FIRST-TIER TRIBUNAL

SOCIAL ENTITLEMENT CHAMBER

Tribunal Judge Phillip Barber

Appellant: [redacted] **(Appointee for** [redacted]**)**	**Tribunal Ref: SC009/19/**[redacted] **NI No:** [redacted]
Respondent: Secretary of State for Work and Pensions	

DECISION NOTICE

1. The appeal is allowed and the decision of the Secretary of State made on the 20 January 2016 is revised.
2. We are satisfied on a balance of probabilities that [redacted] is severely disabled as a result of vaccination against one of the diseases specified in section 1(2) of the Vaccine Damage Payments Act 1979 (as amended).
3. A statement of reasons is attached to this Decision Notice.

Signed: Phillip Barber Tribunal Judge Barber	Date: 06 March 2020
Issued to the parties on: 13/03/20	

FIRST-TIER TRIBUNAL

SOCIAL ENTITLEMENT CHAMBER

Held at Leeds **on** 24/02/2020

Before Tribunal Judge P Barber; Dr V Rogers; Dr M R McClelland

Appellant: [redacted] (Appointee)	**Tribunal Ref. SC009/19/**[redacted] **NI No** [redacted]
Respondent: Secretary of State for Work and Pensions	

STATEMENT OF REASONS FOR DECISION

This statement is to be read together with the decision notice issued by the tribunal

Introduction

1. [redacted] (under her previous name of [redacted]) made a claim to vaccine damage payment on behalf of her daughter, Miss [redacted], on the 15 November 2015. That application is at pages 31 – 41 of the bundle. The application was on the basis that Miss [redacted] was vaccinated on the 24 November 2014 with the seasonal flu vaccine, Fluenz Tetra and has since suffered from narcolepsy with a disablement in excess of 60%. The claim was refused on the 20 January 2016 following medical advice from a medical assessor, Dr Blayney on the basis that causation between had not been established. Over the next 3 years, the issue of causation was reconsidered by a number of different medical assessors who were all in agreement that there was no evidence to establish a causative link between Fluenz Tetra and narcolepsy. On the 14 May 2019, following a request for a Reversal, the Respondent made a decision to refuse that application on the basis that there was insufficient information to support such a request. Ms [redacted] appealed that decision on the 22 May 2019 with the support of her solicitors, Hodge Jones & Allen. The appeal is at pages 1 to 3 of the bundle.

The Law

2. Vaccine damage payments are made under the provisions of the Vaccine Damage Payments Act 1979. Section 1 of the Act, insofar as relevant, provides as follows:

> (1) If, on consideration of a claim, the Secretary of State is satisfied—
> (a) that a person is, or was immediately before his death, severely disabled as a result of vaccination against any of the diseases to which this Act applies; and
> (b) that the conditions of entitlement which are applicable in accordance with section 2 below are fulfilled,
> he shall in accordance with this Act make a payment of [the relevant statutory sum] to or for the benefit of that person or to his personal representatives.

3. Section 1(2) sets out a list of diseases against which vaccination damage might give rise to an award under the Act and it is not in dispute that the Secretary of State has, by Order, added the seasonal flu vaccine to that list for persons under the age of 18 when vaccinated.

4. Section 1(4) provides that "for the purposes of this Act, a person is severely disabled if he suffers disablement to the extent of 60% or more, assessed as for the purposes of section 103 of the Social Security Contributions and Benefits Act 1992 ("SSCBA 1992") … (disablement gratuity and pension).

5. Insofar as relevant, section 103 of the SSCBA 1992 (which relates ostensibly to a disablement pension or industrial injuries disablement benefit arising out of an industrial accident) provides in subsection (5) that:

> In this Part of this Act "assessed", in relation to the extent of any disablement, means assessed in accordance with Schedule 6 to this Act; and for the purposes of that Schedule there shall be taken to be no relevant loss of faculty when the extent of the resulting disablement, if so assessed, would not amount to 1 per cent.

