The Independent Medical Expert Group (IMEG)

Report and recommendations on medical and scientific aspects of the Armed Forces Compensation Scheme

December 2017

Topic 5 - AFCS Worsening

Key Points

- We concluded that the present approach to worsening set out in Article 9 of the AFCS Order 2011 is reasonable medically, and supportive of consistent equitable decisions. It reflects Armed Forces personnel and medical policy and practice of attaining and maintaining maximum functional fitness, employability and deployability.

Introduction

1. IMEG consideration of this topic was first raised during the Lord Boyce Review at a time when few exemplar cases had been seen, largely because worsening can only be considered at Service termination or beyond. More recently the Quinquennial Review (QQR) report (1) identified it as an issue for IMEG comment. Some stakeholders had suggested to the QQR Team that the legislation was too tightly drawn and so some claimants might be unfairly denied compensation. There was particular concern about claims for musculoskeletal and mental health disorders. This short paper discusses medical aspects of the present AFCS approach to worsening of disorders. The QQR suggested that IMEG findings might inform any policy or legislative amendment of the provision. The note will also be of interest to claims' decision-makers and medical advisers and to claimant representatives.

Background

2. Many of the Scheme's attributes, including the "worsening" provision (Article 9 AFCS Order 2011) derive from and aim to reflect the modern Armed Forces, and the ethos and aim of optimising and maintaining function and fitness for work. Wherever a claim is made and, on balance of probabilities, a causal link to service on or after 6 April 2005 is recognised, an AFCS award will normally be made. This may be "due to service" or "worsened" by service with benefits paid at the same level for both categories. For brevity this paper will use the phrase AFCS service to imply military service on or after 6 April 2005 when the AFCS applies.

3. Compared with civil personal injury and compensation schemes such as the Criminal Injuries Scheme, the AFCS has a relatively narrow selected client group of fit young people. High standards of physical and mental function and fitness for work are delivered through effective people management, training, health and fitness promotion, protection and prevention from injury and disease and dedicated occupational health services. For serving personnel, healthcare is also the responsibility of Defence and where injury or disease, mental or physical, is detected, prompt referral for best practice treatment and rehabilitation is provided.

4. Regular health surveillance monitors these measures and medical examination to assess function, medical employability and deployability takes place pre-enlistment and at regular intervals throughout Service to Service termination. Defence practice is to adhere to Health and Safety legislation and the Equality Act 2010 as far as reasonably practical. The primary

focus of medical assessment of function is military employability but since typically people leave service long before active working life is complete, longer term effects are also relevant to post–service civilian employability.

Medical employability, deployability and the PULHHEEMS System

5. Some understanding of the above concepts is important in AFCS worsening. Full details can be found in the MOD Joint Service Manual of Medical Fitness (1). This includes information on disorders whose presence at recruitment or a pre-service history may preclude service entry or require further specialist examination and opinion. The employability standard is awarded based on findings of the medical examination and the PULHHEEMS classification system which assesses and records function and the capacity to perform certain tasks involved in a given service role. The letters in the acronym refer to physical and mental function qualities as below:-

P	physical capacity overall
U	upper limbs
L	locomotion
HH	hearing acuity (right and left)
EE	visual acuity (right and left)
M	mental capacity
S	stability (emotional)

6. The overall assessment of the qualities is the PULHHEEMS profile. The medical employment standard (MES) is derived from that. Medical employment standards are service specific and their award ensure that Service personnel are not employed on duties for which they are unfit. Each quality can theoretically be awarded a grade of 1-8 but in practice only the EE, visual acuity uses all 8. The grades are defined so that:

0	implies medically unfit for duty and under medical care
2	is medically fit for unrestricted Service worldwide
4	is medically fit with minor limitations
4	is fit within the limitations of pregnancy
7	implies major employment limitations and
8	means medically unfit for Service.

