The Independent Medical Expert Group (IMEG)

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

December 2017

Topic 6 - Spanning

Key Points

1. As far as possible, given the marked differences between the War Pensions Scheme (WPS) and AFCS, we recommend approaches based on case facts likely to be documented, in service and medical records, leading to case determinations which are medically robust and defensible, understandable to claimants and administrators.

2. We consider decision-making in spanning cases, potentially challenging and advise that spanning cases should be added to the list of case types where medical advice is mandatory.

Introduction

1. This is the second of two papers, the other being on "worsening", which consider the medical aspects of the present approach to determination of two specific types of AFCS claim. As with "worsening", spanning was first drawn to attention in the Boyce Review and more recently by the QQR team. "Spanning" cases are identified at or beyond service termination and are where the person has served both before and after 6 April 2005. As a consequence they might have entitlement under both the WPS and the AFCS. Where an injury or disorder has been caused before 6 April 2005 entitlement and award under the WPS may be appropriate, while for causation on or after 6 April 2005 the AFCS is the relevant scheme. Although spanning cases should be a temporary phenomenon, at present, more than twelve years post-introduction of AFCS, ex-Service personnel with spanning service are increasingly claiming compensation. The purpose of this paper is to explore and recommend medically sound approaches to such claims. The findings will be of interest to policy colleagues, in particular, in relation to the legislation and also to scheme decision-makers, medical advisers and claimant representatives. For brevity this paper will use the phrase AFCS service to imply military service on or after 6 April 2005 when the AFCS applies.

2. Decisions in spanning cases should as always, be evidence-based, consistent and equitable, reflecting the case service and medical facts, contemporary medical understanding of causation and progress of injury or disorder and the relevant law. They need also to be administratively practical and understandable to claimants. As far as possible two awards and two appeal rights for the same disorder under both the WPS and AFCS should be avoided. Claims categories especially impacted by spanning Service include hearing loss, musculoskeletal/orthopaedic disorders involving both chronic attrition or overuse and acute trauma to joints/structures, and mental health problems.

3. The aim in spanning cases, where possible, should be to make a single award under one scheme, notifying one appeal right. While awards under both schemes are based on a causal link to service and both schemes are individual jurisdictions, with decisions based on evidence, there are innate differences between the two which are set out in the legislation, i.e. Service Pensions Order (SPO) 2006 for war pensions and the AFCS Order 2011:

- War pensions claims can only be made at or after service termination, while it is possible to claim under AFCS while still serving.

- War pension claims have no time limits, while AFCS has normal time limits of seven years along with late-onset provisions.

- War pensions assessment (and hence award) for accepted injury at earliest is from date of service termination. AFCS lump sums may be paid in service with any income stream, the Guaranteed Income Payment (GIP) paid from service termination for life.

- Assessment and award for war pensions is normally for a defined time period with wide gateways for both the pensioner and Secretary of State to request review. For AFCS a key principle is to make full and final awards as early as possible.

- War pensions are medically certified while AFCS is medically advised.

- War pensions standard of proof is "reasonable doubt" while AFCS is "balance of probabilities".

A Double compensation

4. When the AFCS legislation came in, in 2005, it was assumed that a person might first claim under the AFCS, i.e. while still in service, but could only claim war pension at and beyond service termination, i.e. second. To address that situation, a provision was introduced into the WPS to prevent double compensation for the same injury or disorder, i.e. the amendment said that if there was an award under AFCS there could not be one for the same disorder under the WPS.

5. In addition, although the AFCS includes a "worsening" provision, claims can only be made for AFCS worsening after the end of all service. It was thought that if an injury was accepted as attributable under the WPS, any subsequent later increase in disablement would also be accepted under that scheme, and so it was not necessary to introduce a similar exclusion in AFCS for disablement accepted under war pensions.

6. However an Upper Tier Tribunal (UTT) (equivalent of High Court and so binding) judgement (CAF/842/2011) established that these provisions were not robust in avoiding double compensation because causation was established in the two schemes using different standards of proof. The judge found that because war pensions have a lower standard of proof, AFCS worsening would still need to be considered. To address this, AFCS legislation was amended on 7 April 2014 to prevent payment for the same injury or disorder under both schemes.