6. Schedule 6 to the 1992 Act provides in paragraph 1, general provisions for assessment of disablement in the following terms:

> For the purposes of [section 103] above and Part II of Schedule 7 to this Act, the extent of disablement shall be assessed, by reference to the disabilities incurred by the claimant as a result of the relevant loss of faculty, in accordance with the following general principles—
>
> (a) except as provided in paragraphs (b) to (d) below, the disabilities to be taken into account shall be all disabilities so incurred (whether or not involving loss of earning power or additional expense) to which the claimant may be expected, having regard to his physical and mental condition at the date of the assessment, to be subject during the period taken into account by the assessment as compared with a person of the same age and sex whose physical and mental condition is normal;
>
> (b) [...] regulations may make provision as to the extent (if any) to which any disabilities are to be taken into account where they are disabilities which, though resulting from the relevant loss of faculty, also result, or without the relevant accident might have been expected to result, from a cause other than the relevant accident;
>
> (c) the assessment shall be made without reference to the particular circumstances of the claimant other than age, sex, and physical and mental condition;
>
> (d) the disabilities resulting from such loss of faculty as may be prescribed shall be taken as amounting to 100 per cent. disablement and other disabilities shall be assessed accordingly.

7. Regulations made under these provisions include the Social Security (General Benefit) Regulations 1982 and in particular Schedule 2 to these regulations provides a list of injuries, and the corresponding degree of disablement arising out of that injury. So that, for example, "loss of both hands" will give rise to a 100% degree of disablement; "loss of all toes of both feet" give rise to 40% disablement and a "below knee amputation" will also give rise to 40% disablement.

8. Accordingly, the 1979 Act requires the Tribunal to use its medical and legal expertise to obtain the relevant facts from the Appellant about her condition and how it affects her as "compared with a person

of the same age and sex whose physical and mental condition is normal" and "without reference to the particular circumstances of the claimant other than age and sex whose physical and mental condition". Although (as is often the case) [redacted]'s present (and future) circumstances do not readily equate to the table in Schedule 2 to the General Benefit Regulations, that table is still relevant to establishing the degree of disablement.

9. How we do that was considered in the Court of Appeal decision of *SSWP v FG on behalf of John (a minor)* [2017] EWCA Civ 61 and for our purposes the relevant parts of the Court's judgment are set out below:

> 34. Mr Heppinstall argued that the wording of the statutory scheme was such as to require the determination of disablement to be made by reference to an applicant's condition solely at the time he/she presents at the assessment (by the Department or, on appeal, by the tribunal). He said that the scheme, properly interpreted and understood, does not permit a forward - looking assessment which also takes into account likely future disablement.
>
> 35. Whether on a purposive approach to the relevant provisions or on a linguistic approach to the relevant provisions I can see no real basis for that argument.
>
> 36. First, I find it very hard to see the rationale for the argument advanced. If an individual is assessed as having a life-long condition (as here) why should that not be taken into account in assessing the extent of the disablement? Mr Heppinstall suggested by way of answer that such an approach could give rise to uncertainty and could call for difficult evaluations – he suggested speculations – to be made by a tribunal. But courts and tribunals are well used to assessing loss on a balance of probabilities on present evidence by reference to future prospects. It is, for example, the very stuff of personal injury litigation. There is no particular additional difficulty in this over and above what in any event, I would agree, is likely in many cases to be a difficult evaluation as to whether the 60% "threshold" is reached. At all events I do not agree with the suggestion that on the respondent's argument "certainty" is traded for "speculation". The tribunal will not be speculating. It will be making a present judgment as to future events on the balance of probabilities, based on evidence.

10. It follows that the Tribunal is concerned initially with the question of causation: i.e. on a balance of probabilities did vaccination with Fluenz Tetra cause [redacted] to suffer from narcolepsy; and if so, whether the resultant disablement is at least 60%. At the hearing there was a discussion about whether, if we were satisfied in relation to causation, we should proceed to assess the degree of disablement. The view of the Respondent was that we should stop and remit the appeal to the Secretary of State to consider that aspect; the submissions of Mr Todd were that we should proceed to determine all issues in the appeal.