7. Standards for hearing and visual acuity equate to specific measured levels of performance at audiometric testing (hearing threshold levels) and testing of visual acuity. For the other qualities findings on examination and medical judgement are key.

8. The PULHHEEMS profile at entry is designated, P (permanent). Subsequently re-grading may take place following a medical board. If a condition is treatable it may be designated R (remediable) and grading's may be temporary, and held for a maximum of

18 months. If a person does not require in-patient care and is able to remain on duty he or she will be classified according to function down to 7.

9. From 2015, to support consistency across the single Services, the Joint Medical Employability Standard (JMES) was introduced. Awarded by medical staff, this informs the Commanders, who take the decisions, of the medical fitness for deployability and employability of Service personnel. It is important that Service personnel are employed or deployed within their functional capacity i.e. JMES. Only in exceptional circumstances can someone be employed out with their JMES and then following a risk assessment including advice from a consultant occupational physician. In general terms exceptional circumstances are met where life is at stake, or there is no other choice and the repercussions of not carrying out the task would be substantial and serious. The JMES is an alphanumeric code reflecting fitness in Air (A), Land (L), Maritime (M) environments and including category E, which is environment and medical support considerations. There are 6 grade levels for each environment, where 1 is fully fit, unrestricted duty in the specific environment and 6 is unfit any duties in the environment or reflecting environment and medical support consideration.

10. Deployability has three categories, medically fully deployable (MFD), medically limited deployability (MLD) and medically not deployable (MND). Finally to ensure the chain of command has precise understanding of how a person may be employed there are Medical Limitations. These are defined across the domains e.g. miscellaneous land air etc. with identified sub-domains e.g. flying or working conditions or food handling and descriptors of the limitation e.g. unfit solo or specific aircraft type. Medical limitations are documented with various codes, as published in the Joint Service Manual (2).

11. The present AFCS approach to "worsening" – is set out in the legislative extract below:

Extract from The Armed Forces and Reserve Forces Compensation Scheme Order 2011

Injury made worse by service

(1) Subject to articles 11 and 12, benefit is payable to or in respect of a former member of the forces by reason of an injury made worse by service if the injury:

(a) was sustained before the member entered service and was recorded in the report of the medical examination when the member entered service,

(b) was sustained before the member entered service but without the member's knowledge and the injury was not found at that examination, or

(c) arose during service but was not caused by service, and in each case service on or after 6th April 2005 was the predominant cause of the worsening of the injury.

(2) Benefit is only payable under paragraph (1) if the injury has been worsened by service and remains worsened by service on—

(a) the day on which the member's service ends; or

(b) the date of claim if that date is later.

(3) Subject to paragraph (4), in the case of paragraph (1)(a) and (b), benefit is only payable if—

(a) the member or former member was downgraded within the period of 5 years starting on the day on which the member entered service;

(b) the downgrading lasted for a period of at least 6 months (except where the member was discharged on medical grounds within that period);

(c) the member or former member remains continually downgraded until service ends; and

(d) the worsening was the predominant cause of the downgrading.

(4) In the case of paragraph (1)(a) or (1)(b), benefit is not payable if the injury is worsened—

(a) within 6 months of the day service commenced; or

(b) 5 years or more after that day.

(5) In the case of paragraph (1)(c), benefit is only payable if the member—

(a) was downgraded within the period of 5 years starting on the day on which the member sustained the injury and remains continually downgraded until service ends; and

(b) the worsening was the predominant cause of the downgrading.

12. When a claim is made for AFCS worsening it can be considered at Service termination or beyond that date. It cannot be considered during Service (Article 9 (2) AFCS Order 2011). Worsening is recognised wherever any PULHHEEMS quality MES or DS is recorded as having a reduced grade compared with that at Service entry or, in the case of an injury which arose during Service, but was not caused by it, after the injury first occurred or disorder presented. Downgraded is also recognised where, as in Article 2 AFCS Order 2011, for medical reasons, a person undertakes a reduced range of duties but retains rank and pay. For many disorders and diseases worsening may occur over time simply as the natural course of the disorder. For an award to be made the evidence must support Service on or after 6 April 2005 as, on balance of probabilities, the predominant cause of the worsening.