B Suggested practical approaches to decision-making

7. The remainder of this paper suggests some principles and general observations to support medically sound decisions in spanning cases. This is followed by a few worked examples. In all cases it will be appropriate first to determine some case facts:

i) The service dates for all period of service from initial entry until final discharge.

ii) The duration of service periods, pre- and post- 6 April 2005.

iii) What is claimed? What is the contended service link, i.e. event, exposure, behaviour? Is it pre- or post- 6 April 2005?

iv) If a physical or mental disorder as opposed to an incident-related injury is claimed, is there evidence of when the disorder came into existence, its date of clinical onset or when the person first sought medical advice?

v) What are the claimant's medical employability gradings and dates over the total service period?

C Some general observations to bear in mind

8. 6 April 2005 is a wholly artificial date in operational and clinical terms. There may be no factual or medical information at or around it in a specific case. However, where a person sustains an injury or develops a disorder due to service before 6 April 2005, and serves on, is not being investigated or treated and is not medically downgraded on that date, it is reasonable to assume that any extant injury or disorder present on that date has a Nil or very low level of disablement or functional restriction or limitation. We suggest the principle of "taken as found" should then apply to any AFCS consideration. If we take someone into service or allow him or her to continue, we are accepting any vulnerability or susceptibility to develop a disorder.

9. Amongst the most common spanning claims are hearing loss. Since 1987 Service personnel have been able to take civil action against MOD with awards made for lapse of duty of care. From at least the introduction of AFCS, in line with wider UK legislation and best practice, we can assume the use of hearing protection in Defence industrial workshops, range training etc., as the norm. That means that unless there is positive evidence to the contrary we should not accept chronic industrial type noise exposure during AFCS service.

10. It is important in all claims, including spanning claims, to differentiate "predisposition" from "predestination". If a person is "predisposed", a discrete diagnosable disorder is not necessarily present, although he is at risk of developing one. From a legal perspective, it is not appropriate to automatically reject service attribution where formal medical diagnosis of a discrete disorder is first made in service even if the person had symptoms and/or previously sought medical help. Acceptance of a causal link to service may still be appropriate. If, on the other hand, something is predestined, it is inevitable and arises from constitutional factors regardless of external influences and so no entitlement or acceptance of attribution is due even with a low standard of proof as in war pensions, e.g. Huntington's chorea.

11. War pensions entitlement and assessment are determined at or beyond Service termination, regardless of when that occurs relative to 6 April 2005. The WPS legislation is the Naval, Military and Air Forces etc. (Disablement and Death) Service Pensions Order 2006, usually abbreviated to the Service Pensions Order (SPO) 2006. If someone leaves service on 31 October 2017, the "beyond reasonable doubt" Article 40 of the SPO standard of proof applies to war pension claims, from date of service termination for seven years, i.e. until 31 October 2024. To reject entitlement under Article 40 there must be positive evidence that there is no causal link to pre-6 April 2005 Service. It is not enough to have "no evidence of effect". There must be "evidence of no effect".

12. References in the legislation of both schemes to "Service" entry etc., means entry to "any" Service and similarly discharge date means discharge from "all" Service.

13. Finally, the assessment of disablement/disability under war pensions or AFCS, or for medical rehabilitation, is not an exact science. Overall assessment is determined and can rarely, if ever, be apportioned on the basis of aetiology, particularly with chronic exposures lacking dose measurements.

D Spanning Case Examples

Please note these are all fictitious and designed to address particular issues referenced in the paper rather than accurately reflect Defence practice. They should be considered at face value and within their limitations.

Hearing Loss Cases

14. Pure tone audiometry became widely available in the 1970s and the current military system of assessing hearing acuity was introduced in 1981. Reflecting the different operational requirements, principles are shared but slightly different standards apply to the three Services. The military approach to hearing and medical employability, including retention in service, does not depend on any particular level of hearing threshold but on the individual case facts and specialist otolaryngological and occupational health opinions. The military approach involves routine surveillance of overall hearing acuity, detection of the presence and progress of noise damage and the provision of hearing protection suitable for the individual and their circumstances. Allocation to a PULHHEEMS hearing standard is based only on hearing acuity. Pure tone audiometry is carried out at time intervals and, as required, clinically. Hearing acuity tested by pure tone audiometry at 250 Hz to 8 kHz is used to determine the PULHHEEMS category in each ear using the sum of the thresholds (dB) at low frequencies, i.e. 500 Hz, 1 and 2 kHz and high frequencies 3, 4 and 6 kHz.

