

[2016] NZSSAA 072

Reference No. SSA 010/15

IN THE MATTER

of the Social Security Act 1964

AND

IN THE MATTER

of an appeal by **XXXX** of Auckland
against a decision of a Benefits
Review Committee

BEFORE THE SOCIAL SECURITY APPEAL AUTHORITY

Ms M Wallace - Chairperson
Mr K Williams - Member
Lady Tureiti Moxon - Member

HEARING at AUCKLAND 10 August on 2015

APPEARANCES

Graham Foster for the appellant
Mr G Moore for the Chief Executive of the Ministry of Social Development

DECISION

Introduction

[1] The appellant appeals against a decision of the Chief Executive, upheld by a Benefits Review Committee declining to pay Domestic Purposes Benefit at the Care for Sick and Infirm rate (DPB – CSI) for the period 10 March 1986 to 11 March 2002.

Background

[2] The appellant's son XXXX was born in Australia on 10 March 1986. XXXX has Down Syndrome and has various conditions associated with that syndrome.

[3] Ministry records suggest the first time the appellant applied for and was granted a benefit, other than Family Benefit in New Zealand, was on 13 July 1990 when she was granted Domestic Purposes Benefit – Sole Parent. This grant continued until 8 January

1992. It appears the appellant may have returned to Australia in November 1991 and remained there until August 1993, when she again applied for and was granted Domestic Purposes Benefit – Sole Parent in New Zealand. Between 1993 and 2002, she was granted a main benefit on a number of occasions. There were periods when she did not receive income support, apparently, because she was working.

[4] The appellant was first granted DPB – CSI from 11 March 2002. She continues to receive that benefit. At the time DPB – CSI was granted, XXXX was aged 16 years. He was granted an Invalid's Benefit at about the same time.

[5] In February 2014, the appellant requested a review of her entitlement to DPB – CSI between 1986 and 2002.

[6] The appellant's request was considered by the Chief Executive but he declined to make a backdated grant as requested.

[7] The matter was subsequently reviewed by a Benefits Review Committee. The Benefits Review Committee upheld the decision of the Chief Executive. The appellant then appealed to this Authority.

[8] Various reports provided to the Authority, and the appellant's evidence indicate that both in the past and at the present time, XXXX suffers from a heart murmur and is highly vulnerable to many conditions. As an infant, there were problems with him feeding. The appellant recalled that he started walking at 18 months. He was generally harder to care for than her other children. As a child, XXXX soiled his bedding and clothing more than normal. He needed constant care and attention. His speech was underdeveloped and at age 11 years he only had approximately 20 words. He remains unsteady on his feet and lethargic. During his school years he always attended special needs schools where he was given specialist help such as physiotherapy, speech therapy and at one stage behaviour therapy. He had his tonsils removed at age three years as a result of many infections. Apart from his tonsils operation at age three years, XXXX has not been in hospital, with the exception of when he has dental work done, these procedures are done under general anaesthetic and he might have an overnight stay in hospital. When he contracts an infection it takes a long time for him to get over it.

[9] XXXX has been left with caregivers other than his mother from time to time. The appellant's grandmother looked after him while the appellant went to England for her sister's graduation. A neighbour across the road looked after him while the appellant worked between 1995 and 1996.

[10] The appellant said she had been told by a nurse who had worked at Tokonui hospital at some point, that they had had babies like Vaughan living at the hospital.

[11] On behalf of the appellant, it was submitted that in the medical certificate dated 14 March 2002, in response to the question “Would this person be admitted to hospital if not cared for?” The certifying doctor ticked the “yes” box. This constitutes evidence that the appellant met the criteria for DPB – CSI prior to 2002.

[12] On behalf of the Chief Executive it is submitted that a back payment should not be made because:

- (i) It appears that in some of the periods in respect of which the appellant seeks back payment the appellant and her son were living in Australia.
- (ii) The legislation in place in the period 1986 to July 2002 governing the granting of DPB – CSI required that the DPB – CSI could only be paid if the person cared for would otherwise have required to be admitted to hospital within the meaning of s 88 of the Social Security Act 1964 (the Act). It is submitted that XXXX would not have been admitted to hospital in the period prior to 2002.

[13] Ms Cahill, a health adviser with the Ministry of Social Development, gave evidence. She has a nursing background including time spent in the mental health sector. She offered the opinion that any child placed in a long-term hospital situation in the 1990s and early 2000s would have had severe physical disabilities and a need for treatment or severe behavioural problems with a psychiatric overlay.