13. Another issue which may be relevant to the "worsening" provision is the need in AFCS compensation determination to differentiate predisposition from the presence of a medically diagnosed disorder, especially with regard to the pre-Service period. If a

person is “predisposed”, a discrete medically diagnosable disorder is not necessarily present, although he may have symptoms and is at risk of developing a medically diagnosable disorder. From a legal perspective, in the AFCS it is not appropriate to automatically reject Service attribution where a discrete diagnosed disorder presents and is formally diagnosed for the first time in Service, even if symptoms have arisen earlier, pre-Service. Acceptance of a causal link, due to Service, may still be appropriate. Predisposition may be familial or a similar approach is appropriate where, as a result of overall pre-Service experience and non-Service related events, a person is “at risk” of developing a discrete diagnosable disorder. In some cases, for example, a stressor related psychological disorder, there is a dose threshold for discrete diagnosis which may build up through multiple traumas over time. In the meantime symptoms may be accumulating and increasingly functionally disabling.

14. A principle of the AFCS endorsed by Lord Boyce at his 2010 review was that the Scheme should focus on those most disabled due to service. The time limits in Article 9 (4) and (5) were introduced, to reflect that principle. Given the nature of recruit early phase training it is reasonable to consider that breakdown or worsening of a pre-existing disorder in that early period cannot be considered predominantly due to service. Similarly if a person has been functional at average or above, breakdown at five years plus from service entry is not predominantly due to service worsening of a pre-service problem, although it may be a new problem or episode, which may itself be due to service and attract an award.

15. The next section sets out a few case examples of common situations including asthma, musculoskeletal and mental health disorders where worsening may be an issue. **Please note these are all fictitious and designed to address particular issues referenced in the paper rather than to accurately reflect Departmental practice. They should be considered at face value and within their limitations.**

Example 1

JS aged 18 years joined the RAF in May 2005 with a view to being a pilot. At enlistment medical he declared no past history of note and was made P2. He had not been especially sporty at school but did some hill-walking (30-50 mile hikes) for his Duke of Edinburgh’s award with no reported ill effects. Four weeks into initial training he noticed some breathlessness after running and towards the end of rugby/soccer matches. 12 weeks later he reluctantly presented to the Medical Officer (MO) and finally was diagnosed with asthma. At home for some leave his mother recalled “wheezy bronchitis” after whooping cough when he was in Primary 1. His younger brother had eczema as a child which remitted aged 12. He was managed in service in primary care and with occasional use of inhalers he kept well passing all BFTs etc. He was not downgraded. In winter 2009 he had a period of adventure training in Scotland and developed a “heavy chest cold”. Despite antibiotics and oral steroids this was slow to resolve and he was left with significant wheeze, breathlessness etc. and medically downgraded P3. Within 6 months he was again P2. The next winter he again had a chest infection and post acute phase, in steady state he had rather poorer respiratory function and was made P3 permanent. Now clear about career limitations he was eventually medically discharged in April 2013.

Would you accept Service worsening here?

