THCAN Tower Hamlets Community Advice Network

Adviser Checklist - Appealing Against a Benefits Decision

Most benefits decisions carry a right of appeal and in any situation where your client disagrees with a decision or where it seems to you as an adviser that the decision is wrong you should consider disputing it.
Situations where it may be appropriate to dispute may be:

- A claim for benefit to which the client appears to be entitled has been refused
- A benefit has been awarded but the amount does not seem right for the client's circumstances
- Benefit has been stopped, sanctioned, or reduced.
- The client has attended a Work Capability Assessment and been told they no longer qualify for ESA/will receive a lower rate of ESA
- Backdating has been refused
- The client has been asked to repay benefits they have previously received ('overpayments')

Is there a decision letter?

Normally there will be a dated letter clearly stating what the decision is. Where there is no decision letter, for example where a benefit claim has been made but the client has not heard anything yet, or where a client has been told by a benefits officer not to apply for something because they wouldn't be entitled, appeal is not the appropriate response. These situations are better dealt with by enquiry and complaint.
Normally benefits decision letters will also state whether the decision is appealable and what the time limit is for making an appeal.

Is the reason for the decision clear?

- May be on the letter
- Adviser may know from experience
- Client may know
- You can ring the department that made the decision and ask for an explanation
- You can ask for a written statement of reasons for the decision – but ensure that any dispute or appeal is still lodged within the time limit

Time limits for appealing

- For most benefits, an appeal should be made within a calendar month of the decision date.
- Tax credit overpayment disputes: time limit is 3 months
- Tax Credit appeals time limit is 30 days.

Are there any grounds for appeal?

- Interview the client to find out as much as you can about the claim and the decision, using any information in the decision letter or provided by the DWP on the phone.

- Check the rules relating to the decision – you can find information about benefit rules/regulations in the CPAG Handbook or by accessing Rightsnet, Advisernet, or other online sources of information about benefits
- The decision may have been based on facts that the client disputes e.g. about the client's health condition, or that they are working or co-habiting
- The benefits department may have applied the wrong legal rules e.g. applying the Benefit Cap to person receiving DLA
- Consider whether the matter is worth appealing – in some cases, the likelihood of a successful appeal is so low (for example, because there is no evidence to support what the client is saying, or because there is no actual entitlement), or the amount of benefit to the client even if they were successful is so negligible (or where there is no financial benefit at all, e.g. the client just wants an apology) that public funds should not be used to pursue it.

Evidence to support an appeal

- In any case where you are disputing a decision, you should consider what evidence can be brought to show that the decision was wrong, and to support what your client is saying.
- Where the benefit department has mistaken the law, the evidence to support the appeal may simply be an award letter for another benefit
- Examples of types of evidence that can support an appeal: letters from 3rd parties e.g. doctors, consultants, carers; letters from other benefit departments as above; signed statements from other people about your client's circumstances; documents e.g. passports, tenancy agreements, bank statements.

Put the claimants case clearly in writing

- Most DWP decisions now require a mandatory reconsideration before an appeal can be made to the tribunal service.
- There is a standard form available for mandatory reconsiderations although it can also be done by phone; if you have phoned to request the reconsideration you should still confirm in writing as soon as possible together with any available evidence.
- The DWP has no time limit to complete mandatory reconsiderations and in some cases benefit will have stopped pending a decision. You or the client should chase the decision maker for an early decision by Fax/E-mail/Telephone calls.
- If the decision is not changed after a mandatory reconsideration, you should consider putting an appeal – note any time limits.
- A copy of mandatory reconsideration must be enclosed with every appeal.
- All letters whether they are mandatory reconsiderations, appeals or letters enclosing supporting evidence/additional information should be dated.

Appeal/dispute letters

- Give claimant details: name, address, N.I number, any other reference number
- If claimant got a mandatory reconsideration notice, uses SSCS1 form to appeal a DWP decisions and use SSCS5 to appeal HMRC decisions. Forms can be downloaded from Tribunal website. Return the form directly to Tribunal Service.
- If claimant appealing a local authority decision (ie HB, CTB) or appealing a decision not entailing a mandatory review, GL24 form should be completed and sent to the decision maker's office.

- State the facts of the case and refer to any evidence that supports what the client has said, for example the clients says it hurts to walk, any evidence of a diagnosis/medication will help to support that contention
- Enclose any evidence to hand and state what further evidence will be sent
- Check address for appeals and send by recorded delivery; use recorded delivery or ask the client to hand deliver any further letters or evidence. Documents can also in some circumstances be faxed or e-mailed.
- Keep copies of everything

What happens once the appeal has been accepted

- It may be looked at again and the decision changed.
- If not, documents will be passed to the Tribunals Service for a hearing to be arranged.
- Copies of all relevant documents will be put together and sent to claimant representative and tribunal service ('Document bundle' or 'Appeal bundle' will be given).
- Claimant who completed GL24 to put an appeal will receive a TAS 1 (Tribunal enquiry form) to provide further information.

Completing the SSCS1/SSCS5/ TAS1

- Ask for Interpreter if needed
- Does client has any special need e.g. wheelchair access
- Oral/Paper hearing - it is recommended that in all but exceptional circumstances you request an oral hearing to give your client the opportunity to put the facts in person and answer more detailed questions. Tribunals tend to be more sympathetic to credible and articulate appellants than to statements written on their behalf by an advice worker
- From now on any evidence/ further information or arguments go straight to TAS and not to the benefits department that made the decision

The Hearing

- Approximately a month before the hearing, a notice of the venue, date and time of hearing will be sent out.
- At this stage you should check that any evidence you have has been sent to the Tribunal, and chase up any evidence you've asked for but not yet received.
- You can write a submission at this stage and send it. A submission is a summary of the facts of the case, the reasons for disputing the decision, the evidence supporting the claimant's version of events, and reference to any rules/legal arguments you are relying on. The submission is intended to help the Tribunal by directing their attention to the strength of your client's case. It should not simply be a repetition of what the client has said in their claim form/appeal letter.
- Consider representing the client at the hearing - maximises prospects of successful outcome, reassures client, no need for lengthy submissions if timescales are short.