The Evidence

11. We had some 402 pages of documentary evidence in relation to the issues in this appeal and in particular we had the following:

    a. the statement of Ms [redacted], dated 08 February 2019, at pages 14 through to 30;
    b. the statement of Mr Todd, Solicitor, dated 03 January 2020, at pages 304 to 309, exhibiting various documents in support of the appeal;
    c. the statement of Mr O'Neill, from Narcolepsy UK at pages 386 through to 389;
    d. the report of Dr JE Blayney, on behalf of the Respondent, at pages 48 through to 51;

e. the report of Dr K Smith, on behalf of the Respondent, at pages 62 through to 72;
f. the report of Dr K Murphy, on behalf of the Respondent, at pages 73 through to 90;
g. the report of Dr R Stecewicz, on behalf of the Respondent at pages 394 through to 402;
h. we also had [redacted]'s relevant medical records at pages 91 through to 253;

The Hearing

12. Ms [redacted] attended the hearing with her partner, Mr [redacted] and she was represented by Mr Todd, solicitor. The Respondent was represented by Ms Robbins. We heard evidence from Ms [redacted] and submissions from both Ms [redacted] and Mr Todd. We found the submissions of both representatives to be very helpful in focusing our minds on the relevant issues.

Our Findings of Fact

13. We heard evidence from Ms [redacted], who confirmed her witness statement and brought us up to date with how [redacted] is managing her day to day life. We accept Ms [redacted]'s evidence in its entirety. It was on the whole unchallenged by the Respondent and in our judgment, it is both reliable and plausible.

14. Ms [redacted] gave us a shortened history of [redacted]'s presentation both before and after her vaccination and told us that there is no history of narcolepsy in either her or [redacted]'s father's side of the family. [redacted] has had no significant injuries which might trigger the illness and confirmed that she had no symptoms prior to 24 November 2014, the date when [redacted] was vaccinated. Following vaccination, in March 2015, Ms [redacted] told us that she started to notice [redacted] falling asleep at inappropriate times, for example, whilst travelling in the car or at school. On the 02 March 2015, it was reported that [redacted] had fallen asleep at school and that the school was concerned [redacted] was staying up too late at night. At the same time, [redacted] started to feel like she might fall if she laughed and made, what are described as "horrendous" facial expressions. On the 06 March, [redacted] had a fall at school and again over the weekend of 07 and 08 March, she fell whilst out with her friend. Ms [redacted] took her to see the family GP on the 09 March 2015 and she was urgently referred to York District Hospital for an EEG to rule out epilepsy. By the 11 March, Ms [redacted] told us that she was already convinced that [redacted] was suffering from narcolepsy as she had started to research the symptoms on the internet. Following a referral to Dr Paul Reading's sleep clinic at the James Cook Hospital in Middlesbrough, [redacted] was diagnosed with type 1, hypocretin deficient, narcolepsy.

15. She told us that before the vaccination, [redacted] was a popular girl, with a large network of friends; that she was very slim and active and doing well at school. Ms [redacted] told us that since the vaccination, [redacted] has changed significantly and that currently, she will often sleep during the day. She told us that [redacted] wakes at 6.30am to take her medication before going back to bed. She will eventually get up at 8.30am when she has to get ready for college. Ms [redacted] takes [redacted] in the car to college and she will often sleep in the car on the way there – a distance of some 15-20 minutes. At school, [redacted] had access to a bed but now that she is at college, she will "nap" at her desk when tired. She is able to complete a full day at college but after returning home, she will go straight to her bed and sleep, staying in her room most of the evening and night. She might come downstairs in between sleeping but most of the time she is in her room. Ms [redacted] told us that [redacted] is now very isolated and feels that she cannot spend time with friends.

16. Ms [redacted] told us that at school, [redacted] had an Educational Healthcare Plan which included extra support in class; the ability for her to sleep during the day and an extra teacher at school. Ms [redacted] told us that [redacted] did her GCSEs at home and had extra time, including planned breaks. At school [redacted] did not have to take part in PE and instead she would catch up with her schoolwork. We were told that [redacted] is

unable to drive and that she requires support in the kitchen to cook a meal. [redacted] cannot go on the bus in case she falls asleep and generally public transport is not possible for her.