Decision

[14] In the first instance, we note that DPB – CSI is an income-tested benefit. It is not granted simply because the applicant is caring for a person with a significant need for care. The criteria for DPB – CSI are also distinctly different from the criteria for Child Disability Allowance.

[15] The appellant was either living in Australia or her living circumstances were such that she did not apply for a main benefit prior to July 1990. If the appellant did not seek a main benefit prior to 1990 there is no basis on which a retrospective grant of DPB – CSI could be paid to her prior to July 1990. The Authority has therefore focused its inquiry on whether the appellant would have been eligible for DPB – CSI from July 1990, when she was first granted Domestic Purposes Benefit – Sole Parent. We accept that an application for Domestic Purposes Benefit – Sole Parent could have been treated as an application for DPB – CSI.

Legislation

[16] There have been a number of changes in the legislation relating to the eligibility criteria to DPB – CSI in the past twenty years. Coupled with changes in the arrangements for the care of children with intellectual disabilities during this period; the inquiry in this case is not entirely straightforward. It is not altogether clear that the changes in the legislation kept pace with the changes in the arrangements for care of children with disabilities.

[17] Provision for DPB – CSI was first included in the Social Security Act 1964 in 1973. From 1973 until July 2002, s 27G(2) of the Act provided that DPB - CSI could be paid if the applicant was required to give full-time care and attention at home to some other person (other than the applicant's spouse or partner) who would otherwise "be admitted to hospital within the meaning of s 88 of the Act". Section 88 of the Social Security Act 1964 at the time defined hospital as follows:

Hospital means a hospital or other institution maintained by [an Area Health Board under the Area Health Boards Act 1983, or by] a Hospital Board under the Hospitals Act 1957 or a private hospital licensed under Part 5 of that Act; and includes any other institution or place in which sick or injured persons are received for treatment, or in which maternity patients are received for delivery, and which is for the time being recognised and approved by the Minister as a hospital for the purposes of this Part of this Act:

[18] Section 27G was amended in 2001 by the Health and Disability Services (Safety) Act 2001. The amendment came into force on 1 October 2002. The words 'to be admitted to hospital' within the meaning of s 88 of this Act were replaced with the words 'would otherwise receive hospital care' within the meaning of the Health and Disability Services (Safety) Act 2001.

[19] The Health and Disability Services (Safety) Act 2001 defines "hospital care" in the following way:

Hospital care means services that are children's health services, geriatric services, maternity services, medical services, mental health services, or surgical services (or services of 2 or more of those kinds) provided—

- (a) In premises held out by the person providing or intending to provide the services being capable of accommodating 2 or more of the people for whom the services are provided for continuous periods of 24 hours or longer; and

In consideration of payment (whether made or to be made, and whether by the Crown, the people for whom the services are provided or any other person).

[20] The Health and Disability Services (Safety) Act 2001 provides separate definitions for “residential disability care” and “rest home care”. This suggests these types of care were regarded as distinctly different from “hospital care”. There is no specific definition in the Health and Disability Services (Safety) Act 2001 of “children’s health services”. The definition of “mental health services” includes services provided in relation to drug or alcohol abuse.

[21] A further amendment to s 27G of the Social Security Act 1964 occurred in 2007. The categories of care that a person might require for their caregiver to qualify for DPB – CSI was expanded from simply “hospital care” within the meaning of the Health and Disability Services (Safety) Act 2001 to:

- (a) hospital care, rest home care, or residential disability care, within the meaning of the Health and Disability Services (Safety) Act 2001; or
- (b) care of the kind referred to in s 141 of the Children, Young Persons and their Families Act 1989; or
- (c) care of a kind equivalent to any of those kinds of care.

[22] The issue for the Authority is whether, but for his mother’s care in the periods when she was in receipt of a main benefit prior to 2002, XXXX would have been admitted to a hospital as defined in s 88. The legislative history is relevant to the interpretation of the provision.

Changes in care delivery for children with intellectual disability

[23] The complicating factor in this case is that there were significant changes in the delivery of services to children with intellectual disability, and mental illness in the period from July 1990 to 2002.