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Example 2

AB joined the Army aged 19 in 2009. At recruitment medical he said that he had mild asthma as a pre-school child and up to age 8. As a child he was diagnosed at a respiratory unit and thereafter treated by the GP but never used an inhaler regularly and was not routinely followed up either in primary care or at a respiratory clinic. He had never used a nebuliser nor been admitted to hospital and did not recall use of steroids at any time. He admitted to smoking ten cigarettes a day but said he was trying to stop. He denied previous skin trouble but said he had a brother who had problems with itch, weeping and cracked skin etc. The Civilian Medical Practitioner undertook further investigation, wrote to the GP and asked AB to keep a peak flow diary for a month. On review AB was accepted as fit for entry, P2. He enlisted and passed initial training (2010) and began electrical engineering training in early 2012. He much enjoyed this and was considered to be making excellent progress. As his training advanced he was required to use soldering material containing colophony and scrupulously followed the standard best practice exposure control requirements. However after a few months he was soldering more regularly and became aware that in the evenings he was short of breath on exertion and gave up playing football or going to the gym. Symptoms disappeared on holiday and at weekends. He had still not succeeded in stopping cigarettes. In the next few months he did less soldering, did not seek help and remained P2. In 2013 he went on winter adventure training and developed a lower respiratory chest infection. This was difficult to treat - there was associated bronchospasm. He was not admitted to hospital but regular inhaler use was added and by the end of the year he was made P3. He was seen by a consultant respiratory physician. Pulmonary Function tests confirmed marked and sustained deterioration in his function and he was diagnosed as having chronic irritant asthma. He initially required regular follow-up and maintenance according to British Thoracic Society Management guidelines level 3. He was still at work but with restricted duties including no soldering and was further downgraded to P7. He was recommended to change trade but declined to do so and was eventually medically discharged, P8.

Would you accept Service worsening here?

Example 3

RR was an infantryman who joined aged 24. He was tall with a long back and as a teenager although a keen footballer he frequently complained of low back pain. This usually resolved in a few days with rest and he rarely saw his GP and was not investigated. After he left school he worked for himself as a painter and decorator and continued to play amateur football at weekends. The bouts of low back pain continued – sometimes following clear strain or twist, or awkward lifting but sometimes apparently spontaneously. Episodes were not becoming more frequent so he rested and used over the counter medication. He joined up in 2009. He successfully negotiated initial training and passed into the field Army. About two years later on a promotion course route march/run with loaded bergan he had sudden onset of severe back pain. He struggled on but eventually had to seek help as he was finding it difficult to get out of bed in the morning because of the back pain. There was no referred pain or other bowel or bladder symptoms. Investigation was negative and specialist opinion diagnosed mechanical low back pain. He was treated with intensive physio but not downgraded. Over the next few months the episodes became more frequent and commanding and apparently spontaneous in onset or triggered by very minor strains e.g. lifting equipment/the baby and he was downgraded P3 and then P7 in 2012 and remained so until service release. He was attending his Personnel Recovery Unit and claimed in service in 2014 ahead of his final medical board. He had been ineffective in role for 18 months and was unable to do more than minimal physical activity. He could not attempt loaded runs, fitness tests etc. Imaging and neurological testing remained negative.

Would you accept Service worsening here? If the story were similar but…

Example 4

RR was a Royal Marine (RM) who joined aged 24. He was tall with a long back and as a teenager although a keen footballer he frequently complained of low back pain. This usually resolved in a few days with rest and he rarely saw his GP and was not investigated. After he left school he worked for himself as a painter and decorator and continued to cycle, run and play amateur football in evenings and weekends. He had always admired Special Military Units and increasingly had ambition to join up so he worked very hard at physical fitness. The bouts of low back pain continued – sometimes following clear strain or twist or awkward lifting but sometimes apparently spontaneously. Episodes were less frequent and again he rested and used over the counter medication. He joined up in 2009 and did not mention back pain. He successfully negotiated initial training. Following an active deployment to Afghanistan in 2011 but no specific injuries, about a year later on a promotion course route march/run with loaded bergan he slipped and fell awkwardly with sudden onset of severe back pain. He struggled on with all RM training and other activities but eventually, some months later had to seek medical help as the pain, which did not radiate and there were no bowel or bladder symptoms, was becoming more frequent and commanding. Investigation including imaging, and specialist opinion, diagnosed mechanical low back pain and no specific vertebral lesion. He was treated with intensive physiotherapy and initially not downgraded. Keen to be promoted he continued to carry out as much physical activity as he could. Over the

next year the painful disabling episodes became more frequent and commanding. He was downgraded P3 and then P7 in 2012 and remained so until medical discharge P8 in 2013.