17. Ms [redacted] also told about how [redacted] also developed cataplexy and that she will often fall if she laughs or coughs.

18. In terms of [redacted]'s mental state, Ms [redacted] told us that this had been affected to a significant extent. Chloe now suffers from depression and that at times she can feel very low. She has difficulty relating to her peers and this had exacerbated her feelings of isolation. Ms [redacted] told us that [redacted] has recently been referred again to CAMHS having initially chosen not to opt into the service and that [redacted] struggles with her memory, hallucinations and night terrors, which subsist during the day. We were told that [redacted] also has problems with thermo regulation – i.e. she can get very hot, and that these can lead to panic attacks which will bring on cataplexy.

19. In terms of her behaviour, Ms [redacted] told us that [redacted] became a lot more "challenging" after suffering from narcolepsy and can be inappropriately aggressive in her manner. Ms [redacted] told us that she worries about the future for [redacted] and that the possibility of work is limited.

20. At the time of application [redacted] was on a combination of drugs to help control her symptoms. She took Concerta XL (methlyphenodate), Modafinil first thing in the morning and at noon, clomipramine and sodium oxybate. She had been on venlafaxine but had had to discontinue this because of side-effects. [redacted] later had also to stop taking sodium oxybate. At the time of the Tribunal she remained on Concerta XL, modafinil and clomipramine as well as taking baclofen at night. She had also been commenced on a new expensive drug, pitolisant (Wakix) specifically licenced for the treatment of cataplexy. The indications were that her symptoms had been, and remained difficult to control.

21. Miss Robbins on behalf of the Respondent suggested to Ms [redacted] that it is possible some other trigger caused [redacted]'s narcolepsy and points to a reference to "swine flu" in the medical notes on page 151 from 2009, but we agree with Mr [redacted] that this could not be a trigger as it is too far in the past.

22. As mentioned above, we accept all of Ms [redacted]'s evidence about [redacted] and the history of her illness and find as fact accordingly.

23. Accordingly, what is not in doubt is that [redacted] had a seasonal flu vaccination on the 24 November 2014 with Fluenz Tetra; and that in March 2015, [redacted] started to suffer from type 1, hypocretin deficient narcolepsy, a condition which she did not suffer from prior to that date.

<u>Did the vaccination with Fluenz Tetra cause [redacted]'s narcolepsy?</u>

24. In our expert medical opinion, we are satisfied on a balance of probabilities that it did. We accept that there are no epidemiological studies which support a link between the Fluenz Tetra vaccination and the commencement of narcolepsy, but we agree with Mr Todd, that the absence of any large-scale study is neutral, it nether supports a causative link nor does it disprove a causative link. What we know is that [redacted] was vaccinated with Fluenz Tetra on the 24 March 2014 and that subsequently she started to suffer from narcolepsy of a type which would require a trigger and that something must have triggered the onset, accordingly and whilst an epidemiological study may well have helped, it's absence does not decide the appeal.

25. The Respondent has amassed no less than four medical reports from four separate medical advisers employed for the purpose of carrying out medical assessments and advising on entitlement to various

benefits. All four assessors agree with each another and advise the Respondent that [redacted]'s narcolepsy was not caused by the vaccination. All four assessors rely to a greater or lesser extent on the absence of any epidemiological study to establish a link but as already stated, in our view, this is evidentially neutral.

26. In response, the Appellant has provided us with a short, but highly persuasive report from Dr Croft, a Consultant Public Health Physician – Medical Epidemiologist, working out of offices in Harley Street London. Dr Croft on the second page of his letter states that:

