Inconclusive medical diagnosis – Lessons from the AAT

A recent case before the AAT – Clayton Croker and the NDIS – illustrates that permanency of disability can be demonstrated without a confirmed medical diagnosis.

You can read the full description of the case online; we have provided a summary below.

The case

Mr Clayton Croker hopes to join the NDIS, but his access request was declined, with the NDIS arguing that he does not experience substantially reduced functional capacity.

Mr Croker has suffered from pain in his hands and wrists since the 1990s, and has tried pain relief, physiotherapy and splints to no avail. The pain makes it difficult for him to handle or lift objects, and it makes him tired.

He would like assistance to complete domestic activities, to increase his social participation, to access the community, and to be more involved in activities outside the home.

He has been treated by many doctors over the years, but no diagnosis can be confirmed. His symptoms are not in doubt, but no physical cause has been found. A specialist immunologist reported that he had 'significant symptoms with minimal clinical findings'. He had also seen a psychiatrist, who has suggested his pain might stem from a mental disorder (i.e. a somatoform disorder), but this could not be confirmed due to lack of information.

The AAT noted that 'the NDIS Act is not concerned with what caused a person's disability. All people with disabilities who meet the access criteria can be participants, whether the disability came about through birth, disease, injury or accident'.

The AAT therefore concluded that Mr Croker has a disability relating to the use of his hands and wrists – the fact that it is unclear whether this should be attributed to a physical or mental condition is irrelevant.
The Tribunal also concluded that as Mr Croker had tried a number of remedies over nearly three decades, the impairment was likely to be permanent.

However, the AAT did not accept that Mr Croker suffers from substantially reduced functional capacity to undertake relevant activities – a requirement to join the NDIS.

His GP said that 'he did not need any assistance for mobility, communication, social interaction, learning or self-care.' She did think he needed assistance with self-management, on the basis that he was struggling with cleaning jobs which exacerbate his symptoms.

However, upon questioning, the AAT found that Mr Croker cooks for himself, and cleans the areas of his shared home that he is responsible for, although he manages these tasks slowly and paces himself (self-care). He can walk, take public transport and get around unaided. He walks to the supermarket 100m away, does a large shop once a fortnight, and carries the bags home (mobility).

The AAT found no evidence that Mr Croker lacks the capacity for self-management, i.e. the '*cognitive capacity* to organise his life, plan and make decisions, and to take responsibility for himself'.

The Tribunal noted that Mr Croker has multiple goals and is able the pursue them in a systematic way; for example, he is studying at tertiary level and has successfully negotiated reasonable adjustments (such as assistance with note-taking).

In general, although Mr Croker experiences pain, gets tired, and has to pace himself, he lives an active life involving study, the arts and personal fitness.

This indicates he does not have *substantially* reduced functional capacity, and, therefore, despite having a permanent disability, he is not eligible to join the NDIS.

What can we learn from this case?

This case provides a clear example that one must meet *all* of the requirements of section 24 of the NDIS Act to join the NDIS – just having a permanent disability is not sufficient.

This case also illustrates that it is not necessary to have conclusive evidence about the *cause* of a disability – it is possible to prove that a disability exists and it is permanent, even where there is a lack of clarity about why a disability has come about.