Would you accept"worsening" here? In general does continued physical activity worsen low back pain, lumbar spondylosis or osteoarthritis of lower limb in general? Please see Musculoskeletal Disorders Part 1 paper in this 4th IMEG Report

Example 5

AB, an infanteer joined up in 2007, aged 18 after a spell of unemployment and no regular job since leaving school. Two older brothers were at college and he had always looked upon himself as a bit different and much less clever and successful. At Service entry he was enthusiastic for an Army career, physically fit and daring, and made P2. He did well in initial training and passed out into the field Army. He was deployed to Afghanistan in 2009. He looked forward to it but the tour was busy and three men were lost. He was not present but was close to one of them. He himself narrowly missed being involved in an Improvised Explosive Device (IED) explosion in which colleagues lost limbs. On return to UK he was noted by friends to be drinking more than previously, was much quieter and unwilling to socialise. He denied any problem. Just as he completed post tour leave he developed severe skin scaling and joint problems affecting scalp, trunk and limbs and swelling and arthralgia of knees and elbows. He was eventually six months later diagnosed with psoriasis. This failed to settle with standard treatment and he had PUVA and methotrexate was considered. He was downgraded first to P3 and finally as the disorder was not settling made P7. Although he volunteered no pre-service history at entry he now said that there was a family history of skin trouble and he remembered a scaly rash on arms and legs a few times as he was growing up e.g. when he was sitting the 11 plus. On these occasions the rash abated by the time he was seen by his GP and no diagnosis was made. His skin improved but his joints remained problematic and after developing low mood and diagnosed with adjustment reaction and being sick at home for a year he was made P8 and medically discharged.

What would you do about the claimed psoriasis? Was that due to or worsened by Service?

Example 6

In 2007 JR joined the Army from school aged 17. He had a difficult childhood. His parents split up when he was 4 and his mother had a history of depressive illness and alcohol misuse. He and his two brothers were several times taken into care and eventually he went to live with his grand-parents. His life improved in all respects and he was especially close to his grandfather who had been a regular soldier for 22 years. It was largely this example which led to his joining up. As hoped he loved the Army and did well in recruit training. A year after enlistment his grandfather died suddenly. He was distraught and despite good support from the chain of command, the unit MO and his peers seemed to take a very long time to get over this. He was not downgraded and declined to be referred to the Community Mental Health Team. He also defaulted on MO follow-up. In 2010 he requested transfer to be nearer his grandmother. As an Army wife she reassured him that she was managing and that she would be happy to see him as leave etc. permitted. Transfer was not granted. Over the next 6 months he became socially isolated and several times had to be talked out of going Absence Without Leave (AWOL) by his peers. Previously adamant that alcohol was not for him he began to drink heavily and alone and eventually was persuaded to seek help. He was made P3 in 2011 and initially supported re an alcohol problem but it then came to light that he was also gambling heavily and was in considerable debt. Seen by a consultant psychiatrist, major depression was diagnosed and he was hospitalized as a potential suicide risk and made P0. He made slow progress and after a year, ineffective, when he declined further treatment in a military setting. He was made P7 and medically discharged for follow-up as a civilian. A month before Service termination he claimed mental health disorder under the AFCS which he contended was due to chain of command failure to agree his transfer.

Would you accept Service worsening here? Was his illness due to or, worsened by service?

Example 7

RR, born 1986 did engineering at university and joined the Army in November 2007. He did well at RMA and quickly passed out into REME. He was sociable collegiate and observed by his commanding officers (CO) to have leadership qualities. In 2009 on his way to a course driving his own car and spending an overnight with an aunt near the course venue, he was in a motorway pile up. Ten vehicles in front of him were involved. He had only minor physical injuries but several cars were significantly damaged and the next day he discovered that a child and mother in the second row of the collision had lost their lives. He did not see their car or the impact. At first he recovered well physically and mentally but, he had a 6 year old niece (daughter of his sister) of whom he was very fond; he was also increasingly thinking about modern warfare and the implications of collateral damage and for the first time having some doubts about his career choice. Six weeks after the incident he admitted to friends he was having difficulty sleeping and occasional nightmares about the Road Traffic Accident (RTA). He was able to work and concentration, mood etc. were “normal”. Following discussion with his peers he sought help from the MO and, over

a few weeks and several visits the symptoms abated and by four months post incident he appeared well and functioning normally. No formal mental health referral or diagnosis was made and he was not downgraded remaining P2S2. He continued to work in his mainly administrative technical role. He shared with the MO that when he was about five, his mother was admitted in the night to hospital for several weeks. He woke up to find she had disappeared and was not allowed to visit. Following this he had always tended to be a worrier. In January 2011 he deployed to Afghanistan. He had a good tour exercising his skills as an engineer and received commendation from his CO. Three weeks before he was due to return to UK he, with six of his men was involved in an ambush. No one was killed but two men sustained multiple gunshot wounds. He was unharmed. His conduct of the incident in its immediate aftermath was exemplary but on return to UK after decompression in Cyprus on his post deployment leave, he gradually became low in spirits, irritable with poor concentration. He developed nightmares of the event and of the RTA and avoided news bulletins re the conflict or any trauma. He referred himself to medical attention on his return to duty in October 2011 and was eventually diagnosed with PTSD and downgraded P3. He was made P0 and treated with 12 sessions of cognitive behavioural therapy, with initially some improvement in function but that soon plateaued and an attempt at a GRoW programme in an undemanding job was only partially successful. He awaits a Medical Board to review his medical employability grading. He is still serving…

He claimed for PTSD under the AFCS. This was rejected as not due to Service. **Do you agree with that?**

Assuming he remains P3 or P7 or even P8 after the Medical Board and is eventually medically discharged or decides that as promotion may be compromised he wishes to leave, **would you accept worsening by Service on or after 6 April 2005 if considered at Service termination?**

Conclusion and recommendation:

1. We have carefully considered the AFCS concept of worsening including the background Defence policy to medical employability and deployability grading. We have also considered some fictitious exemplar cases including musculoskeletal and mental health diagnoses.

2. We conclude that the present approach, set out in Article 9 of the AFCS Order 2011 is reasonable medically and supportive of consistent equitable decisions. We find no evidence that it is likely to lead to unjust decisions. It reflects Armed Forces personnel and medical policy and practice of attaining and maintaining maximum functional fitness, employability and deployability. We also support the fact that AFCS claims determination is informed by factual documented employability grading evidence, rather than purely medical judgement.

3. Where Armed Forces personnel and medical policy and practice as set out in JSP 950, leaflet 6-7-7 are adhered to, cases where worsening by service on or after 6 April 2005 is the basis of the award should be uncommon.

4. We agree with the policy that where an award is made, the amount of benefit paid for injury or disorder due to AFCS service and that for injury or disorder worsened by service, should be the same.

5. We recommend that claims for worsening would benefit from mandatory medical advice as with the other categories identified following the recommendation by Lord Boyce in the 2010 Review (3).

6. IMEG should routinely monitor from 2019-20, final outcome annual rates and types of claims where AFCS worsening is claimed, accepted and rejected.

References:

(1) The Armed Forces Compensation Scheme Quinquennial Review (2016) MOD London

(2) Joint Services Publication 950 Medical Policy Part 1 vol 6 Occupational Medicine/Health Chapter 7 Medical Employment Standards Policy Leaflet 6-7-7 Joint Service Manual of Medical Fitness

(3) MOD 2010 The Review of the Armed Forces Compensation Scheme Cm7798 London