[24] The Authority has received a variety of information about these changes.¹

¹ (i) A summary prepared by Mr Pat Hanley of Auckland Action against Poverty dated 26 August 2015; (ii) A letter from the office of the Director of Mental Health, Ministry of Health dated 15 December 2015; Letters from IHC dated 26 April 2016 and 15 June 2016; (iii) Claire Stewart & Brigit Mirfin-Veitch *Impact of deinstitutionalisation on the Families of the Kimberley Centre Residents* (Donald Beasley Institute, Dunedin, 2008),. (iv) Julia Millen *Breaking Barriers – IHC’s first 50 years* (Bridget Williams Books, Wellington, 1999). (v) Patty Green & Denyse Wilcox *Review of Children and Young Persons in IHC Care* (IHC, 2000)

[25] In summary, during the 1950s and 1960s, a number of institutions known as psychopaedic hospitals existed for the exclusive care of children with intellectual disabilities. In addition, in some areas there was provision for children in hospitals providing mental health services for adults. The appellant has always lived in the Auckland area when she lived in New Zealand. In the Auckland area, Mangere Hospital was a psychopaedic hospital providing care for children with intellectual disabilities.

[26] The institutions caring for children with an intellectual disability were referred to as hospitals and were staffed by doctors, nurses and nurse aids. We accept that in 1990, these institutions were hospitals or institutions maintained by either an Area Health Board² or a Hospital Board and clearly fell within the definition of hospital contained in s 88 of the Social Security Act 1964. However, by 1990 the arrangements for the care of children with intellectual disabilities were undergoing or had undergone significant change.

[27] In summary, the information available is:

- As early as the 1970s there was a movement to keep children with intellectual disabilities in the community.³
- In 1985, the government of the day adopted a policy of community living for people living in long-stay institutional care.
- Mangere hospital in Auckland was the first of the psychopaedic hospitals to close. The closure process started in the early 1990s and was completed by 1994.
- The letter from the Ministry of Health states that it is possible that after the decision to close the psychopaedic hospitals, children could have been admitted for a limited period of time for respite care, to provide intensive management for particular behavioural problems, or when they were unwell.
- A letter from IHC New Zealand Incorporated confirms that “It was commonly understood that the Department of Health directed that children were not to be admitted to full-time institutional care except in rare circumstances”. There may have been some variation in how different areas and institutions implemented this policy, however, the experiences of people who worked in

² Administration of the psychopaedic hospitals and mental health institutions was transferred to Health Boards by the Mental Health Act 1969.

³ Julia Millen *Breaking Barriers – IHC’s first 50 years* (Bridget Williams Books, Wellington, 1999) at 81 - “In 1974 the government imposed a moratorium on the expansion of psychiatric and psychopaedic hospitals”.

or had contact with health-funded residential institutions was of very few children being admitted to full-time care.

- Some indication that admission of children to psychopaedic hospitals ceased or was restricted can be found in the report on the closure of Kimberley Hospital; the last of the psychopaedic hospitals to close.⁴ The report states that of the 375 people living at Kimberley in 2005 none were under the age of 31 years.

[28] The information available from the Ministry of Health suggests that children would have only been admitted for short-term periods. Ms Cahill gave evidence that child admissions would have been limited to cases of severe physical or behavioural difficulty with a psychiatric overlay. This is confirmed by the information from IHC.

[29] There are a number of medical reports available regarding XXXX's condition in earlier years. A report dated 26 August 1993 refers to XXXX having indistinct speech and suggests a need for exercises to improve his articulation. Under the heading "Cognitive skills" it is noted that he is able to complete a six to eight piece puzzle. Under "Fine motor skills" it notes that he is able to hold a crayon correctly. Under "Play skills" it notes that XXXX has been observed playing appropriately, but alone – plays with cars, balls and hoops. Under the heading "Language" it is noted that he follows two-step directions, identifies common objects, and understands "in", "on", "under" and "behind".

[30] On 22 July 1997 a report completed by a paediatrician at Starship Hospital, when XXXX was 11 years old, noted under the heading "Current level of function":

XXXX is able to walk and run. He is able to dress himself a little inaccurately and tries to brush his teeth and wash himself. He is able to feed himself well and take himself to the toilet although he often ends up a little wet and a little dirty because he has not finished passing urine or completely wiped himself ... XXXX has around 20 words in his vocabulary although these are quite unclear. He is not reliable with numbers or colours. He is able to draw a circle and build a tower of six blocks. ...

He is on no medications, has no allergies and is up to date with his immunisation except for his MMR booster. ... XXXX is receiving speech language therapy input two monthly. They are not in contact with IHC but plan to establish contact with them soon.

⁴ Claire Stewart & Brigit Mirfin-Veitch *Impact of deinstitutionalisation on the Families of the Kimberley Centre Residents* (Donald Beasley Institute, Dunedin, 2008),.

His heart sounds were normal and there were no murmurs. His chest was clear and his abdominal examination was normal. He was able to walk well and broad jump. He was reluctant to run or hop for me today.

The report concludes with an action plan as follows:

1. Formal audiology at the National Audiology Centre;
2. Check thyroid function tests;
3. Letter to Special Education Service to request educational psychologist involvement with XXXX's behavioural difficulties at school;
4. We discussed the issues of Alamo Axial Instability;
5. Follow-up will be in Paediatric Developmental Clinic in six months.

[31] At page 64 of the s 12K report, a report of the Special Education Service, which is undated, outlines XXXX's fine motor skills and cognitive abilities. His level of ability was assessed as having been at three years, two and a half years, and two years in relation to the skills tested. The follow-up suggestions are that XXXX would benefit from:

1. Being placed in a satellite class with peer models available;
2. Intensive language work;
3. A developmental programme that addresses the above identified needs; and
4. A programme to improve his communication skills.

[32] A letter of 18 July 1997 from a paediatric registrar at Starship Hospital to the Special Education Service states "his behaviour difficulties are proving problematic at school and a suggestion to the school about handling this would be most helpful".

[33] We are in no doubt that caring for XXXX as a child was challenging. He had a need for care and supervision well above that of a child of his age without Down Syndrome. There is no doubt that as a child he met the criteria for Child Disability Allowance, but to be eligible for DPB – CSI the issue is whether or not he would have been placed in a hospital if his mother had not been available to care for him.

[34] The evidence available suggests that XXXX was basically healthy, particularly after he had his tonsils taken out. The issue around his care was his intellectual disability. The various reports suggest that support and treatment for children with

XXXX's disabilities was community-based through the Special Education Service and special needs classrooms in schools and not by placement in an institution.

[35] There is no evidence suggesting that XXXX was a child needing treatment in a hospital, or that his physical condition could be regarded as severe, or that there was a psychiatric overlay to his behavioural problems.

[36] While a doctor completed a certificate in 2002 ticking a box to the effect that XXXX would have been in a hospital had his mother not been available to care for him, this statement seems to have been accepted at the time without question, despite the fact that by 2002, there would not have been a 'hospital' facility which would have taken him as a long-term patient. At best we can only infer that the doctor was interpreting the word 'hospital' with regard to the past practice rather than the situation that existed in 2002.

[37] A certificate from a doctor in such circumstances is a guide for the Chief Executive in making a decision but is not binding on the Chief Executive. Ultimately, it is for the Chief Executive to decide whether or not an applicant meets the eligibility for a particular benefit.

Interpretation Act 1999

[38] We have considered whether there is room to interpret the term "other institution or place in which sick or injured persons are received for treatment" as including residential disability care. The Interpretation Act 1999 provides that an enactment applies to circumstances as they arise. It is curious that prior to the 1990s the mother of a child with Down Syndrome would clearly have qualified for DPB – CSI but following the closure of the psychopaedic and psychiatric institutions this was not clearly the case. In Burrows and Carter *Statute Law in New Zealand* the learned authors note "Although the precise subject matter no longer exists there may be something closely analogous to which the statutes' provisions can be held to apply, almost as a kind of statutory cy-près (as near as possible) doctrine".⁵ The authors note that an Act may cover new developments provided two conditions are satisfied:

- (i) The developments are within the purpose of the Act.
- (ii) The words of the Act are capable, albeit by liberal interpretation, of extending to them.

⁵ RI Carter *Burrows and Carter Statute Law in New Zealand* (5th ed, LexisNexis, Wellington, 2015) at 402.

[39] The language of the statute must be flexible enough to cover the new development and the development must be within the Act's purposes. The learned authors quote *Osborne v Chief Executive of the Department of Social Development*⁶ "Parliament intends the Courts to apply to an ongoing Act a construction that continuously updates its wording to allow for changes since the Act was initially framed".