> "It is now generally accepted that narcolepsy is due to the precisely-targeted destruction of hypocretin-secreting cells in the hypothalamus. The precise targeting, it is thought, is due to 'autoimmune disfunction', in which the affected individual produces antibodies (also known as 'autoantibodies') against particular cells. Once killed, the cells cannot regenerate.
> .....
> Narcolepsy is a rare adverse event of some vaccines.
>
> In the case of 'Pandemrix' it has been shown [*by Ahmed 2015, Segal 2018, et al]* that certain nucleoproteins on the vaccine have a configuration which mimics the body's own hypocretin receptors. In a small subgroup of vaccine recipients, the vaccine's nucleoproteins trigger the production of antibodies, and through some as yet unknown mechanism these antibodies cross the blood-brain barrier and destroy hypocretin-secreting cells in the brain, causing narcolepsy.
>
> In the case of 'Fluenz Tetra', this process has not been shown to occur – but nor, however, has it been shown not to occur. There simply have not been no focused, large-scale studies of this risk.
>
> It is in my view entirely plausible that 'Fluenz tetra' could in some circumstances and in some susceptible individuals cause narcolepsy, through a series of immunological events similar to those described above. Like 'Pandemrix' (and like the influenza virus itself), 'Fluenz Tetra' contains nucleoproteins which mimic those in the hypothalamus' hypocretin-secreting cells.
>
> **Was [redacted]'s narcolepsy caused by 'Fluenz Tetra'?**
>
> In my view Yes, on the balance of probabilities and because (i) by analogy with 'Pandemrix' there is a plausible scientific mechanism for this adverse event; (ii) narcolepsy following vaccination, while rare, is especially common in children; (iii) the time of onset of [redacted]'s symptoms in relation to the time of administration to her of 'Fluenz Tetra' suggests a causal relationship, and (iv) no other plausible cause has been advanced for [redacted]'s narcolepsy."

27. Dr Croft's evidence, is, in our view clear and reliable. We were provided with a copy of Dr Croft's CV on page 433 of the bundle (the additional pages of evidence), and this demonstrates that Dr Croft is a leading expert in Public Health Medicine. During his career he has taught, researched and published many papers on public health issues and amongst other things currently works as a post-doctoral research fellow at Portsmouth University. His list of areas of professional expertise is long and in our view, this demonstrates the necessary authority behind which his assessment as to the cause of [redacted]'s narcolepsy can be relied upon.

28. Dr Blaney appears to rest her view on causation on the absence of any epidemiological study on the question of a link which we have already indicated is, in our view neutral on the question of causation. We were also unaware of whether Doctor Blaney was acting with any degree of expertise on the issue as she does not indicate anything in her report other than the fact, she is a doctor. Accordingly, it follows that we do not think Dr Blaney's view should be afforded as much weight as that of Dr Croft.

29. Dr Smith concurs with Dr Blaney and adds very little to the question of a causative link. Again, she falls into the trap of assuming that because there is no epidemiological study which demonstrates a link between the vaccine and narcolepsy, then the one cannot have caused the other. Again, we were of the view that Dr Smith adds little if anything to support the Respondent's argument on causation.

30. Dr Murphy, in her report, attempts to grapple with the scientific papers submitted by the Appellant in support of the claim, however, as has been submitted by Mr Todd, her use of irrelevant factors in arriving at her opinion on causation goes a long way to undermining the weight to be attached to her report. So, for example, Dr Murphy makes reference to "older age groups" on page 80 of the bundle: an irrelevant consideration as [redacted] is a child but also an inaccurate statement: see Miller, Stowe et al. published in the journal, Sleep (vol 39, No. 5, page 1051) which reported that there is "a significantly increased risk of narcolepsy in adults following Pandemrix vaccination in England".

31. Dr Murphy makes reference to the Department of Health "Green Book" in which there is no association between narcolepsy and the seasonal flu vaccine. However, we agree with Mr Todd that the Green Book takes the matter no further as it is a general account of available vaccines, their use and any associated risks. What it does not deal with is individual illnesses and the cause. It is hardly surprising that the Green Book makes no mention of narcolepsy as there has been no large-scale study to establish a link.

32. Dr Muphy's view paraphrased is that "although [redacted] has narcolepsy, which must have been caused by something, it was not caused by vaccination as there is no evidence of a causal link" we do not agree with the logic of that assessment for the reasons given above.