The standards are as follows:-

	Low frequencies	**High frequencies**
H1	not more than 45	not more than 45
H2	not more than 84	not more than 123
H3	not more than 150	not more than 210
H4	more than 150	more than 210

Example 1

An infanteer served 1988-2007. In training in 1989 a colleague accidentally discharged his weapon causing acute acoustic trauma to his left ear. Hearing loss and tinnitus settled over time. He had an uneventful tour of Iraq in 2004/2005. He had a normal discharge and claimed in 2012.

- The legislation provides that his claim is deemed to be made to either scheme.
- It is for the Secretary of State to determine which scheme applies.
- In this case the facts as claimed are confirmed in the Service medical record and the case worker considers the claim to have been made under the War Pensions Scheme.
- At service termination in 2007 he was H1H1 i.e. good hearing in both ears.
- Article 40 SPO applies and on the facts of the case, at service termination the medical adviser certified entitlement to acute acoustic trauma assessed at 1-5% for ongoing tinnitus (mild) with no assessable hearing loss. A gratuity was paid.
- Appeal rights under the SPO were notified.
- There was no AFCS award.

Example 2

An infanteer served 1988-2007. Service to 6 April 2005 was uneventful. He had a busy Iraq tour and in June 2005 suffered a blast injury to his right ear. He was medically discharged in 2012 for a musculoskeletal (MSK) condition. He claimed compensation for hearing loss while still serving in 2010. He made his in-service claim under the AFCS and Service medical records confirmed his history and medical support and follow-up.

- His in-service claim was made under the AFCS.
- The facts of the case as claimed were documented.
- Pure tone audiometry dated December 2005 was unremarkable in pattern.
- At claim he was H2H2 with evidence of asymmetrical high frequency sensorineural hearing loss.

- He was awarded blast injury to ear from AFCS Table 7 with appeal rights.

- No entitlement under the WPS and no appeal rights.

Example 3

A gunner, WO1 born 1960 served 1976-2011. He had several deployed tours to Iraq (2003, 2004, March 2005) and Afghanistan 2006 but did not experience any identifiable acoustic trauma or blast incidents from the 2006 tour. He complained of hearing loss which he related to early weapons training and general weapons noise in Iraq. At service entry he was H1H1 (forced whisper test). He was downgraded H2H3 after 2001 but allowed to deploy with restrictions, e.g. base areas and use of double hearing protection. He said he did not use hearing protection in early years but was meticulous about it after 2001. He was not medically discharged. At service termination in 2011, he was again H2H3. He claimed hearing loss in 2009. The audiometric pattern was suggestive of bilateral noise-induced sensorineural hearing loss. The left ear deficit was slightly greater than right ear.

- He claimed expressly under AFCS.

- His long pre-2005 service was recognised as well as his claims history.

- The SofS accepted chronic noise exposure in the first service period but not in the second, i.e. post 6 April 2005.

- There was sparse audiometry in WPS service until 2001 and then a few audiograms which showed gradually accruing sensorineural hearing loss with no particular pattern.

- At service termination he had hearing threshold 33 dB averaged over 1, 2 and 3 kHz right and 42 dB averaged for the left ear.

- He served 27 years before AFCS and was notified in a letter that his claim would be considered at service termination under WPS.

- The history, audiometric pattern and rate of increase of hearing loss led eventually at service termination to certification under SPO of bilateral noise-induced sensorineural hearing loss assessed at Nil final.

- He was given War Pension appeal rights and no notification/appeal rights under AFCS.

Example 4

Cpl B was an RAF mechanic. He served 1976-2011 when he was discharged with hearing loss. He was first noted to have hearing problems allegedly due to hangar noise

in 2003 and was downgraded H3H3 so he was not fully deployable and only deployable in any role/location with double hearing protection. He twice after 2005 deployed to Iraq and Afghanistan and for, at least one period during the Afghanistan tour, he was servicing planes by day and his accommodation was next to noisy generators. He did not however receive regular post-tour surveillance. One audiogram in 2007 showed H3H3. He was not screened after Afghanistan but picked up in 2009 at his age 50 medical. He was H3H4 with average threshold of 50dB averaged over 1, 2 and 3 kHz (right) and 52dB left. This was shown at audiogram dated 12 December 2010. He was medically discharged in 2011.

- The SofS accepts noise exposure before and after 6 April 2005.
- No evidence of acute acoustic trauma.
- Service where the War Pensions Scheme applies was 1980-April 2005.
- There were several audiograms confirming the pattern of developing bilateral noise - induced hearing loss.
- He remained H1H1 or H2H2 until 2003 when he was H3H3.
- Audio in 2007 showed some slight further deterioration in hearing thresholds but he was again within H3H3 grading.
- The final audio, in 2011 said to be reproducible and repeatable was H4H4.
- The thinking here is that this man was noise-exposed across his service and so needs to be considered under both schemes.
- In the absence of information on noise dose across the service period it is too simplistic to simply identify the “predominant cause” by service length. By his own account post-2003 service was noisier.
- WPS assessment must apply from service termination where, because noise injury stops when the person is removed from the noise, the assessment in this case will apply from actual service termination but based on the audiometric hearing threshold at or around 5 April 2005.
- No acoustic trauma so the compensation threshold applies.
- Bilateral noise-induced hearing loss was certified as attributable to WPS service and assessed at Nil final. Appeal rights were given.

- All sensorineural hearing loss was then accepted under AFCS.

- Apportionment of loss between the two schemes would result in no award under either scheme and would be manifestly unfair.

- The reasons for decision need to explain this reasoning/approach very clearly.

- With two accepted injuries under two schemes, exceptionally, he will have appeal rights under both schemes.

E Musculoskeletal Disorder/Traumatic Injury

Example 1

A Royal Marine SSgt, born 1965, served from 1982 – 2012 when he was medically discharged with a principal invaliding disorder of low back pain. The medical records make reference to short-lived episodes of low back pain regularly from 1990. There was no identifiable discrete incident, but he had several episodes of deployed service in the Gulf 1990/91, the Balkans in 1996/7 as well as Iraq 2003. Usually, symptoms became troublesome on return from deployment or following a training exercise/"yomping", etc. with loaded bergens. He was not downgraded in WPS service and was treated with physiotherapy and simple analgesia, and later he carried out his own exercises without medical intervention. In 2007 in Afghanistan he was on the edge of an IED blast and fell, injuring his lower back. It did not come to immediate medical attention but on return home until service termination he complained of more frequent and more severe episodes of low back pain. The pain did not radiate and neurological examination was normal. He was investigated with X-rays negative, but MRI showed mild generalised signs of degeneration throughout the lumbar spine. He was treated by intensive physiotherapy and facet injection and engaged fully, but he failed to improve significantly and was progressively downgraded from 2008. First he was made P3 then P7 and on restricted duties. At service termination, having been advised against surgery, he was awaiting an appointment at a pain clinic.

- This man had 30 years physically demanding service of which 23 years was covered by the WPS.

- While symptomatic during pre-2005 service no formal diagnosis was made, clinical examination was normal and he was not downgraded.

- Similarly, while there was an event-related injury in 2007 in Afghanistan, the evidence is that this was primarily soft tissue.

- Clinical examination in 2008 was normal and neuroimaging by MRI showed no focal bony damage as might be expected secondary to trauma, but rather generalised lumbar degenerative change likely to signify more cumulative load damage.

- His case was considered at service termination and on the history, and under Article 40 SPO, the medical adviser certified lumbar degenerative change attributable to service.

- An appeal right was given.

- There was no entitlement under AFCS.

What if the 2009 incident had resulted in prolapsed intervertebral discs with neurological signs and extending over several levels of vertebrae which required surgery in 2010 and again led to invaliding?

- On these case facts it would have been reasonable to take his back symptoms pre the 2007 incident as predisposing features.

- We could then go on to accept all back disablement under AFCS using a descriptor from Table 2. This would take account of the spine pathology, clinical neurological signs and surgery and attract a GIP.

- An element of the AFCS award would take account of lumbar OA present and subsequent to the traumatic injury.

- An appeal right would be given under AFCS.

- No entitlement or award under SPO.

- An alternative, in view of his long Service, might be to give lumbar spondylosis attributable under the Service Pensions Order assessed at Nil Final with all disabling functional effects accepted under AFCS as above.

Example 2

AB is in the RN and a submariner engineer. Born 1980, he served from 2000 and is still serving. Pre- service, he was a keen amateur athlete and suffered recurrent right knee pain. Radiologically and clinically no discrete pathology was identified and by age 17 he was asymptomatic, and similarly at service entry aged 20 years. He therefore did not report the pre-service knee pain at service entry. He passed all fitness tests in training and subsequently continued to be fit, taking part successfully in all physical training and representative team sports. From 2000-2005 he was P2L2. In 2007 he sustained a right knee twisting injury at football during an organised game. He was first treated conservatively. After the acute phase he did not attend medical centre, nor was he downgraded. In 2012 he again twisted the right knee at football and gave a history that his symptoms had not completely settled from 2007. He was downgraded P3 L3 in 2013. He came to arthroscopy in October 2014 when he was found to have a right knee meniscus bucket handle tear and the tibial platform showed grade two osteoarthritic

changes. The meniscus was removed arthroscopically and tibial cartilage tidied up. He remains P3 (September 2015) and has now claimed under AFCS.

- From age 17 (1997) until 2007 there were no complaints and apparently full function.
- This suggests the pre-service pathology was one of the juvenile osteochondroses which usually remit as the skeleton matures.
- In 2007 we have an incident-related injury but no formal diagnosis. He was not downgraded.
- In 2012 he had another injury in an organised game, when he then said 2007 symptoms had not fully resolved.
- He was then downgraded and remained so at date of claim.
- He was investigated and required operative examination and treatment.
- He was given an award under Table 9 AFCS Musculoskeletal injuries.
- Because no investigation nor discrete diagnosis was made pre or in service pre 2005, no entitlement was given under WPS. He was assumed only to be predisposed to further injury/symptoms.
- AFCS awards in Table 9 include any associated expectable consequential osteoarthritis.

F Mental Health Disorders

In both schemes, no award is made for symptoms alone but only for discrete diagnosed disorder. For the SPO this requirement is a matter of case law, not legislation and specialist diagnosis is preferable but not required. For AFCS, on the other hand, the legislation provides that awards are made only for discrete diagnosed disorders and must be made by a consultant psychiatrist or clinical psychologist. Neither scheme accepts alcohol-related injury or injury from the non-therapeutic use of drugs. Both schemes have late onset/delayed onset presentation arrangements.

Example 1

CD is a fusilier. Born 1970, he joined up in 1988 and served in the Balkans. There was no pre-history nor family history of mental health problems, but he had a difficult tour on account of civilian and child casualties and on return to UK he began to drink heavily and run into relationship difficulty at home. Eventually he was persuaded to get help and was diagnosed as adjustment reaction in 1996. He was treated with Cognitive Behavioural Therapy (CBT) and made good progress, returning to full fitness P2S2 within 24 months. He did well in his career, was promoted and went to Afghanistan as a platoon Commander in 2007. The 2007 tour was unremarkable but he redeployed in

2010 when three men and the Commanding Officer (CO) were lost from his regiment. After coming home he again started to drink and was very reluctant to seek further help, fearing a negative impact on further promotion. His wife gave him an ultimatum re treatment. In 2013 he was diagnosed with PTSD and depression. There was suggestion of self-harm and he continued to misuse alcohol, but often denied this. He found it difficult to engage with CBT or Eye Movement Desensitisation Therapy (EMDR) in military service and did not complete an adequate course of best-practice treatment. He was angry and was downgraded unfit to bear arms or work for more than a year. A Medical Board dated April 2016 recommended P8 medical discharge. The invaliding disorders were PTSD, alcohol misuse and depressive disorder. He deferred rehabilitation but said he would engage with civilian mental health services for the sake of his marriage and children. Transition from Defence Medical Services to his local NHS was arranged. He claimed these disorders under the AFCS. Run out date November 2017.

- He has long service and documented mental health symptoms during pre-2005 service, and a formal medical diagnosis. The evidence is he responded well to treatment.

- At service termination this adjustment disorder could be considered under the WPS but the history and that diagnosis suggests that residual assessable disablement from that formal diagnosis is unlikely.

- Its existence will however have predisposed him to further symptoms and disorder. His invaliding disorders are confirmed as PTSD, depressive disorder and alcohol misuse.

- The history confirms that PTSD and co-morbid depressive disorder are due on balance of probabilities to AFCS service. Alcohol misuse is excluded from the schemes.

- Under the SPO an option would be to accept adjustment disorder attributable to service. Assessed at service termination, given the documented case facts and the natural history of adjustment disorder, this would be assessed at Nil.

- His PTSD and depressive disorder would be accepted under AFCS Table 3.

- The award would be interim.

- Although case formulation records two diagnoses in this case, AFCS uses generic descriptors which cover, under one descriptor and award, all functional restriction and limitation resulting from all diagnoses for the appropriate duration. (This issue is further discussed in the QQR response section of this fourth IMEG report).

Example 2

DD is in the RAF. She joined in 1996, graduate entry aged 22, and attended officer training at RAF Cranwell. She was quickly promoted and had glowing reports. She had deployed service to Sierra Leone and in January 2002 attended training camp in Canada where she sustained a fractured ankle skiing. There were complications and she required multiple operations, and it was not until September 2003 that she was fully upgraded. During that time she complained of low mood and was seen by a consultant psychiatrist who felt this was reactive to her injury and no discrete diagnosis was present. She recovered by mid-2004 but suffered reversal of mood, apparently out of the blue, and including thoughts of self-harm in December 2005. She had family troubles around this time. Reluctantly, she again sought help and was seen a few times and given anti-depressants. She continued to function at work in an admin/personnel-type role and by July 2007 was recovered. She was not downgraded or on restricted duties. She began preparation for deployment to Afghanistan in late 2011. She looked forward to this because of the likely positive impact on promotion but on tour, starting in July 2013, she was very busy because of short staffing, and complained of exhaustion. She was sent home in October 2013 after four months and over the next few months became increasingly depressed. She remained under medical care and was finally diagnosed with bipolar disorder in October 2015. A distant family history was revealed. She was retained in service during treatment but made slow progress and was progressively downgraded to P7. She is to be medically discharged in March 2018 to continue treatment in a civilian environment. The invaliding condition is bipolar disorder. Rehabilitation and resettlement deferred. She has now claimed under the AFCS.

- This lady, born 1974, will have completed 22 years service at service termination.
- Pre-service she enjoyed good mental health and no history of symptoms.
- During the nine years of pre-2005 service she had a serious service-related ankle injury which will be for acceptance under the WPS.
- There were complications and treatment and rehab was prolonged and accompanied by low mood, but no discrete diagnosable mental health diagnosis was made.
- All awards for injury or physical disorder under the AFCS include an element for mental health symptoms, short of a discrete diagnosable disorder.
- Eventually she made a good and full functional recovery.
- In 2005-7 she had another bout of low mood, apparently triggered by family issues. Again this remitted.
- In 2013 she deployed to Afghanistan. She was enthusiastic and looked forward to it but the tour was demanding and she became exhausted and had to be sent home. She became increasingly depressed and in

October 2015 a diagnosis of bipolar disorder was made.

- She has been downgraded since late 2014.
- Treatment is ongoing and she is to be medically discharged in March 2018, S8P8.
- By its nature and given the case facts bipolar disorder is not due on balance of probabilities to AFCS service.
- The time course of events will preclude acceptance of worsening under AFCS.
- Given the history, the disorder can also be considered under Article 40 SPO.

Conclusion and recommendation:

1. We have carefully considered the issues raised by spanning service including the marked differences between the two no-fault compensation schemes.

2. As far as possible we have tried to recommend approaches based on case facts likely to be documented and which should lead to case determinations which are robust and defensible.

3. A particular issue is apportionment of disablement or functional compromise between the two schemes and the fact that that may not be scientifically possible.

4. Where, as with example 4 in the Section on hearing loss, apportionment on the basis of evidence is possible, any approach must also deliver a just outcome. We consider that this issue is most likely to arise in hearing loss cases because of the hearing compensation threshold found across UK no-fault personal occupational injury schemes, i.e. Industrial injuries, WPS and the AFCS.

5. We consider reasonable, fair, robust and defensible decision-making in spanning cases is potentially challenging and advise that spanning cases should be added to the list of case types where medical advice is mandatory.

6. IMEG should monitor from 2019-20, final outcome claims rates and disorder types of spanning cases.