[40] The purpose of DPB-CSI is to provide a modest financial incentive to the caregivers of people who would otherwise be cared for in institutions. Arguably, the term "other institution or place" could be extended to a facility such as a residential disability facility. The qualification that it be a place in which sick or injured persons are received for treatment may be seen as problematic, however, this qualification applied when the psychopaedic hospitals were operating. Such institutions were in many respects the providers of accommodation, and training and/or diversional therapy for their residents, rather than 'treatment' in the commonly understood sense of the word. It would not be unreasonable to give a liberal interpretation to the word 'treatment'.

[41] Ministry policy guidelines in 2004 suggest a person who would otherwise be placed in either a hospital or in residential care could be eligible for DPB – CSI suggesting that the Ministry considered residential disability care facilities should be included in the definition in s 88.

[42] We note the following:

- (i) Although as a result of the change in care arrangements intellectually disabled children may no longer have been admitted to 'hospital', the provisions relating to DPB – CSI did not become redundant. The benefit could still have been paid to the parent of a seriously ill child who would otherwise need hospital care. It would also have applied to persons caring for adults in a variety of situations. For example, someone caring for a person who was terminally ill or who for medical reasons required hospital level care.
- (ii) When the legislation was amended in 2002, there was no attempt to expand the "hospital" criteria to specifically include "residential disability care". It was not until 2007 that the provisions relating to residential disability care or care of a type under s 141 of the Children, Young Persons and Their Families Act 1989 was added. Arguably this may have been because it was generally understood that these types of care were covered in the existing provision.

⁶ [2010] 1 NZLR 559 (HC) at [64].

[43] In our view, an interpretation of the words “other institution or place in which sick or injured persons are received for treatment” could be interpreted as including residential disability care.

Children, Young Persons, and Their Families Act 1989

[44] A further matter impacting on this case is that in 1989 the Children, Young Persons, and Their Families Act (CYPF Act) was passed. In the first instance, this legislation placed great emphasis on maintaining children in their families. The Act did however contain some specific provisions for the care of severely disabled children and young persons. Section 141 provides for a child or young person who is so mentally or physically disabled that suitable care for that child can be provided only if that child or young person is placed in the care of an organisation or body approved under s 396 of the CYPF Act to provide care for such a child or young person. Section 142 provides for agreements between parents and the operator of a residential disability care facility.

[45] We understand that had the appellant indicated she did not want to continue caring for XXXX, the matter should have been dealt with under the CYPF Act. It is likely that in the first instance, suitable foster care or a similar form of out-of-home placement would have been sought for him, ideally within his extended family, but if not, placement through one of the organisations dealing with children with intellectual disability. For the reasons previously outlined there is no suggestion that he would have been classified as a severely disabled child and dealt with under s 142 of the Children, Young Persons and their Families Act 1989. In her presentation ‘A rights gap for children with disability’, Patty Green suggests at the time of her presentation this group was “a small group of – approximately sixty children and young people”.⁷

[46] The provision of residential disability care for children under 17 years of age appears to have been very limited. There were a small number of residential schools, for example, the Hohepa School in the Hawke’s Bay and two facilities run by the Ministry of Education. Children in these facilities went home to family during the holidays. In fact, organisations such as IHC moved away from the provision of residential care during this period. The emphasis was on providing support for children to stay with their families and in the community. If they needed an alternative to their own family, then care in a foster home was the most likely outcome. It is reasonable to infer that unless a child was severely disabled in most instances they would not have been placed in residential disability care.

[47] Predicting what might have happened more than 20 years ago during a period of change is not a simple matter, but we are not satisfied on the balance of probabilities that

⁷ Presented to Disability Studies Conference ‘Every Body’ 2011, Otago University.

in July 1990 when the appellant first applied for Domestic Purposes Benefit in New Zealand or subsequently, that had the appellant not been available to care for him, XXXX would have been cared for in either a hospital or a residential disability care facility.

[48] We are not satisfied that the appellant met the criteria to receive DPB – CSI in the periods she was in receipt of a main benefit between 1990 and 2002.

[49] The appeal is dismissed.

[50] The appellant may wish to consider whether an approach to the Ministry of Health for funding for her care of XXXX under the ‘parents as caregivers’ initiatives would be appropriate, if she has not already done so.

DATED at WELLINGTON this 18th day of July 2016

Ms M Wallace
Chairperson

Mr K Williams
Member

Lady Tureiti Moxon
Member