33. Dr Stecewicz is a latecomer to the issue and his report is at pages 394 to 402 of the bundle, dated 23 January 2020. He considers the new evidence provided by the Appellant, i.e. the witness statements of Ms [redacted] and Mr O'Neill and advises that this does not change the previous assessment that the vaccination did not cause [redacted]'s narcolepsy. He agrees with the previous assessments of the three previous doctors and he takes the matter no further.

34. Generally, we do not think that any of the medical reports submitted on behalf of the Respondent properly grapple with the question as to whether the vaccination caused [redacted]'s narcolepsy and accordingly, we prefer the expert medical view of Dr Croft to the four opinions expressed by the medical assessors instructed by the Respondent and we find on balance that the Appellant has shown that [redacted]'s narcolepsy was caused by taking the vaccination, Fluenz Tetra.

An Assessment of Disability

35. We considered at this point whether the matter should be remitted to the Secretary of State for an assessment as to the degree of disablement. We decided not to do that for the following reasons: firstly, in our view and having heard from Ms [redacted], it is so obviously apparent that [redacted] is severely disabled as a result of the vaccination and that that disablement is at least 60% that it seems to us pointless sending the matter back; secondly, this matter has now been going on long enough. The application was made as far back as November 2015 and given that [redacted] and her family have been waiting for the issue to be resolved for over 4 years, now, it would be grossly unfair to delay the matter even further; and finally, it just strikes us as being fair to proceed to determine the degree of disablement, given that we have heard the necessary evidence and that we are, in fact, an expert Tribunal with the expertise to make the assessment.

36. Our findings of fact set out above give a broad indication of how [redacted] is affected by narcolepsy with cataplexy and the resultant loss of faculty. It affects every aspect of her daily life and takes its toll on both her physical and mental health. [redacted] will be permanently disabled as a result of narcolepsy and the destruction of the hypocretin neurones is incurable. [redacted] has tried a number of different treatments for the condition but none has in any way resulted in anything other than minor improvements.

37. As a result of her narcolepsy, [redacted] has a number of symptoms associated with her illness as follows:

    a. Excessive daytime sleepiness
    b. Cataplexy
    c. Weigh gain
    d. Automatic behaviour and microsleeps
    e. Memory difficulties
    f. Mood disturbance
    g. Problems with her personal relationships
    h. Hypnogogic hallucination
    i. Thermoregulation problems
    j. Behavioural difficulties, and
    k. Disruption of her education

38. We are satisfied that cumulatively these symptoms have a significant impact in relation to [redacted]'s day to day life. [redacted]'s education has suffered to a significant extent; her relationships with her peers and her family has been affected and it is possible that, for example, in the future [redacted] will be unable to drive. We are satisfied that the type of work [redacted] will be able to undertake in the future will be severely limited with lower earning potential.

39. In short, we are satisfied that the disabilities arising out of [redacted]'s narcolepsy are significant and will be life-long.

40. Considering Schedule 2 to the Social Security (General Benefit) Regulations 1982, we note that there are only two injuries giving risk to a degree of disablement of 60%: loss of one hand and amputation at knee resulting in end-bearing stump or below knee with stump. Whilst we understand the significant impact either of these injuries might have on day to day life, we thought that generally they would not prevent a person from working regular hours; pursue an academic career or intellectually challenging career; they would still be able to drive (albeit an adapted car); they would still be able to study; the injury would not affect them cognitively and it would not affect their ability to enter into and hold down relationships. Given that loss of leg at the knee or loss of a hand amounts to 60% disablement and taking on board our views as to the day to day effect of narcolepsy on [redacted], we are satisfied that [redacted]'s disability arising out of her loss of faculty is at least 60% and probably as much as 70%.

The above is a statement of reasons for the Tribunal's decision, under rule 34 of the Tribunal Procedure (First-tier Tribunal) (Social Entitlement Chamber) Rules 2008.

Signed Tribunal Judge: Phillip Bamber Date: 06 March 2020

Appellant: Ms [redacted] (Appointee)	Tribunal Ref: SC009/19/[redacted] Date of Hearing: 24/02/2020

Statement issued to

Appellant on: 13/03/20

Respondent on:

Typist: