’s interesting that you say that and then also there is quite a reliance on medical evidence as well.

P Yeah. Yeah. So, we just bombard them with it, so a consultant, neurologist, specialist says/ stated… Um, yeah, yeah then the medical members, I don’t know, I don’t know what it is about the medical professionals sometimes. Some of them are very understanding. Others, I think… they are um, you know, they’re quizzing the client about the medication. Most people, they’re prescribed a medication they just take it, don’t they? They think well, a doctor told me to take it, so I'm taking it. You know, and they sort of go down lines where you think really is, is that relevant? I… I really seriously don't think is. But I mean overall, you know, it doesn't need to be a majority… it just needs to be a majority decision not a unanimous decision, so you know, it’s the judge that you want to be the person that understands. And if one of… you know, the medical member, maybe they, sometimes I just feel, you know, they’re showing off a little bit. Don't get me wrong, you get some really good medical members as well, but you do get ones that start to almost interrogate the client about their condition. It's like look, the client didn't write, you know, that's how you feel, but the consultant’s report is there, it's there in black and white. Why do you need to ask, when it's already been clear? They had a brain tumour, it was debunked, it was removed, it was pressing on their optic nerve, you know, they've been left with double vision and no vision and now they've had a…. Where they're quite good is say if a client’s had a stroke and then they seem to have a, you know, they’ll understand that like 6, 9, 10, 12 weeks down the line, the person's speech hasn’t come back, their strength hasn't come back and… so medical members can be really sort of more sensitive and good about it, and other times, you know, you feel that they're really quite detached from, you know, from the notes, it's like, this is a personal struggle too, you know, they're living it, they’re living it so... Yeah.

I Have you had a, maybe a different reception with different conditions?

P Uh… yeah, yeah. Any, um, any conditions where, like I say, things like nystagmus, it's more difficult. Loss of peripheral vision, it's more difficult. If somebody has any kinds of, quite rightly, any kinds of dementias that are worse, for instance, they seem to know those types of diagnosis and conditions. Where a person has had a stroke sometimes that can be difficult, where it looks like there might be some improvement, you know, through physio or through time. I think that… sometimes different if the client was born with their eye condition, born, registered as a child and went to blind school or something like that, then I think they… sometimes those clients are treated differently. Um, clients with learning disabilities, if it's… um, sometimes if they haven’t… if we can't kind of evidence that through like, they went to a special needs school, who had one-to-one support, that can be difficult. Some, I think mental health… issues around depression and anxiety are probably more difficult. If a person's just been on a long-term antidepressant for a number of years and they're not, they're not, you know, it’s always like, you know, the person has no specialist input. And it's like, well, they either don't have any specialist input because they're just managing their condition now, there’s always this idea that someone should have specialist input. You know, it's got to be the most extreme and for it to be seen as a problem sometimes, mental health, I think. I don’t know if that answers your question or not but yeah, definitely. If you can show, like a person who has an eye condition where they've like got very, very, very limited central vision, then you know that they're going to be stronger cases and probably better understood.

I Why do you think that is?

P Probably people can relate to it more. They probably have a better idea of what it means to lose your central vision looking straight on. But to lose your peripheral vision just feels too abstract. Does that make sense? You know that people end up with tunnel vision. I don't think, um, yeah, I don't know but it’s a real problem. You know, they’ll go ‘but your vision is 6:6’, you know, which is like 20:20, so yeah, but it’s a pinhole they can only see that much, you know. Through that kind of lens, so, you know, they've got like 80% loss of the visual field, and they'll go, ‘but you know, the person can turn their heads’, so yeah. When they turn their head, they don't appreciate… so, sometimes what we do in our submissions is we try to put in images of how a person sees, you know, you can get them off the internet and we’ll kind of put those in to try and give an impression because it's very difficult for people try to explain it.

Um, I suppose one of the things with PIP that makes it, that we do talk about a lot is, you know, it's about whether somebody can do the activity reliably, so where there are issues with safety, which is one of the most… one of the relevant and reliability factors, which is very good and we can evidence clients where their safety has been… like I say, clients where, it's horrible, you know, but they say ‘oh yeah I've got my left ankle pinned or my right one pinned’ and, yeah. You know, or ‘I've got a steam burn, a steam burn on this arm’. ‘I've cut this finger’. You know, for preparing food or whatever we know their issues around their sight loss, they're about safety issues. All the time, ‘falling down the stairs, I missed a step, I went down a pothole, I've gone over on an uneven pavement, I’ve hit my face on a door’. You know, ‘I’ve walked off to the side of…’, you know, all these things. ‘I’ve made a memory map of my home, but then once I go out of my home…’, you know, it's, it's everywhere. So, we, we can talk a lot about safety within submissions and I think that, um, that is something that everyone can relate to and understand. And then if you try and relate that into words, you know, that the anxiety comes from the risk of serious harm…

I And what do you do with people when, as you… as you said just a second ago, about no specialist input?

P Um, well we would sort of address by saying, well it's not required. It's monitored by their GP, it's ongoing, it still has a long-term impact on their health and well-being, mental health services are restricted, the person’s managing it themselves. The evidence that they take is strong, you know, proof that they have such an ongoing health concern is the level of the medication that they take, you know, they might be on quite high level of antidepressant, they’ve needed to take it for a long time, they can't come off it. Um, just try to kind of, couch it in those terms. But I think there still is that view that if it were really serious, they’d have specialist input. Which again is just like, saying this kind of judgement about how severe something should be… Quite often, you know, the clients really just say, well it's, you know, it goes back to this kind of frontline GP service, they've had it in the past, it’s no longer helpful, you know, it's been resolved through remaining on whatever medication it is they have. But it's definitely a perception that if you don't have that, then your problem can’t be that bad.

I Hm… well thank you so much. It's been really good to talk to you.

P You’re welcome. That’s good

I Just to let you know, sort of what, what the next steps are. So, I'm gonna be sending a research summary to anyone that's asked for one sort of just. Hopefully it'll be interesting, based on what's come out and you'll be able to see sort of what, what's come out from other people's experiences as well. That's probably end of the year, early next year. But if you've got any questions or anything that pops into your head, feel free to get in touch with me.

P I will do, if I get something that jumps out at a tribunal I’ll be like right, I’ll let you know, good or bad. Good luck with everything.

I I would love that, thank you. Thank you so much. I hope you have a good rest of the day as well.

P Yeah, nearly lunchtime now. [laughs]

I [Laughs] Yeah, it is! Thank you.

P All right. Bye.

I Bye.

[End of recording]